TRAUMA FOCUSED COGNITIVE BEHAVIORAL GROUP THERAPY FOR ABUSED CHILDREN WITH POST TRAUMATIC STRESS DISORDER: THE CASE OF KECHENE CHILDREN'S HOME AND OPRIFS

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ABSTRACT

*The high prevalence and the devastating negative consequences of sexual and physical abuse initiate research inquiry in to the treatment aspect of the problem. This study examined whether trauma focused cognitive behavioral group therapy is effective in treating either sexually or physically abused children in two NGOs namely Kechene Children's home and OPRIFS. The study was a control group pre test post test quasi-experimental design. Sixty female participants aged 8 to 18 were selected purposefully based on inclusion criteria. They were divided in to two groups (treatment group and control group) which were made equivalent in terms of their score of child post traumatic stress symptoms scale and type of abuse they experienced. The treatment group received TF-CBGT for 3 sessions a week for a total of 12 sessions. Child posttraumatic stress disorder symptoms scale (CPSS) was used to measure post traumatic stress symptoms of participants. Test was conducted before the treatment, just after the treatment and 15 days after the treatment. Results of dependent t-test indicated that, participants engaged in treatment group showed statistically significant reduction in PTSD symptoms (df=29 t=**2.618)** from pre to post test while the control group did not. The therapy gain/outcome was maintained at follow up measure. Independent t test indicated that the mean CPSS for the control group and the treatment group was statistically significant at post test (df=58 t=2.068). There was no statistically significant difference in post traumatic stress symptoms mean score between different types of abuse (sexual and physical) and age groups (younger children aged 9 to 12 and teenagers aged 13 to 16) both before and after therapy. It is recommended to conduct a large scale study with more sample size and diversity to expand the findings of this study.*

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ACRONYMS AND ABBREVIATIONS

CBT	Cognitive behavioral therapy
CCT	Child centered therapy
CPSS	Child post traumatic stress disorder symptoms scale
CSA	Child sexual abuse
N	Number
OPRIFS	Organization for Prevention Rehabilitation and Integration of Female Street Children
PTSD	Post-traumatic stress disorder
REBT	Rational emotive behavior therapy
SD	Standard deviation
TF-CBT	Trauma focused cognitive behavioral therapy
TF-CBGT	Trauma focused cognitive behavioral Group therapy
UN	United Nations
USA	United States of America
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

1.1 Back Ground of the Study

Sexual and physical abuse against children and adolescents are major public health and social problems around the world. According to world health organization estimates, 20% of females and 5 to10% of males in the general population reported child sexual abuse (World Health Organization, 2002). The overall prevalence of physical abuse is estimated to be 10 to 25% in the general population (Carr, 2006). Child physical and sexual abuses occur in all cultural, socio economic, educational, racial and ethnic groups. This kind of violence may cause a number of adverse effects in the victim's physical cognitive, emotional and social development. The problems and symptoms that have been associated repeatedly with childhood sexual abuse and physical abuse history are often over lapping. Among these overlapping symptoms the most common are symptoms of posttraumatic stress disorder, low self-esteem and guilt, anxiety, depression and interpersonal dysfunction (Carr, 2006).

Child abuse or child maltreatment includes all forms of physical and emotional ill treatment that results in actual or potential harm to the child's health, development or dignity (World Health Organization, 2004). This broad definition includes sexual abuse, physical abuse, emotional abuse, neglect and negligent treatment and child exploitation. Among these sexual abuse and physical abuse are the most disastrous and well studied (Saunders et al., 2004). Sexual abuse is defined as sexual activity with a child or adolescent that he/she does not fully understand, to which he/she is incapable of consenting, or that violets social taboos (Glasser, 2010). Child physical abuse refers to deliberately causing physical damage or pain on a child.

The physical injury may result from many different acts including hitting, kicking, slapping, burning choking, throwing, whipping and/or padding (Carr, 2006).

As mentioned above both sexual abuse and physical abuse are frequently associated with various types of psychological or mental disorders. However, PTSD is assumed as the best conceptualization of disturbance that occurs after child abuse in many researches. Studies have shown that almost half of sexual abuse survivors will develop PTSD symptoms (Hamblen, 2003). It has been suggested that, this is due to the frequent presence of various traumatizing factors during or after sexual abuse like interpersonal violence, physical injury and fear of dying. Many studies also indicate that physical abuse frequently leads to post traumatic stress disorder since it involves both physical and psychological trauma as a result of sudden and brutal attack on a child who cannot defend him/her self (Briere, 1992).

Various efforts have been made worldwide to prevent or reduce child sexual and physical abuse. United Nations (UN) convention on child rights insures children's rights of provision of services, participation in society and rights of protection and care. The role of criminal justice system is significant in discouraging the perpetrators behavior, reinforcing the low and providing relief for the victims. Efforts are also being made by advocates to create public awareness regarding the child maltreatment. Various programs are developed and implemented in different countries to prevent or minimize child abuse. Researchers have made considerable contributions to understand various aspects of the issue, like the prevalence, causes and consequences of violence against children.

As far as intervention is concerned understanding the nature and extent of abuse and neglect and their consequences is important to the design of treatment programs. Many treatment programs and models have been developed to specifically deal with the psychological problems

of children who have experienced sexual as well as physical abuse. Some of them include abuse focused cognitive behavioral therapy, play therapy, music therapy, art therapy, non directive supportive therapy, developmental touch therapy and trauma focused cognitive behavioral therapy. However, the effectiveness of these therapy modalities is yet to be investigated.

The high prevalence of sexual and physical abuse and the negative psychological consequences initiate researchers to investigate the effectiveness of psychotherapy in treating victims. One Meta analysis has summarized various research findings on psychotherapy of abused children (Skowron & Reinemann, 2005). This study has concluded that cognitive behavioral therapy was relatively more effective than other treatment modalities, and recommended more researches and replications with more rigorous research designs. In addition, it indicated that trauma focused cognitive behavioral therapy (TF-CBT) was more effective in reducing symptoms of post traumatic stress disorder (PTSD) and restructuring dysfunctional beliefs which accompany various psychological disorders.

The field of empirical research into the psychological treatment of children who have been sexually and/or physically abused is relatively new, only few studies can be mentioned before1980. In Ethiopia few research works have been carried out about child sexual and/or physical abuse in general not to mention the treatment aspect in particular. More recent research worldwide has tended to focus on cognitive behavioral therapy (King, 1999). Important questions remain about the efficacy and effectiveness of different psychological treatments in Ethiopian context. The aim of this study is to assess the effectiveness of cognitive behavioral group therapy in the treatment of post traumatic stress symptom of sexually or physically abused children.

1.2 Statement of the Problem

As mentioned above, sexual and physical abuse of children are a prevalent social and public health problems around the world including developing and the developed nations. Even though large scale nationwide studies have not yet been conducted in Ethiopia, some small scale studies conducted in various parts of the country indicate that there is high prevalence of sexual abuse. For instance, in one study 38.5% of the sample who are students reported that they have experienced sexual abuse at least once (Gobena, 1998).Physical punishment (corporal punishment) of children is culturally accepted which increase the incidence of physical abuse in our culture. The negative consequences of child physical and sexual abuse can get even worse (exacerbated) by wide spread poverty and HIV Aids.

Ethiopia has ratified the convention on the rights of the child which entitles children protection from all forms of abuse until age 18. The criminal code of Ethiopia has a number of protective provisions against child abuse. In addition to the legal provision, various efforts have also been made to raise public awareness on the issue of child abuse by some NGOs and the media.

However, little or no efforts have been made to address the psychological needs of the victims of child physical and/or sexual abuse. For instance, there are few counselors if any trained in the field of child counseling. More importantly, it is not known to what extent the treatment approaches developed in western countries work to Ethiopian cultural and socio economic situation. Research in USA, Europe and other parts of the world indicate that cognitive behavioral therapy is one of the most empirically supported therapy technique among the many therapy techniques that are developed to deal with the needs of abused children (National Child

Traumatic Stress Network, 2008). However, efforts have not been made to adopt or investigate the effectiveness of cognitive behavioral therapy in Ethiopian particular situation.

Based on the above discussion, the research attempted to answer the fallowing research questions:

- ✓ Is there statistically significant difference in posttraumatic stress symptoms from pre-to-post treatment measures in the treatment group (abused children who were treated with trauma focused cognitive behavioral therapy)?
- ✓ Is there statistically significant difference in posttraumatic stress symptoms from post treatment (just after the treatment) to follow up (15 days after the treatment) measures in the treatment group? In other words, is the treatment gain after TF -CBT maintained at follow up measure?
- ✓ Is there statistically significant difference in posttraumatic stress symptoms from pre-to-post treatment measures between treatment group (abused children who were treated with trauma focused cognitive behavioral therapy) and control group?
- ✓ Is there statistically significant difference between the post traumatic stress symptoms score of the children who experienced physical abuse and those who experienced sexual abuse at pre test and post test one?
- ✓ Is there statistically significant difference between the post traumatic stress disorder symptoms score of the younger children (9 to 12 years of age) and the teenagers (13 to 16 years of age) at pre and post test one?

1.3 Objectives

The general objective of the study is to examine the effectiveness of trauma focused cognitive behavioral group therapy (TF-CBGT) to treat post traumatic stress symptoms of children who have experienced either physical or sexual abuse.

The specific objectives are:

1. To examine whether there is statistically significant difference in post traumatic stress symptoms from pre-to-post treatment measures in the treatment group.
2. To examine whether there is statistically significant difference in post traumatic stress symptoms from post treatment to fallow up measures in the treatment group.
3. To investigate whether there is statistically significant difference in post traumatic stress symptoms from pre-to-post treatment measures between the treatment group and control group.
4. To explore whether there is statistically significant difference in post traumatic stress symptoms measure between sexually abused children and physically abused children before and after treatment.
5. To explore whether there is statistically significant difference in post traumatic stress symptoms measure between younger children (9 to 12 years) and teenager (13 to16 years) before and after treatment.

1.4 Significance of the Study

The researcher hopes that the results of the study are helpful in many ways. Trauma focused cognitive behavioral therapy was provided to abused children as part of the study which would help children recover from the symptoms. The findings of the study are valuable for counselors and social workers working with sexually and/or physically abused children by providing

relevant information. It also encourages researchers to investigate TF-CBT as well as other psychotherapies in the field of child abuse. Generally it plays an important role in adapting, developing and using TF-CBT in Ethiopian context.

1.5 Delimitation of the Study

This is quasi-experimental study on the effectiveness of trauma focused cognitive behavioral group therapy. This study is limited only to examining posttraumatic stress symptoms of children who have experienced either physical or sexual abuse and is conducted on a sample of 60 children.

1.6 Operational Definition of Terms

A Child: For the purpose of this study a child is defined as a human being 18 years of age and below.

Child abuse: Child abuse in the context of this research is used to refer to child sexual abuse as well as child physical abuse.

Child Sexual Abuse: for the purpose of this study child sexual abuse is defined as sexual activity (rape and child molestation) involving persons, 18 years of age or younger perpetrated by an adult. Sexual activities can include situations where there is contact (like touching, caressing, oral sex or sexual penetration) as well as no contact (like voyeurism, verbal harassment, pornography, and exhibitionism).

Child physical abuse: is defined as injury to a child or adolescent by a parent or other care giver after intentional physical contact. The physical injury may result from many different acts including hitting, kicking, slapping, burning choking, throwing, whipping and/or padding. It may cause bruises, broken bones, burns etc on the victim child. It does not include physical injury due to sexual activity.

Posttraumatic stress symptoms: In the present study is a debilitating psychological condition caused by a major traumatic event of sexual abuse and/or physical assault. Symptoms include, but are not limited to: nightmares, flashbacks about the incident, low startle threshold, difficulty sleeping, difficulty concentrating and loss of desire to do things the individual formerly enjoyed, isolating, and avoidance of reminders of the trauma.

CHAPTER TWO

LITERATURE REVIEW

In order to provide a broader context for the study relevant literature in the field of child abuse is reviewed. The literature review part is divided in to four parts: sexual abuse, physical abuse, cognitive behavioral therapy and psycho therapy research. Sexual and physical abuse definitions, prevalence, effects, predisposing factors and their relationship to PTSD are reviewed. Similarly CBT history, view of human nature, basic premises, goals and process, techniques, are discussed. TF-CBT is discussed including its components and application in group settings. Finally, literature in the area of the effectiveness of child abuse psychotherapies is reviewed including the effectiveness of TF-CBT.

2.1 Child Sexual Abuse

2.1.1 Definition of child sexual abuse

Child sexual abuse is defined by the type of activities considered being sexual and the circumstances considered to constitute abuse (Claire and Donna, 2006).However, the type of activities considered sexual and the circumstances that constitute vary across cultures, historical time and disciplines resulting in variety of definitions. Glasser (2010) mentioned the definition given by Schechter & Roberge (1976) as the best working definition which stated:

> *"Sexual abuse is defined as the involvement of developmentally immature children and adolescents in sexual activities they do not truly comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles."*(p.5)

Child sexual abuse is an umbrella word that includes varied forms of abusive acts. Child sexual abuse may or may not involve contact with the child and the perpetrator may or may not use force in order to get the child engaged in the abuse. Sexual activities can include touching, caressing, oral sex or sexual penetration (genitalia, anus). Sexual abuse also includes situations in which there is no physical contact, such as voyeurism, verbal harassment, pornography, and exhibitionism. Whether the victim gives consent or not, whether the perpetrator employ, persuade or coerce the victim it is considered an abuse if the victim is less than 18.

2.1.2 Prevalence of child sexual abuse

There are numerous studies which show the prevalence of child sexual abuse. However the statistics varies according to the type of the sample used (e.g., clinical vs. community samples), the definition used, method of obtaining information (e.g., telephone survey vs. clinical interview), and age of respondent. Generally reported cases are fewer than actual incidences since due to secrecy many cases remain unreported.

Varied and large amount of studies show the prevalence of sexual abuse in USA which may not represent the prevalence in developing countries, particularly Ethiopia. The statistics is alarming in USA, according to national child traumatic stress network estimates, one in every four girls and one in every six boys are victims of some kind of sexual abuse before the age of 20 (National Child Traumatic Stress Network, 2008).An international prevalence statistics come from world health organization (2009) which reports a mean rate of 20% for females and 5-10% for males having experience of childhood sexual abuse.

Research findings suggest high sexual abuse prevalence in Ethiopia. A study sponsored by World health organization was conducted in rural part of Ethiopia called Meskan and Mareko. In the study 3110 woman aged 15-49 were interviewed, 7% of them were sexually abused before

age 15 while 17% reported their first sexual encounter was forced (World healtn organization, 2005). Another study conducted on school girls revealed that 38.5% experienced sexual abuse (Gobena, 1998).

2.1.3 Predisposing factors of child sexual abuse

Various factors related to the child, his/her family, the perpetrator that predisposes children to sexual or physical abuse are identified by researchers. Some of the child related factors associated with child abuse include lack of strength, lack of assertiveness, fear of the consequences of not engaging in abuse, physical or mental disability (Carr, 2006).

Many family or marriage related factors are associated with child sexual abuse. Under organized families where there is chaotic relationship among the members and over organized families where there is dissatisfaction and avoidance of conflict may predispose the child to sexual abuse (Carr, 2006). The absence of one or both parents is a significant contributor and the presence of step father doubles the risk for abuse of female child (Hale, 2003). Generally, families in low socio economic status, alcoholism, presence of other abused child, unemployment poor housing, single parenthood, low educational level are all risk factors for child abuse (Hale, 2003).

2.1.4 Effects of child sexual abuse

Sexual abuse is well studied compared to other forms of child maltreatments and its negative consequences are well documented. Sexual abuse has a devastating effect on the victim's physical, cognitive, emotional and social life both in the short term and in the long term. However, there is great individual variation depending on the risk factors and protective factors that the child will encounter (Gilgun & Sharma, 2008).

Child sexual abuse may cause physical/medical problems like physical injury, sexually transmitted disease, headaches and stomachaches. Frequently indicated psychological effects include post traumatic stress disorder, depression, low self esteem, anxiety, personality disorders and dissociative disorders. They also might show behavioral problems like sexualized behavior, substance abuse, eating disorder, sexual dysfunction, sleep difficulties and school problems (Carr, 2006).

2.1.5 Sexual abuse and cognitive distortions

Either sexual abuse or physical abuse occurs on a child who cannot physically or psychologically resist or defend against the abuse. The child has lesser social status, smaller physical size and lesser strength than the adult abuser, making resistance impossible or unsuccessful. This leads the child to perception of helplessness and chronic danger which in turn results in many cognitive distortions that give rise to different psychological disorders (Briere, 1992).

Flinkelhor and Browne (1985) list four troumagenic dynamics that they think are especially destructive which are traumatic sexualization, stigmatization, betrayal, and powerlessness. Particularly, stigmatization, betrayal, and powerlessness are cognitive factors that arise from certain forms of sexual abuse or certain psychological events. They alter the child's cognitive and emotional orientation to the world distorting a child's self concept and affective capabilities (Briere, 1992).

2.1.5 Sexual abuse and post traumatic stress disorder

Post Traumatic Stress Disorder (PTSD) is an anxiety disorder or condition that develops after someone has experienced or witnessed a life-threatening or traumatic event; such as combat, natural disasters, terrorist incidents, serious accidents or physical or sexual assault. This

event involved actual/perceived death or serious injury and caused an intense emotional reaction of fear, hopelessness, or horror PTSD usually begins immediately after the traumatic event, but it can start later, even years later (Colman J. , 1984).

In order to diagnose a person as having post traumatic disorder, certain criteria should be met. First, the person should have experienced or witnessed a traumatic event like natural disaster or interpersonal violence. However, all people who have experienced traumatic event do not develop PTSD. Second, the person with PTSD usually re-experience the traumatic event in the form of flash backs, repetitive unwanted memory, or nightmares. They also show persistent avoidance of the stimuli related to the traumatic event. Finally, the person shows persistent increased arousal like lack of sleep, irritability and inability to concentrate (National Center for Post-Traumatic Stress Disorder, 2000).

Some studies of the prevalence of PTSD in the general population indicate that 15-43% of girls and 14-43% of boys have experienced at least one traumatic event in their life time. From these children and adolescent who experienced trauma 3-15% of girls and 1-6% of boys could be diagnosed with PTSD (Hamblen, 2003).

Rate of PTSD is much higher for children and adolescents selected from at risk population. The rate of PTSD for those at risk population vary from 3-100.As much as 100% of children who witnessed parental homicide or sexual assault develop PTSD. Similarly 90% of sexually abused children, 77% of children exposed to school shooting, 35% of youth exposed to community violence develop PTSD (Hamblen, 2003).

Many studies have documented post traumatic stress disorder as very likely result of sexual abuse related trauma (Briere, 1992). Studies have shown that almost half of sexual abuse survivors will develop PTSD symptoms. Renick etal and Breslu etal found results suggesting that

assault and rape are the most frequent traumas associated with PTSD in both men and women (Clardie, 2004).

Studies have explored the factors that may contribute to the development of PTSD in victims of sexual trauma. Several factors related to the nature of traumatic experience have been described as predictive factors, including the involvement of interpersonal violence, severity of the trauma, chronicity of the traumatic experience, whether it involved a fear of dying. The recovery environment is very important predicting factor of the development of PTSD if it is associated with secondary stressors such as pain, relocation, school dropout or blame (Clardie, 2004). Many sexual abuses are violent and that childhood sexual abuse often occurs in a chronic course. Secondary stressors are common in the context of sexual assault and abuse, especially self blame is common in sexual assault survivors and many disclosures are met with victim blaming attitudes and response by others. Many victims of sexual abuse have to relocate due to danger or fear and others unable to continue school obligations. If sexual abuse is measured against these factors, it can be suggested that sexual trauma is an experience likely to result in PTSD (Clardie, 2004).

Post traumatic stress disorder among sexually abused children is often characterized by intrusive symptoms. Flash back is the most uncontrollable and perceived bizarre intrusive symptom which is sudden and intrusive sensory memory. Among sexually abused it often includes images of the abusers face, or aspects of the actual sexual abuse taking place, like hearing the perpetrators voice making abusive statements, smell of the abusers alcohol laden breath, feeling hands grabbing ones legs, tights, genitals. These flash backs are usually triggered when sexual abuse survivor comes in contact with abuse related events or stimuli.

Sexually abused survivor may also have repetitive, thoughts and/or memories of sexual victimization which makes it difficult to concentrate or have a normal mental life (Briere, Treating adult survivors of severe childhood abuse and neglect:, 1992). Typical intrusive thoughts are about danger, humiliation, sex, guilt and badness. Intrusive memories usually involve unexpected and unwanted recollection of specific abusive or traumatic events (Briere, Child Abuse Trauma, 1992).

Abuse related nightmare may also frequently disturb sexually abused children and adults. There are two types of abuse related nightmares namely realistic and symbolic. Realistic nightmare repeats the actual abuse in nightmares and usually occurs for a short period of time after the abuse. Symbolic nightmares are a symbolic representation of victimization which occurs both in the short term and long after the abuse. Symbolic nightmares usually involve intrusion, violation, violence, and danger (Briere, 1992).

2.2 Child Physical Abuse

2.2.1 Definition and prevalence of child physical abuse

Physical abuse refers to causing physical harm by beating, hitting, punching, kicking, biting, burning, or any other act which causes physical pain. This type of abuse can be caused by discipline or punishment that is inappropriate for the child's age. It also includes deliberately poisoning a child to cause pain (World healtn organization, 2003).

It usually occurs within the family as disciplinary measure against the child. The overall prevalence of child physical abuse is estimated to be from10 to 25% depending on the definition used, population studied and the age range of childhood (Carr, 2006). One study on child maltreatment in USA concluded that 20% of all child maltreatment is physical abuse (Menesota Child Maltreatment Statistics, 2009).

2.2.2 Predisposing factors to child physical abuse

Various factors related to the personality of the abused, family of the abused, and behavior of the parents is identified to be associated with child physical abuse. The factors related to the abused child himself/herself like prematurity, developmental delays, frequent illness, difficult temperament, oppositional or aggressive behavior of the child may prompt parents to physically abuse their children (Carr, 2006).

There are also family related factors which predispose the child for physical abuse. Some of these factors include poor parenting style, dissatisfaction with marital relationship, poor communication skills, ineffective problem solving skills and violent marital relationship in the family (Carr, 2006).

2.2.3 Effects of child physical abuse

Child physical abuse can have a devastating effect on the child's physical cognitive, emotional and social development. Physical consequences include immediate pain, physical injury, physical disability, brain damage, eye damage, or death. Emotional problems such as anger, hostility, fear, anxiety, and humiliation result from physical abuse (Gail, 2008).

Various psychological and emotional disorders are frequently associated with child physical abuse. Post traumatic stress disorder, generalized anxiety, separation anxiety depression, low self esteem are most frequently mentioned. Behavioral problems include aggression, juvenile delinquency, oppositional behaviors occurring with parents, teachers and peers. They also show inter personal problems including misreading social cues, low status among peers, fewer social skills, negative social network, perform less in school (Gail, 2008).

2.2.4 **Child physical abuse and cognitive distortions**

The cognitive impact of physical abuse is not only the result of physical punishment but also the function of psychological aspect of such victimization. Naverre (1987) notes that:

> "*The assault is not only on the physical body but upon the individual's perception of the self as valuable, the individuals perception of the self as competent, the individuals perception of the world as beneficent or neutral rather than inherently hostile*" (cited in Briere, 1992,p. 39).

Physically abusive parents usually justify their violent behavior by blaming the child implying that the abuse is deserved punishment. The psychological aspect of the physical abuse and the justification of the abuse increase the victim's sense of guilt, shame and responsibility for the abuse which intensify the child's sense of badness (Briere, Child Abuse Trauma, 1992).

2.2.5 Physical abuse and post traumatic stress disorder

Physically abused children and adolescents show similar symptoms of post traumatic stress disorder with those who experienced sexual abuse. However, they show more autonomic arousal and avoidance of abuse related thought or stimuli. They experience flash backs, repetitive memories and nightmares like sexually abused children. There are certain differences with regard to the content of the memories and nightmares (Briere, 1992).

Children and adolescents who have been sexually abused have intrusive thoughts and nightmares of being violent or of suddenly being injured more than those who are sexually abused. These sudden and uncontrollable violent thoughts suggest uncontrollable aggressive impulse and possibly violent behaviors. Flash backs of physical abuse survivors are often triggered by the survivors own energy or feelings, overt conflict with others, violent events or being in the presence of physical threat. The content of the flash backs may be about instances of

injury, blows, torture, bondage, ritualistic maltreatment or about times when the abuser feared death or sudden injury (Briere, 1992).

2.3 Cognitive Behavioral Therapy (CBT)

As the name indicates cognitive behavioral therapy is a rational integration of behavioral therapies and cognitive therapies. It is based on both behavioral learning theories like classical conditioning, operant conditioning and cognitive learning theories like information processing, schema theory etc. Over time CBT have evolved to be effective mainstream treatment for many emotional and behavioral problems (Holly & Craske, 2002).

2.3.1 History of CBT

The history of CBT can be traced back to the time of the Greeks to the Greek philosopher Epictetus who said that "people are disturbed not by things but by the view which they take of them". An influential psychologist Alfred Adler noted that our emotions and behavior are the result of our beliefs. In 1920s learning theories (classical conditioning and operant conditioning) were proposed which give rise to behaviorally oriented psychotherapies. However, the development of rational emotive behavioral therapy (REBT) (which is considered as the parent of cognitive behavioral psychotherapies) in 1950s by Albert Ellis was a turning point in the history of CBT (Corey, 2001).

The basic assumption of rational emotive behavior therapy was that our emotions are the result of our beliefs, evaluations and interpretations of situations and events. People learn or create irrational beliefs about themselves and the word which adversely affect their emotions and behaviors. The goal of therapy is therefore, to help clients modify or replace irrational thoughts and beliefs by a more rational and adaptive thoughts and beliefs as well as develop better

philosophy of life. Various behavioral and cognitive and emotive techniques can be used by the counselor (therapist) to achieve the goal (Collagde, 2002).

In 1960s Aaron Beck developed cognitive therapy which is similar to REBT in basic assumptions but emphasizes cognitive insight and uses a different technique. Donald Meichenbaum developed cognitive behavior modification which emphasis clients self verbalization. A number of other CBT oriented therapies developed following these pioneering works. Today more than 20 therapies are labeled as 'cognitive' or 'cognitive behavioral' including trauma focused cognitive behavioral therapy (Corey, 2001).

2.3.2 View of human nature and psychological disturbances

The basic assumption of all cognitive behavioral therapies is that human emotions and behaviors are the result of their beliefs, thoughts, evaluations and interpretations about themselves, other people and the world. It is what people think about the situations not the situations themselves that determine how they feel and behave. However, it is also assumed that a person's feelings and behaviors are influenced by his/her biology too. Therefore, there is a limitation to what extent a person can change through CBT (Leahy, 1996).

In CBT it is assumed that all emotional and behavioral disturbances are due to dysfunctional, irrational or maladaptive thoughts. A belief is maladaptive, dysfunctional or irrational when it impairs a person from achieving their goal, hurts themselves or others. It is also in contrast with reality since it is incorrect interpretation of the reality. It is illogical way of evaluating oneself, others and the world in general (Forgat, 2006).

2.3.3 Basic premises of CBT

There are basic assumptions and principles which are shared by all cognitive behavioral models and techniques of therapy. Stevens and Craske (2002)discussed the following major assumptions:

- ✓ All psychological dysfunctions are the results of learning and cognitive processing: CBT is a rational integration of behavioral and cognitive approaches incorporating both learning theories (classical conditioning & operant conditioning) and cognitive learning theories (information processing).
- ✓ Thought and behavior are inherently adaptive and are subject to change. Since behavior is the result of the interaction of environment and cognition, it is lawful, predictable and changeable.
- ✓ There is a core feature or element that causes variety of symptoms and dysfunctional behaviors. Therapy identifies, targets and changes core features so that mal adaptive thoughts, feelings and behaviors will change.
- ✓ CBT assumes that change occurs when maladaptive learning experience is replaced by new and more adaptive learning and information processing.

2.3.4 The goal and process of CBT

Cognitive behavioral therapy is aimed at helping people understand the connection between thoughts, feelings and behaviors and making people in control of their emotions and behaviors. All CBT approaches depend on structured psycho educational model to achieve their goal. The therapist teaches the client how to identify core negative beliefs that cause emotional and behavioral disturbances. The client is encouraged to dispute mal adaptive beliefs and replace

them with more adaptive thoughts. The client is also encouraged to act against the irrational beliefs often in the form of homework (Leahy, 1996).

CBT emphasizes a collaborative relationship between counselor/therapist and client. Therefore, a counseling relationship based on empathy, warmth and respect is essential for the success of CBT. Assessment of the problems, context of the problem and the person is an important aspect of the process of therapy. CBT places responsibility on the client by emphasizing the role of homework in the process of therapy. Evaluation of therapeutic outcome is usually an ongoing process throughout the therapy sessions (Corey, 2001).

2.3.5 Techniques of CBT

CBT uses 'selective eclectic approach' to choose the techniques in therapy where any technique that works and is compatible with CBT is used. However, the techniques can be generally categorized as cognitive, behavioral and imagery techniques. Examples of cognitive techniques which emphasize thought include rational analysis, double standard dispute and reframing. Behavioral techniques which emphasize action include exposure, shame attacking, paradoxical behavior, practicing the new behavior. Imagery techniques emphasize emotion and include time projection, worst case technique and the blow up technique. In addition to these techniques, skills training and home works are important strategies in CBT (Hough, 2006).

2.3.6 Trauma-focused cognitive behavioral therapy (TF-CBT)

Trauma focused cognitive behavioral therapy is a model of psychotherapy developed to address the needs of children with post traumatic stress disorder, depression, behavior problems and other difficulties related to traumatic life experiences. It is a short term treatment approach that works in 12 sessions. It also can be provided for a longer time depending on the needs of the child or the family (NCTSN, 2010).

Trauma-focused cognitive-behavioral therapy was developed by Cohen, Deblinger and Monarino initially for sexually abused children (Cavett, 2002). Later it was expanded to other traumas like physical abuse, disaster, terror and life threatening illness. The therapy was developed to resolve posttraumatic stress disorder, and depressive and anxiety symptoms, as well as to address underlying distortions about self-blame, safety, the trustworthiness of others, and the world (Cavett, 2002).

2.3.6.1 Components of TF-CBT

TF-CBT incorporates different components that are derived from cognitive therapies, behavioral therapies and family therapies. The major components of TF-CBT include the following (National Child Traumatic Stress Network, 2008):

- Psycho education and parenting skill training: In TF-CBT the therapist discuss and teaches both the child and the parent about child abuse, post traumatic stress disorder and other emotional and behavioral consequences of abuse. Parents also learn skills on how to properly deal with their children.
- Relaxation Training: TF-CBT helps children control their anxiety and stress by teaching them relaxation techniques like focused breathing, progressive muscle relaxation and thought stopping.
- Affective expression and regulation: TF-CBT helps children and adolescents learn about their feelings so that they can identify and control their feelings towards the traumatic event. They also learn how to express their feelings in more appropriate ways.
- Cognitive copping: TF-CBT helps children understand the relationship among thought, feelings and behavior. Children's attribution about the abuse that occurred

against them is very important in predicting various symptoms that follow physical and/or sexual abuse.TF-CBT helps children develop a more rational and realistic view of the abuse so that they will have healthier feelings and behavior. Children for instance learn not to blame themselves for the abuse which in turn reduces their feelings of shame and guilt over the abuse.

- Trauma narrative: is an important component of TF-CBT in which children narrate the trauma that they have experienced in detail. It helps children develop a new perspective in to their experience. It is a kind of exposure therapy which helps children control their strong emotions so that they will not be overwhelmed by the memory any more.
- Invivo exposure: in this technique children are exposed to non threatening trauma reminding stimulus in their environment. This procedure helps them not to avoid situations or stimulus which reminds them the trauma but is no more dangerous.
- Parent child sessions: in this aspect of therapy both the child and the nonabusing parent come together in a therapy session to enhance communication and make therapeutic discussion.
- Enhancing personal safety and future growth: In TF-CBT trainings are provided regarding healthy sexuality, social skills and coping skills against future stressors.

2.3.6.2 TF-CBT in Group Setting

Even if cognitive behavioral therapy is generally more effective and efficient compared to other psychotherapies, researchers are working to make it even more efficient. Some approaches to increase the efficiency of CBT treatments include adapting individual treatments to a group format, self help materials and bibiliotherapy and computer assisted therapy

programs.TF-CBT was first developed for individual clients ,later it is adapted to a group settings (Steven & Craske, 2002).

Group therapy may be conducted as a short-term (12 session) program with 5 to 8 group members in a closed group. For these groups to work well, it is useful if they are fairly homogeneous, with participants being the same age and having suffered either intra familial or extra familial abuse. Ideally, such groups are run jointly by a male and female therapist, who offers the child an alternative model of parenting to that offered by their own parents, marked by openness, clear communication and respect (Carr, 2006).

When therapy is provided in group settings, members will be able to escape isolation which many abused children experience. As Furnisn (cited in Tilman,2010) points out, belonging to a group whose members share the common attributes of having been abused allows individuals within the group to discover a new and personal identity .sharing provides these experiences helps to raise low self esteem. The group setting also an opportunity for the therapist to observe and assess children's further therapeutic needs as it is a social environment.

Particularly for trauma survivors group setting provides environment where survivors are able to share traumatic material with safety, confidence and empathy from other survivors. As they discuss they learn to cope with shame, anger, and self blame (Tilman, 2010). Trauma narration (telling the story) within the group setting enables trauma survivors to cope with trauma symptoms, memories and other aspects of their life.

2.4 Research on the Effectiveness of Child and Adolescent Psychotherapies

Child and adolescent psycho therapy is wide in its scope and forms particularly in developed countries. Some 551 specific types of psychotherapies are developed so far to deal with psychological problems of children and adolescents without including eclectic approach

developed by each therapist (Weisz, 2004).Some of these therapies are very familiar (like trauma focused therapy, play therapy, child centered therapy etc) while others are unfamiliar (like Alf group, Let's pretend hospital, Blind fold treatment etc). Cost wise, US alone spends some 11.75 billion annually to address psychological problems of 6% of the entire population 18 or younger (Waisz, 2004).

Research inquiry about the effectiveness of psychotherapy is growing as a result of need for accountability and managed care. In 1950's Eyesinck reviewed studies of adult psychotherapies and Levitt did the same for child psychotherapies. Both of these studies by Eyesinck and Levitt concluded that there is no evidence that psychotherapy leads to more improvement than mere passage of time. Since then, research in to the area has grown in complexity and rigor, and by 2000 there were1500 therapy effectiveness studies in the area of child and adolescent psychotherapy (Waisz, 2004).

Different research methods are implemented to study the effectiveness of psycho therapy in various settings and different group of clients. Among these methods the most acceptable one is experimental design study which has been called the standard of effectiveness study (Weisz, 2004). In experimental studies subjects are randomly assigned to either treatment group which receives some form of psychotherapy or control group which do not receive psychotherapy or receive another form of psychotherapy. The two groups would be systematically matched and made equivalent to control any extraneous variable. Then, the two groups (treatment and control) are compared both before and after the treatment with regard to the symptoms they show. Studies with such a design are relatively fewer than studies with other designs. One, Meta analysis of various outcome studies identified 29 studies of which only 3 were truly experimental (Finkelhor & Burliner, 1995).

Another study design of effectiveness studies is quasi experimental study. In this study design the subjects would be randomly assigned to either experimental group (who receive treatment) or control group (who do not receive treatment). However, the two groups are not necessarily equivalent. The weakness of such designs is that the groups might be different in some way being influenced by external variable and that the treatment outcome may not be entirely due to treatment. It is considered better than other research methods since it has a comparison group having similar symptoms.

The third type of study design frequently used in effectiveness study is single design pre-post study. In this type of study design a particular group of subjects are assessed at two or more different points in time while the intervention is provided for them. The limitation of this study design is that it is not known whether the positive outcomes after the treatment are due to therapy or mere passage of time. However, failure to improve (reduce negative symptoms) definitely imply treatment ineffectiveness.

Case studies are also important method to examine the effectiveness of psychotherapies. The advantage of case study is that it demonstrates the details about the process of psycho therapies .It also explains why a particular client is responsive to treatment program and why therapy does not work for the other client by clarifying the context of the particular case. However, the findings of case studies cannot be generalized since there is no representative sample (Royal College of Psychiatrists , 2004).

2.4.1 Research on effectiveness of TF-CBT

The Substance Abuse and Mental Health Services Administration (SAMHSA) of US has recognized TF-CBT as a model program, because well-designed scientific studies have shown it to be so effective in treating children who’ve been sexually abused. SAMSHA is encouraging its

broader use by practitioners, and the National Child Traumatic Stress Network is training clinicians in this approach (National Child Traumatic Stress Network, 2008).TF-CBT is rated as well supported efficacious treatment, since it has well developed theory, general clinical acceptance and empirical research support (National crime victims research and treatment center, 2004)

For instance, meta-analysis of studies published in England, between 1975 and 2004, assessing the different kinds of psychotherapy for victims of sexual abuse was carried out (NCTSN, 2010). The studies that used cognitive behavioral therapy (CBT) as treatment have shown better results when compared to other forms of non-focal therapy for children and adolescents with symptoms of anxiety, depression and behavioral problems resulting from sexual abuse. In addition, the CBT focused on the trauma has been presenting a high effectiveness rate in reducing the symptoms of post-traumatic stress disorder (PTSD) and in restructuring dysfunctional beliefs in regard to the sexual abuse experience.

Cohen and Mannarino (2004) conducted two parallel, randomized, controlled trials for 67 sexually abused preschoolers (3 to 6 years old) and 82 children and young adolescents (7 to 14 years old), comparing TF-CBT to nondirective supportive therapy (NST). The nondirective supportive therapy consisted of play for younger children and child- or parent-directed supportive therapy for older children. The preschool study demonstrated the superiority of TF-CBT in improving PTSD symptoms and the differences were maintained over a one-year follow-up.

In other study (Cohen etal, 2004) randomly assigned 229 sexually abused children with PTSD into TF-CBT group and child centered therapy group (CCT). The children were 8-14 years old and 90% of them had experienced trauma in addition to sexual abuse. The result

demonstrated that children in TF-CBT group were significantly better in PTSD symptoms measure than children in child centered therapy.

In Iran 14 girls who had been sexually abused received 12 sessions CBT or EMDR treatment.post traumatic stress symptoms and behavior problems were measured at pre treatment and post treatment. The result showed that children treated with CBT improved significantly than those with EMDR (Nasrin etal, 2004).

In general, TF-CBT is well investigated and demonstrated to be highly effective in reducing post traumatic stress symptoms experienced by sexually abused children. It is also well demonstrated that it is superior to other psychotherapy models developed for abused children like supportive and child centered approaches. It works for very young children (as young as 3 years old) as well as to adult survivors of sexual abuse. Practitioners are encouraged to use it for treatment and that it is recommended to train students in this model.

The literature review section is summarized as follows:

Sexual abuse is defined as any sexual activity with a child younger than 18 induced by an adult or older child. Approximately, 20% of females and 5-10% of males experience sexual abuse before age 18, which results in a number of adverse physical and psychological consequences. Many adverse psychological symptoms that fallow sexual abuse are conceptualized as PTSD symptoms. Research findings indicate that about half of sexually abused children develop PTSD symptoms.

Child physical abuse is any deliberate attempt to cause physical pain or damage to a child by beating, kicking, hitting, burning poisoning etc. It has 20-25% over all prevalence in the general population accounting for 20% of all cases of child maltreatment. It has a number of negative consequences ranging from physical injury to psychological disorders like PTSD,

depression and low self esteem. Physically abused children frequently report PTSD symptoms, traumatized by often sudden and brutal physical assault.

CBT is a general psycho therapy approach developed In 1960s and 70s,which combines behavioral and cognitive techniques in bringing about change in clients.CBT assumes learning theories like classical conditioning and operant conditioning as well as cognitive processing theories. Behavior is the result of the interaction of cognition and environment, is lawful and is susceptible to change. It also assumes core beliefs to be responsible for any desirable or undesirable behavior and therapy targets on changing those beliefs.CBT targets to replace maladaptive learning and cognitive processing with more adaptive ones.CBT therapists have a scientific attitude, always developing new hypothesis about the client's cognition and behavior and are not bound by a specific technique.

TF-CBT is a specific therapy approach within CBT designed to deal with therapeutic needs of traumatized children and adults.TF-CBT is consisted of psycho education, cognitive restructuring, copping skills training, relaxation training, trauma narration and in vivo exposure. In an effort to make it more effective TF-CBT adopted a group setting where clients share information, develop their identity, learn coping mechanism and raise their self esteem.

The devastating effect of child abuse as well as need for accountability and managed care motivated research in to the effectiveness of psychotherapies. There are various research designs employed to examine the effectiveness of psychotherapy of which randomized controlled experimental design is considered as the best method. There is growing empirical evidence showing the effectiveness of TF-CBT to treat PTSD symptoms and that its use in clinical and counseling settings is encouraged.

CHAPTER THREE

THE RESEARCH DESIGN AND METHODS

3.1The Study Design

The study was a quasi experimental control group pre post design with intra and inter-group comparisons over time, in which the intervention was carried out in one group (treatment group) and the outcomes are compared in regard to each participant over different periods within the same group as well as between the treatment and control/comparison groups. The aim of the group therapy was reducing symptoms of post-traumatic stress disorder, and helping in restructuring dysfunctional beliefs in regard to the sexual or physical abuse experience. Participants were assessed through psychological tool in three different stages: before group therapy, just after the group therapy and 15 days after the therapy.

FIGURE 1: DESIGN OF A QUASI-EXPERIMENTAL DESIGN

Study Groups		X	
Treatment Group	O_1	----------	O_2
Control Group	O_3	----------	O_4

Where:

- The **Treatment group** was sexually or physically abused children who received trauma focused cognitive behavioral group therapy.

- The **Control group** was sexually or physically abused children who did not receive trauma focused cognitive behavioral group therapy.
- $\mathbf{0_1}$ and $\mathbf{0_3}$ refer to mean scores of dependent variable (Posttraumatic stress symptoms) **before** the treatment for both the treatment group and control group.
- **X** refers to trauma focused cognitive behavioral group therapy delivered by the researcher and other counselors in the institutions.
- $\mathbf{0_2}$ and $\mathbf{0_4}$ refers to mean scores of posttraumatic stress symptoms **after** the treatment for both the treatment group and control group.

3.2 Research Site

The study was conducted in two nongovernmental charity organizations namely Kechene children's home and OPRIFS (Organization for Prevention, Rehabilitation and Integration of Female Street Children). Kechene children's home was established in 1945 while OPRIFS was established in 2000 EC. The aim of both of the organizations is to provide protection and assistance to girls (age 18 and below) who are orphans or children who suffer from various types of social problems, such as domestic violence, abuse, victims of trafficking, etc. Kechene children's home currently accommodates 233 girls up to 18 years of age while OPRIFS accommodate 190 enrolling for rehabilitation services. Most children in Kechene children's home stay up to 18 years of age some of them integrate with the family while OPRIFS usually provides temporary shelter for the children until they integrate with their families. Kechene children's home and OPRIFS as nongovernmental organizations, provide services free of charge. The girls receive accommodation, medical care, counseling and education.

3.3 Population and Sample

From both of the charity organizations (Kechene children's home and OPRIFS) 60 female children were selected as participants of the research based on the following criteria:

- They have experienced either sexual or physical abuse
- They are within the age range of 8-18
- They are willing to participate in the study
- They scored more than 15 on the CPSS

They were identified by the social workers and counselors who are working with the children. All the participants scored more than 15 on the CPSS which suggest that they at least show mild symptoms of PTSD.

3.4 Allocation of Participants to Treatment or Control Group

After the participants take the pre test on child post traumatic symptoms scale (CPTSS) they were divided in to two groups. The participants were allocated to one of the groups purposefully based on their pre test score and type of abuse they experienced. Then, lottery method (coin toss) was used to determine which group would be treatment group (the group that receives treatment) and control group (the group that is used as a comparison group).This was done to make the control group and the treatment group equivalent with regard to the two variables namely score on child post traumatic symptoms scale and type of abuse.

3.5 Variables

3.5.1 Independent Variable

The independent variable for the research design was trauma focused cognitive behavioral group therapy. Trauma focused cognitive behavioral group therapy was provided for

the treatment group and it was not provided for the control group.TF-CBT was imposed by the researcher and it was supposed to bring about a change on the other variable-dependant variable.

3.5.2 Dependent Variable

The dependent variable is posttraumatic stress disorder symptoms. The dependent variable was measured by self-report measure called child posttraumatic stress symptom scale (Foa et al., 2001).

3.6 Data Collection Method

Two sets of questionnaires were used to gather the required information about the participants before and after the treatment program: demographic data sheet and Standardized test.

1. **Demographic data sheet**: Demographic data sheet was used to gather demographic information about the participants of the study.
2. **Standardized test: t**he child posttraumatic stress symptoms scale (CPSS) was used to measure post traumatic stress symptoms which is the dependant variable in the study.

The Child Posttraumatic Stress Symptoms Scale (CPSS):

It was used to measure children's post traumatic stress level after they have experienced either physical or sexual abuse. The children's post traumatic stress level was measured before treatment after treatment, and 15 days after treatment for the treatment group. The control group was also measured at two points in time which is before the treatment was offered to treatment group and after the treatment.

The child posttraumatic stress symptoms scale(CPSS), which is used for children aged 8 to 18, is based on diagnostic statistical manual version four (DSMIV) criteria of post traumatic stress disorder (Foa et al., 2001). It has two parts. Part one is consisted of 17 items each item

representing PTSD symptom as described by DSMIV. These items are rated based on likert scale ranging from 0 (no symptom in two weeks) to 3(5 or more times in two weeks) yielding a total score which ranges from 0-51 The second part is consisted of 7 items which measure level of functional impairment as a result of the symptoms of PTSD. The second part is rated dichotomously as absent (0) or present (1) yielding a total score range from 0-7 higher score indicating greater functional impairment. Hence, a total score for both parts ranges from 0 to 58.

Regarding the psychometric characteristics of the test it is described that it has .84 internal consistency for the total score. Its convergent validity was also high that its correlation with child post traumatic stress index is.80 (Foa et al., 2001).

As mentioned above the total score for CPSS ranges from 0 to 58.Taking 15 as a cutoff score of CPSS, the following ranges were adapted for the purpose of this study (Foa et al., 2001):

- ✓ Scores between 0 and 15 are indicative of minimum levels of posttraumatic stress symptoms.
- ✓ Scores between 16 and 24 are indicative of mild levels of posttraumatic stress symptoms.
- ✓ Scores between 25 and 39 are indicative of moderate levels of posttraumatic stress symptoms.
- ✓ Scores between 40 and 58 are indicative of severe levels of posttraumatic stress symptoms.

Translation and Pilot Testing:

The standardized child post traumatic stress scale (CPTSS) was translated earlier by other researchers and adopted for this study. It was pilot tested on 20 samples to test its reliability. Using Cronbach alpha it has inter item correlation coefficient of .734 which is adequate level to be used for the purpose of the study. However, younger children needed some support to

understand the items so that it was administered in the form of interview measure by the researcher rather than in self report form.

3.7 Data Collection Procedures

First, the researcher presented the objectives of the research and obtained a permission to work in Kechene children's home and OPRIFS from the directors of the organizations. Then, the researcher introduced the purpose and procedure of the research to social workers and counselors in the organizations and requested for collaboration. The social workers and counselors identified children living in the organizations that have experienced sexual or physical abuse and did not receive counseling service. The counselors also agreed to participate in the treatment program of TF-CBT to work as co counselors with the researcher. Group therapy offered by male and female counselors jointly is ideal since it provides the children with alternative parent model to that offered by their own parents (Carr, 2006).

Pre test was administered for all participants identified as having experience of child physical or sexual abuse. Then they were divided in to two groups each group having 30 members. The children were allocated to each of the groups based on their score on CPSS and type of abuse they experienced so that the groups are made equivalent with regard to these variables. Then, coin toss was used to determine the control group and the experimental group. Then the treatment group received trauma focused cognitive behavioral group therapy for a total of 12 sessions, 3 sessions per week. This is the minimum number of sessions required for TF-CBT (NCTSN, 2010).After the completion of the treatment program, post-test was administered for both treatment and control groups. This was to examine whether there is statistically significant difference in the mean CPSS score of the two groups. Fallow up measures of CPSS

score was also taken for the treatment group so as to examine whether the outcome measures at the post treatment test were maintained.

3.8 Ethical Considerations

Throughout the research process care was taken to make it consistent with ethical guidelines and principles. Participants' informed consent (willingness) was the basis to participate in testing as well as the treatment program. The participants were assured that whatever they share in the process of the study (in counseling and in testing results) would be strictly confidential.

3.9 Method of Data Analysis

The quantitative data collected was analyzed using the statistical package for social science (SPSS). Descriptive statistics, frequency distributions and percentage were used to describe participants' demographic characteristics. Dependent and independent t-test is used to compare the mean difference between the pre-test and post-test as well as follow up measures of CPSS.

CHAPTER FOUR

RESULTS

The purpose of this study was to examine the effectiveness of trauma focused cognitive behavioral therapy to treat post traumatic stress disorder symptoms of children either physically or sexually abused. In order to achieve this goal, a standardized scale was administered to measure post traumatic stress symptoms of children who experienced sexual abuse or physical abuse. Participants were assigned to treatment group who received trauma focused cognitive behavioral therapy for 12 sessions and control group who did not receive the treatment. Then the test was ones again administered for all the participants in order to examine the changes in post traumatic stress symptoms after counseling(for the treatment group)and after mere passage of time (for the control group). A follow up measure of the level of post traumatic stress symptom of the treatment group was conducted in order to examine whether the outcome measures were maintained over time.

Here, the collected data is presented in relation to the objectives of the research. The results section includes demographic characteristics of participants, results of dependant t test which shows change within a particular group and independent t test which shows the difference in CPSS between the control group and the treatment group. The dependant t test shows results for mean difference in CPSS score from pre to post test for both treatment and control groups. It also shows mean difference in CPSS score between different age groups and types of abuse. Alpha level of 0.05 is used.

4.1 Demographic Characteristics of Participants

Table 1

Demographic Characteristics of Treatment and Control Group

Characteristics		Treatment Group		Control Group	
		Frequency	Percentage (%)	Frequency	Percentage (%)
Age	9-12	11	36.7	14	46.6
	13-16	19	63.3	16	53.3
	Total	30	100	30	100
Sex	Female	30	100	30	100
	Male	-	-	-	-
	Total	30	100	100	100
Educational Level	Elementary	22	73.3	25	83.3
	Secondary	8	26.7	5	16.6
	Total	30	100	30	100
Type of Abuse	Sexual Abuse	15	50	15	50
	Physical Abuse	15	50	15	50
	Total	30	100	30	100
Time Stayed in the Institution	Less than two Weeks	15	50	20	66.6
	2-4 weeks	11	36.7	8	26.6
	More than 4 weeks	4	13.3	2	6.6
	Total	30	100	30	100
Counseling Received	Yes	-	-	-	-
	No	30	100	30	100
	Total	30	100	30	100

As indicated in the table1 the majority of the participants were aged 13-16 which is 63.3% in the treatment group and 53.3% in the control group. Likewise, most of them (73% from treatment group and 83% from control group were elementary school students. As far as total number of participants concerned there were equal number of physically and sexually abused children in both treatment and control groups. Almost all participants stayed less than a month in the institutions (86.3 in the treatment group and 92.6% in the control group).All participants in both groups have never received counseling service prior to the study. Generally, the participants are fairly distributed in the treatment group and control group with little difference in their socio demographic characteristics.

4.2 Post Traumatic Stress Symptoms

Table 2

Posttraumatic Stress Symptom Level of Treatment Group before Treatment after Treatment and at Follow Up

Level of Post Traumatic Stress symptoms	Pre Test		Post Test 1		Post Test 2	
	Frequency	Percentage (%)	Frequency	Percentage (%)	Frequency	Percentage (%)
0-15 (Minimum)						
16-24 (Mild)	11	36.7	16	53.3	16	53.3
25-39 (Moderate)	17	56.7	14	46.7	14	46.7
40-58 (Sever)	2	6.7	-	-	-	-
Total	30	100	30	100	30	100

As shown on the table 2 before the treatment 56.7% of participants in the treatment group were on moderate level of post traumatic stress symptoms, 36.7% showed mild level of PTSD symptoms, while a 6.7% measured high on the scale. After the treatment those on the moderate level decreased to 46.7%, those on the mild level of post traumatic stress symptoms increased to 30% and there were no respondent on the sever level of PTSD symptoms. These treatment gains at post test 1 (just after the treatments) were maintained at post test 2 (follow up) measures.

Table 3

Posttraumatic Stress Symptoms Level of Control Group before and after Treatment

Level of Post Traumatic Stress Symptoms	Pre Test		Post Test 1	
	Frequency	Percentage (%)	Frequency	Percentage (%)
0-15 (Minimum)				
16-24 (Mild)	10	33.3	12	40
25-39 (Moderate)	18	60	18	60
40-58 (Sever)	2	6.7	-	-
Total	30	100	30	100

As can be seen from table 3, 60% of participants in the control group have shown moderate level of post traumatic stress symptom, 26.7% mild and the rest 3.3% showed sever level of PTSD symptoms. At post treatment level of measurement 60%showed moderate level of PTSD, 40%were mild and no one was measured sever on the scale.

4.3 Analysis of Dependent t-test

Table 4

Dependant t-test of the Mean Post Traumatic Stress Scores of the Treatment Group Before and After the Treatment (N=30)

Treatment Group	**Post traumatic Stress Symptoms Scores**			
	Mean	**SD**	**t**	**Significance**
Before Treatment (Pre Test)	27.1333	6.5849	2.618	.014
After Treatment (Post Test)	24.7	5.9140		
Paired Difference	2.4333			

*Statistically significant at P<.05

Table 4 indicates that the mean post traumatic stress symptoms score for the treatment group before treatment was 27.1333, with SD of 6.5849 .After the treatment (post test 1) the mean post traumatic stress symptoms score was reduced to 24.7 with SD of 5.9140 the mean difference being 2.4333. Paired t test indicated that the difference is statistically significant (df= 29, t =2.613)

Table 5

Paired t-test of the Mean Post Traumatic Stress Scores of the Treatment Group at Post Test One and Post Test Two (N=30)

Treatment Group	Post traumatic Stress Symptoms Scores			
	Mean	**SD**	**t**	**Significance**
Post test 1 (just After Treatment)	24.7	5.9140	-.445	.660
Post test 2(Fallow up)	25.1333	6.2738		
Paired Difference	0.4333			

ns not statistically significant

As table 5 indicates the mean post traumatic stress symptoms score just after the treatment was 24.7 with a SD of 5.9140 while it was 25.1333 with SD of 6.2738 at the follow up measure (post test two).The difference between the two means was 0.4333 which is not statistically significant.

Table 6

Paired t -test of the Mean Post Traumatic Stress Scores of the Control Group at Pre Test and Post Test

Control Group	Post traumatic Stress Symptoms Scores			
	Mean	**SD**	**t**	**Significance**
Before Treatment (Pre Test)	28	4.9200	0.433	.668
After Treatment (Post Test)	27.5667	4.7610		
Paired Difference	0.4333			

It is shown on the table 6 that the mean post traumatic stress symptoms measure for the control group at the first point of measurement (pre test) was 28 with standard deviation of 4.92. At the second point of measurement (post test) it was reduced to 27.5667 with standard deviation of 4.7610.The difference of the two measures was 0.4333 which indicates a reduction in the level of symptoms. However, the difference was not statistically significant.

4.4 Analysis of Independent t-test

Table 7

Independent t-test of the Mean Post Traumatic Stress Scores of the Treatment Group and Control Group

PTSD Score	**Groups**		**Mean Difference**	**t**	**Sig.**
	Treatment	**Control**			
Pre-test	27.1333	28.00	**0.8667**	**-577**	**.566**
Post-test	24.7	27.5667	2.3	2.068	.043
Mean Difference	2.4333	0.4333			

As shown on the table 7 before treatment the mean of post traumatic stress symptoms score of the treatment group was 27.1333 while the mean of post traumatic stress score of the control group was 28 the difference of the means of the two groups being 0.8667.An independent t test of the equality of the two means indicates that the difference of the two means of PTSD score was not significant at 0.05.

After the treatment the mean post traumatic stress symptoms score of the treatment group was 24.7 and the mean of post traumatic stress score for the control group was 27.5667. the difference of the mean for the treatment group and for the control group was 2.3.When a two tailed t test was used to test the mean difference between the control group and the treatment group, there was statistically significant difference between the two means at 0.05(df=58, t=2.068).That is the treatment group showed statistically significant reduction in the mean score of post traumatic stress symptoms at post test compared to the control group.

Table 8

Independent t-test of the Mean Post Traumatic Stress Scores of the Sexually Abused and Physically Abused Children

PTSD Score	Groups		Mean Difference	t	Sig.
	Sexually Abused	**Physically Abused**			
Pre-test	28.0769	26.4118	1.6651	.680	.502
Post-test	24.8824	24.4615	0.4209	-190	.149
Mean Difference	3.1945	2.8824			

As table 8 shows the mean score of post traumatic stress symptom scale at pre test was 28.0769 for sexually abused children and 26.4118 for physically abused children. The difference of the mean post traumatic stress symptoms for sexually abused children and for physically abused children was 1.6651. The difference between the two means (sexually abused and physically abused) before treatment is not statistically significant at 0.05.The mean score of PTSD symptoms for sexually abused children was slightly more than that for physically abused even though it was not statistically significant.

It is also indicated on the table that the mean score of PTSD symptoms after the treatment (post test 1) was 24.8824 for sexually abused children and 24.4615 for physically abused children. The difference between the two means was 0.429 which is not statistically significant when tested with independent t test at 0.05.However the difference was still maintained that sexually abused children scored higher on PTSD symptoms scale once again after the treatment.

Table 9

Independent t-test of the Mean Post Traumatic Stress Scores of the Younger Children (9-12) and Teenagers (13-16)

PTSD Score	Groups		Mean Difference	t	Sig.
	Younger Children(9-12)	**Teenagers (13-16)**			
Pre-test	26.1818	27.6842	1.5024	.595	.556
Post-test	25	24.52	2.3	.208	.837
Mean Difference	1.1818	3.1642			

As can be seen on table 9 the mean post traumatic stress symptoms score before treatment for younger children(children aged 9-12) was 26.1818 while it was 27.6842 for the teenagers (13-16 years of age), the teenagers scoring slightly more than the younger children. The difference between the mean post traumatic stress score of the two groups was 1.5024 which is not statistically significant tested with independent two tailed t test at 0.05.

When the test was administered after the treatment the mean post traumatic stress symptoms score for teenagers (13-16 years) was (24.52) was less than the younger children (25).The difference of the two means which is 2.3was not statistically significant when tested with independent t test at 0.05.

CHAPTER FIVE

DISCUSSION

This study was conducted to examine the effectiveness of trauma focused cognitive behavioral group therapy to treat PTSD symptoms of children who experienced sexual or physical abuse. To these end the results of the finding are discussed in the light of the literature.

5.1 Post Traumatic Stress Symptoms before the Treatment

The finding of this study indicated that majority of children who are the victims of physical or sexual abuse show moderate level of post traumatic stress as measured by CPSS. As indicated in the results section, 63.4% of participants in the treatment group showed moderate or severe level of post traumatic stress symptoms(56.7%)moderate and 6.7% sever).Majority of the participants in the control group as well were at moderate (60%) and sever (6.7%) level of post traumatic stress symptoms.

This finding is consistent with many other findings. Rodriguez et al (1992) found that 72% of sexually abused children from clinical sample met criteria for current post traumatic stress disorder. Saunders et al. (1992) found significantly higher rates of lifetime posttraumatic stress symptoms in participants reporting contact sexual abuse and child rape compared to participants reporting non-contact sexual abuse experiences. In a clinical sample up to 90% showed PTSD symptoms, however, all of these children have experienced trauma other than sexual abuse (Finkelhor & Burliner, 1995).

In the study of children and adolescents (9 to 16 years old) who live in child care centers in North Carolina USA found out that 90% of them experienced at least one traumatic event in their life time (North Carolina department of social services and the family and childrens' resource program, 2005). In another study in USA researchers examined PTSD symptoms of 659 young

adults who had been placed in family foster care found that 1 in four (25%)of them had experienced PTSD which is double of the US war veterans. Most of them were sexually or physically abused (North Carolina department of social services and the family and childrens' resource program, 2005).

Before the treatment there was little to no difference between the control group and the treatment group, with regard to the socio demographic variables like age, educational level and time stayed in the institutions. There were equal number of sexually abused children and physically abused children in the treatment group as well as in the control group. As far as post traumatic stress symptom is concerned the mean score of the control group was 28 while it was 27.1333 for treatment group indicating that there is no statistically significant difference between the two groups.

The study also has shown that the mean post traumatic stress symptom for sexually abused children was 28.07 before treatment and it was 26.41 for physically abused children. The difference between the means is not statistically significant though. The literature confirms that physically and sexually abused children show similar types of symptoms of anxiety, low self esteem, depression and post traumatic stress disorder (Carr, 2006).

The literature shows that both sexually abused and physically abused children frequently experience PTSD symptoms. The difference between the two groups is the type of symptoms they show. Sexually abused children frequently experience flash backs, repetitive unwanted memories, and abuse related nightmares while physically abused children usually avoid trauma related memories and stimuli, experience violent nightmare and irritability (Briere, 1992).

As indicated in the results section, the mean PTSD score before treatment was 27.6842 for the teenagers while it was 26.1818 for the younger children. The teenagers scored slightly more than the younger children but were not statistically significant.

Literature indicates that there are some differences in the expression of PTSD symptoms between elementary school children and adolescents. Adolescents show more adult like symptoms like flash backs, nightmare ,emotional numbing, avoidance of trauma related stimuli, substance abuse, withdrawal, suicidal thoughts, school avoidance ,sleep disturbances and confusion. In younger children extreme withdrawal, inability to concentrate, nightmares, irritability refusal of school, outburst of anger are more common (North Carolina department of social services and the family and childrens' resource program, 2005).

5.2 Post traumatic Stress symptoms after the Treatment

The treatment group showed statistically significant change in post traumatic stress symptoms at the second point of measurement (post test one).The mean post traumatic stress symptom score shifted from 27.1333 before treatment to 24.7 after treatment which is statistically significant difference.

Here it would be appropriate to mention some single design pre-post test studies that examined the effectiveness of cognitive behavioral therapy. In one of such studies, Deblinger et al (1996) investigated the effectiveness of CBT for children aged 3-16 suffering from PTSD. The study included 19 children and they were assessed using structured clinical interview. Measures of PTSD and other symptoms were taken twice before treatment (to check for symptom stability) and ones after treatment. The children showed significant improvement in many symptoms and no child meet the criteria for clinical PTSD symptom after treatment.

The control group also showed reduction of post traumatic stress symptoms from the mean of 28 before treatment to the mean of 27.56 after treatment. The difference was 0.44 which is not statistically significant. The insignificant improvement in post traumatic stress symptoms can be explained by some findings which suggest that abused children show improvement in symptoms by the mere passage of time. Some suggested that the time since the last abuse is responsible for the improvement while others stressed the time since the discovery of the abuse is important particularly in the case of sexual abuse (Skowron & Reinemann, 2005).

There are findings which show that in the long run PTSD symptoms get reduced whether therapy is provided or not. For instance, Foa et al conducted a non randomized controlled trial on 20 children suffering from PTSD symptoms where he provided short term TF-CBT. Fallow up measure after two months showed that there were fewer cases of PTSD in treatment group than in comparison group. After five months the difference between the two groups was only the severity of the symptoms (cited in Marit etal, 2007).

As indicated in the results section, at post test the mean post traumatic stress symptom measure of the treatment group was 24.7 while it was 27.5667 for the control group. An independent t test indicates that the difference between the two means is statistically significant. This shows that the therapeutic intervention has brought about significant change among the treatment group compared to a control group.

This finding is consistent with many other findings which show the effectiveness of TF-CBT to treat children with PTSD symptoms.For instance, one study by Maritt etal (2007) 143 patients with acute post traumatic stress disorder were randomly assigned to either brief cognitive behavioral therapy or a comparison waiting list. Cognitive behavioral therapy was consisted of education, relaxation exercise, imaginal exposure, in vivo exposure and cognitive

restructuring. Main outcome of PTSD score was measured by structured interview. The outcome was measured just after the intervention and 4 months after the intervention .PTSD symptoms showed significant reduction among treatment group compared to the waiting list just after the treatment and the difference between the two groups was insignificant after 4 months.

In other study, Berliner and Saunders (1996) have investigated the effectiveness of Cognitive behavioral group therapy to reduce various symptoms including PTSD, anxiety and depression; they divided 86 children in to treatment group and comparison group. The treatment group received cognitive behavioral group therapy with co-counselors. Outcome scores were measured just after the treatment and one year after the treatment. The result was that the treatment group showed statistically significant improvement of symptoms for the treatment group (cited in Maritt, 2007).

Cloitre and Koenen (2001) recruited participants with posttraumatic stress symptoms related to child sexual abuse to participate in a study of a 12-week interpersonal process group. Participants in the groups in which there were no members diagnosed with borderline personality disorder showed significant improvement on measures of anger and posttraumatic stress symptoms.

After the treatment, the mean of PTSD score for the younger children was 25 while it was 24.52 for adolescents. Here the teenagers scored less than the younger children. Even though, the difference was not significant it might indicate that the teenagers recovered better than the younger children suggesting that they were more responsive to therapy.

Research findings indicated that CBT is comparatively more effective than other therapies for different age groups from preschoolers to adults. For instance, Cohen and Marino (1996) randomly assigned eighty six preschool children either to a cognitive behavioral therapy

or to a non directive supportive therapy. Treatment outcome measures included behavior check list, the child sexual behavior inventory and the weekly behavior report. Children who were treated with CBT showed significantly better improvement in all measures compared to children who received non directive supportive therapy. They repeated similar design for older children aged 7-14 and used social competence scale, behavior profile scale, children's depression inventory, and sexual behavior inventory.CBT was found to be significantly more effective in older children (7 to14years old) as well.

The finding of the study indicates that there was no significant difference in mean score of post traumatic stress symptoms between the children who experienced sexual abuse and children who experienced physical abuse both before and after the treatment. However, sexually abused children showed consistently higher score in both pre and post tests than physically abused children though it was not significant.

The consistent higher score of sexually abused children compared to physically abused children even though not statistically significant can be explained by some literature indicating sever PTSD on sexually abused children than physically abused children (Skoworn & Enereman, 2005).It can also be due to different symptoms of PTSD experienced by the two groups.

These findings are encouraging that TF-CBGT can help abused children with PTSD recover from the symptoms better than no treatment situation. Further studies are needed to verify and expand these findings in different settings.

5.3 Follow up

Follow up measure of post traumatic stress symptoms was performed after 15 days of the first treatment outcome test. This was in order to test whether the treatment outcome will be maintained through time. The test revealed that post traumatic stress symptoms show slight

increase compared to post test one. However, the difference was too small to be statistically significant which indicates that the treatment outcome was maintained at post test 2.

There are contrasting findings regarding the consistency of treatment outcome at follow up studies. A study by Deblinger etal (1999) fallowed children with PTSD who receive cognitive behavioral therapy for two years measuring PTSD symptoms, child depression inventory and child behavior checklist. The measures were taken 1month, 6 month, 12 month and 2 years after the treatment program. The result shows that the treatment gain was maintained in all the tests and in all follow up times.

In another study, Marit etal (2007) have shown that the participants in short term TF-CBT treatment program recovered from PTSD symptoms one week after the intervention. It was conducted on a sample of 143 which is divided in to treatment group (79) and control group (64).Four months after intervention the difference between the control group and the treatment group in symptoms of PTSD, depression and anxiety was insignificant.

The amount of evidence that show the effectiveness of trauma focused cognitive behavioral therapy is growing worldwide and this research adds to the growing evidence. The strength of theses study is the presence of a control group with which to compare the outcome measures. However, it was not intended to be a randomized controlled study where the two groups are equivalent.

This study included a limited number and variety (only 30 children living in charity organizations) of participants which limits its applicability to the general population. It would have been better if the fallow up test was long after the treatment and repeated measure in order to test whether the treatment outcome is maintained. Future studies may examine the

effectiveness of TF-CBT on larger sample and with a repeated fallow up over a long period of time in order to test the consistency of results over time.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

1.1 SUMMARY

This is a quasi experimental study conducted to examine the effectiveness of trauma focused cognitive behavioral therapy for either sexually or physically abused children who are with post traumatic stress symptoms. It is to make comparison of the difference of mean score of post traumatic stress symptoms scale between the experimental group and the control group as well as within the experimental and control groups. It also intends to compare the CPSS scores of children with physical abuse and sexual abuse and younger children (9 to 12 years old) and teenagers (13 to 16 years old) within the treatment group at the end of treatment program. Participants of the study were selected from two different NGOs namely Kechene children's home and OPRIFS.

Sixty children who were either sexually or physically abused were selected as participants. They were divided in to two groups each group having equivalent participants in terms of child PTSD symptoms score and type of abuse. Using lottery method (coin toss) one of the groups was made treatment group and the other control group. The treatment group received TF-CBT for 3 sessions a weak for a total of 12 sessions. The participants were asked to fill standardized scale (CPSS) which measures the level of post traumatic stress symptoms before the treatment, and after the treatment (for both groups)and 15 days after the treatment(only for treatment group).

The results indicate that the majority of the participants were measured moderate on PTSD symptoms scale (56.7% from treatment group and 60% from the control group) at pre test. Before the treatment there was no statistically significant difference in the mean score of PTSD symptoms scale between the treatment group and the control group. The findings also indicate

that there was no significant difference in PTSD measures among different sub groups within the treatment group. That is there was no significant difference in the mean score of PTSD symptoms of sexually abused children and physically abused children. Similarly, the difference in PTSD symptoms measure of younger children 9 to 12 years and teenagers 13 to 16 years was insignificant.

After the treatment the majority of participants in the treatment group measured to be mild (53.3%) in PTSD symptoms scale while the majority of those in the control group remained moderate (60%) on the scale. An independent t test indicated that there was significant statistical difference between pre test and post test measures of PTSD symptoms among the treatment group (df=29 t=**2.618)**.This treatment gain was maintained after 15 days fallow up measure. On the other hand, the paired t test of the mean scores of the control group at pre and post test was not significant.

An independent t test was conducted to examine the difference of the mean PTSD symptoms scores of the control group and the treatment group. The result show that there was statistically significant difference between the two groups (df= t=2.068).This finding is consistent with many other findings.

Independent t test was used to compare the mean PTSD symptoms scores of two sub groups within the treatment group at pre and post test. It is found that sexually abused children scored more than physically abused children (showing more PTSD symptoms) but the number was too small to reach statistical significance. Similarly, teenager aged 13 to 16 showed more PTSD symptoms at pre test and less PTSD symptoms after treatment compared to younger children, though the difference was not statistically significant.

5.2 CONCLUSIONS

The following are major findings of the study.

- ✓ Majority of the participant's 56.7% from the treatment group and 60% from the control group experienced moderate levels of post traumatic stress disorder symptoms before the treatment.
- ✓ The treatment group showed a statistically significant reduction in the level of post traumatic stress symptoms from pretest to posttest mean of post traumatic stress symptoms scores after the completion of trauma focused cognitive behavioral therapy.
- ✓ There is no statistically significant difference in the mean PTSD symptoms score of the post test one and post test two for the treatment group. The treatment outcome (PTSD symptoms measured at the end of treatment program) was maintained after 15 days fallow up measure.
- ✓ The control group didn't show a statistically significant reduction in post traumatic stress symptom mean score from pretest to posttest measures**.**
- ✓ There was statistically significant difference between the treatment group and the control group in the mean score of PTSD symptoms after the treatment.
- ✓ There is no significant difference between the mean PTSD score of the children who are sexually abused and children who are physically abused at pre and post test measures.
- ✓ There is no significant statistical difference between the PTSD symptoms level of younger children 9 to 12 years and teenagers 13 to 16 years of age both before and after treatment.

5.3 RECOMMENDATIONS

This study has indicated that trauma focused cognitive behavioral therapy can be effective in reducing post traumatic stress symptoms of both sexually and physically abused children. However, we need extensive large scale studies with larger and more diverse samples before we can talk about TF-CBT in Ethiopian context with adequate certainty. Given the number of children suffering from various types of abuse and traumas that actually need psychological and mental health services together with this kind of study make it necessary to conduct more studies on the effectiveness and adaptation of various psychotherapies particularly TF-CBT.

Many nongovernmental organizations accommodate vulnerable children and provide them with basic needs like shelter, food, education and medical services; however, the need of counseling and mental health services for these vulnerable children is usually not recognized (OPRIFS & Kechene children's home do provide counseling services). Since it is obvious that there is a need from the children and that they can be helped, wider and more appropriate use of counseling is to be encouraged in these institutions.

This study attempted to examine the effectiveness of trauma focused cognitive behavioral group therapy for physically or sexually abused children. There is growing evidence globally that show the effectiveness of trauma focused cognitive behavioral therapy that some organizations like the Substance Abuse and Mental Health Services Administration (SAMHSA) of US have encouraged its use and training of counselors in this form of therapy. Even if the evidence is too small to suggest that TF-CBT is generally effective in Ethiopian context, the evidence suggests that TF-CBT can be used by counselors to help children with PTSD.

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APPENDICES

Appendix A

Demographic Data Questionnaire

2. Age: _____

3. Educational level: _____

4. For how long times have you lived in this institution

6. What type abuse have you experienced?

A. Sexual Abuse B. Physical Abuse C. Other

7. Have you ever received counseling before?

1. Yes 2. No

Appendix-B

Child Post Traumatic Stress Symptoms Scale

Instruction: Below is a list of problems that children sometimes have after experiencing an upsetting event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you in the last 2 weeks. All the responses will be kept confidential. Thank you for your corporation!!!

Part-1					
S.N	**List of Problems**	**Responses**			
		Not at all (0)	Once a week (1)	2 to 4 times a week (2)	5 0r more times a week (3)
1	Having upsetting thoughts or images about the event that came into your head when you did not want them to				
2	Having bad dreams or nightmares				
3	Acting or feeling as the event was happening again (hearing something or seeing a picture about it and feeling as if I am there again)				
4	Feeling upset when you think about it or hear about the event (for example, feeling scared, angry, sad, guilty, etc)				
5	Having feelings in your body when you think about or hear about the event (for example, breaking out in to a sweat, heart beating fast)				
6	Trying not to think about, talk about, or have feelings about the event				
7	Trying to avoid activities, people, or places that remind you of the traumatic event				

8	Not being able to remember an important part of the upsetting event				
9	Having much less interest or doing things you used to do				
10	Not feeling close to people around you				
11	Not being able to have strong feelings(foe example, being unable to cry or unable to feel happy)				
12	Feeling as if your future plans or hopes will not come true (for example, you will not have a job or getting married or having kids)				
13	Having trouble falling or staying asleep				
14	Feeling irritable or having fits of anger				
15	Having trouble concentrating(for example, losing track of a story on the television, forgetting what you read, not paying attention in class)				
16	Being overly careful(for example, checking to see who is around you and what is around you)				
17	Being jumpy or easily startled(for example, when someone walks up behind you)				
Part -2					
Indicate below if the problems you rated in Part-1 have gotten in the way with any of the following areas of your life DURING THE PAST 2 WEEKS					
18	Doing your prayers				
19	Chores and duties at home				
20	Relationship with friends				
21	Fun and hobby activities				
22	Schoolwork				
23	Relationships with your family				
24	General happiness with your life				

Appendix-C

1. ፆታ፡ _____

2. ዕድሜ _____

3. የትምህርት ደረጃ፡ _____

4. በዚህ ድርጅት ውስጥ ለምን ያህል ጊዜ ኖረሻል? _____

6. ከድርጅቱ የምክክር አገልግሎት ተጠቅመሻ ታውቂያለሽ?

1. አዎ 2. አይደለም

ማጠይቁ ተጠናቋል፡፡ አመሰግናለሁ

Appendix-D

መመሪያ፡-ቀጠሎ የተዘረዘሩት ጥያቄዎች ልጅች የደረሰባቸውን አሰቃቂ ጥቃትን ተከትለው የሚሰቱ የስሜትና የማፈስ ሚበሽ ችግሮች የሚኩ ሲሆኑ እያንዳንዱን ጥያቄ በጥሞና በማንበብ ወይም በማዳመጥ ችግሩ **ላለፉት ሀለት/2/ ዛምንታት** ከተሰጡት አራት/4/ አማራጮች (0-3) የአንቺን ስሜት በትክክል ይገልፃል ባልሽው ምርጫ ሥር "✓" ምልክት በማድረግ ማልሽ፡፡ የሚጥሽው ምላሽ ሀሉ በሚስጥር ይቀመጣል፡፡ ለትብብርሽ በጣም አመሰግናለሁ!!!

ክፍል 1					
ተ.ቁ	ጥያቄዎች	አማራጮች			
		ምንም የለም (0)	በሳምንት አንድ ጊዜ (1)	በሳምንት ከ2 እስከ 4 ጊዜ (2)	በሳምንት 5 ጊዜ እና ከዚያ በላይ (3)
1	ስለደረሰብኝ ጥቃት የሚያስፈሩና የሚያስጨነቁ ሀሳቦች ሳልፈልጋቸው በአዕምሮዬ እየተመላለሱ ያስቸግሩኛል				
2	ሜታ ሜታ መጥፎ ህልሞች እመለከታለሁ ወይም ያታክሰኛል				
3	የደረሰብኝ ጥቃት በድጋሚ የሚከሰት ዓይነት ስሜት ይሰማኛል፣ ሚችም ስለ ጥቃቱ የሆነ ነገር መስማት ወይም ሞት እና እዚያ ቦታ ላይ እንደገና የማኘት ስሜት ይሰማኛል				
4	ስለደረሰብኝ ጥቃት ሳስብ ወይም ስሰማ የሚያስፈራ እና የሚያስጨነቅ ስሜት ይሰማኛል /ለምሳሌ፡-የመንገጥ፣ የመፍራት፣ የመናደድ፣ የማዘን፣ የወጅለኝነት ስሜት ይሰማኛል/				
5	ስለደረሰብኝ ጥቃት ሳስብ ወይም በሰማው ጊዜ በሰውነቴ ላይ የተለያዩ ለውጦች ይከሰታሉ /ለምሳሌ፡- ማላብ፣ የልብ ምት መጨመር/				
6	ስለደረሰብኝ ጥቃት ማውራና መገር ወይም ስለጥቃቱ ምንም ዓይነት ስሜት እንዲሰማኝ አልፈልግም				
7	የደረሰብኝን አሰቃቂ ጥቃት ሊያስታውሱኝ የሚችሉ ድርጊቶች፣ ሰዎች እና ቦታዎች ለማወገድ እሞክራለሁ				
8	ስለሚብሰኝና ስለሚያስጨነቀኝ ሁኔታ አስፈገላጊውን ወይም ዋነኛውን ጉዳይ ለማተዋስ አለመቻል				
9	ከዚህ በፊት የምሥራቸውን ሥራዎች የመሥራት ፍላጎቴ በጣም ቀንሷል				
10	በአካባቢዬ የሚኙ ሰዎችን የመቅረብ ስሜቱ የለኝም				
11	ስሜቴን በአግባቡ መግለፅ አልችልም /ለምሳሌ፡-የደስታ ስሜት ማጣት፣ ለሚልቀስ መቸገር/				
12	የወደ ፊት ዕቅዶቼ ወይም ተስፋዎቼ የሚሳኩ መሰሎ ይሰማኛል /ለምሳሌ፡-ሥራ አለማገኘት፣ አለማገባት፣ ወይም ልጅ አለመውለድ/				
13	እንቅልፌ የተቆራረጠ እና የተረበሸ ወይም እንቅልፍ ላይ ለረዥም ጊዜ እቆያለሁ				
14	የማጨጫፍ የመናደድ ስሜት ይሰማኛል				
15	አዕምሮዬን በአንድ ሥራ ላይ እንዲያተኩር ማድረግ ያስቸግረኛል /ለምሳሌ፡-ቴሌቪዥን መከታተል አለመቻል፣ ያነበብኩትን ሚሳት፣ ከፍል ወስጥ ትኩረት ማድረግ አለመቻል/				
16	ለእያንዳንዱ ነገር ከማጠን በላይ ጥንቃቄ አደርጋለሁ				

	/ለምሳሌ፡-በዙሪያዬ ማን እና ምን እንዳለ ደጋግሞ ሚረጋገጥ/				
17	በቀላሉ መደንገጥ፣ መፍራት ወይም መሳቀጥቀጥ /ለምሳሌ፡ ከኃላ የሆነ ሰው ሲመጣ/				
ክፍል-2					
በክፍል-1 ሥር የሚጥሻቸው ችግሮች በሚከተሉት እንቅስቃሴዎች ላይ **<u>ላለፉት ሀለት ሳምንታት</u>** በአንቺ ላይ ችግር አስከትለው ከሆነ "አዎ" ካልሆነ ደግሞ "አይደለም" በሚለት ሚልስ ስጪ፡					
18	ሀይሞታዊ ግዴታዎች/ለምሳሌ ጸሎት/ በበቂ ሁኔታ በመጣት ረገደ			አዎ	አይደለም
19	በዕለት ዕለት የቤት ሥራዎችን በበቂ ሁኔታ በመጣት ረገድ			አዎ	አይደለም
20	ከጓደኞችሽ ጋር ባለሽ ሚልካም ግንኙነት ላይ			አዎ	አይደለም
21	የሚዝናኑ እና የሚስደስቱ እንቅስቃሴዎችን በሚከናወን ረገድ			አዎ	አይደለም
22	የትምህርት ቤት ሥራዎችን በሚከናወኑ ረገድ			አዎ	አይደለም
23	ከቤተሰቦችሽ ጋር ባለሽ ሚልካም ግንኙነት ላይ			አዎ	አይደለም
24	በአጠቃላይ በደስተኛ ህይወትሽ ላይ			አዎ	አይደለም

Appendix-E

Treatment Plan

Introduction

PTSD is a type of anxiety disorders that occurs after the person is exposed to a traumatic experience. It causes a change in thoughts, feelings and behaviors and is usually characterized by flash backs, repetitive intrusive memories, sleep disturbance, feeling frightened and vulnerable, nightmares etc. Traumatic experiences that cause PTSD tend to be unique to an individual based on his/her personality, belief system, personal values, past experiences, intensity of the traumatic event and the support available to recover from the trauma. Five to forty percent of those who experience traumatic event develop PTSD symptoms. Regardless of the causes, an effective treatment can significantly reduce chronic and intense PTSD symptoms and improve the chance of recovery.

CBT is a therapy modality based on both learning theories and cognitive psychology. Behavioral therapies are based on the assumption that our behavior is learned through the principles of learning like classical conditioning and operant conditioning. Classical conditioning states that our behavior is learned through association of stimulus and response while operant conditioning proposes that our behavior can be strengthened or weakened by the reinforcing or punishing consequences. On the other hand, Cognitive therapy emphasizes internal cognitive structure (schema) and cognitive process (information processing etc) in explaining human behavior.CBT is a rational blending of the two modalities which become an effective treatment for variety of psychological disorders.

Many resent findings have shown that CBT is an effective therapy for children and adolescents with PTSD. A review of studies identified three factors that were involved in successful

treatments: emotional engagement with the trauma memory, organization and articulation of a trauma narrative, and modification of basic core beliefs about the world and about oneself. The treatment plan attempted to include all of these aspects in a treatment of 12 sessions each session lasting 50-60 minutes.

Session One: Rapport Building

Objectives

1) Introduce the children to each other

2) Clarify with the children the purpose of the group

3) Give an outline of how the group will be conducted

4) Establish group responsibilities

Materials

pens, pencils

Attendance Sheet

Activities

Introducing Group Members

- ❖ Have the children sit in a circle on the floor or on chairs around a table.
- ✓ Ask the children to break into pairs and tell each other their name, age, grade, favorite subject, favorite thing to do for fun, favorite food, favorite TV show, etc. -Have each child introduce her or his partner to the group, telling as many things about that person as they can remember.
- ✓ Have the children each tell something good and something not so good that has happened to them during the past week. The therapists may start this activity in order to model for the group.

Description of Group Purpose

- ✓ Describe that everyone in the group is there for the same purpose reducing the negative symptom (feelings, behavior and thought) that they have experienced as a result of being a victim of abuse.

- ✓ Describe to the children that we will discuss in detail their experiences regarding the abuse. This group is a place where they will learn how to cope with negative thoughts, feelings and behavior particularly post traumatic stress disorder.

- ✓ Let the children know that there are a lot of things that they will be expected to talk about during the next 12 weeks.

Establishing Group Responsibilities

- ❖ Explain that you want to make this group a safe place where the children can feel comfortable talking. To do that, they each have some responsibilities to remember.

Discuss the following responsibilities

1. Talking (confidentiality)

- Tell the children that private is something that is personal, it belongs to you and nobody else. Explain that the things they say can also be private--the things talked about in here are private.

- Let them know that they should not tell other people about something someone else said in the group but that they can tell about something they said if they want to.

- Let the children know that the therapists also have responsibility about talking. Things said in the groups will generally not be told to other people, including their parents/caregivers.

2. Be respectful.

✓ Explain that in this group, being respectful means no interrupting while other people are talking, no hitting, no name calling, and no swearing, stay in the room unless you have permission to leave.

✓ Ask the children to suggest additional rules.

Assessment Questions

✓ Each week the children are asked some questions to assess their understanding of the material covered in that session and in previous sessions.

Remind the children that it is important to come to each session.

Session 2-5 Psycho Education

Objectives:

- Psycho education about PTSD
- Psycho education about cogitative behavioral model (the relationship among cognition, affection and behavior)
- Teach about coping mechanisms

Therapeutic activities

- Describe Posttraumatic Stress Disorder

1. Help the children understand what PTSD is, how and why it begins

2. Mention cluster of symptoms of PTSD and tell them why they are maladaptive
3. Tell them that they are not alone that many other people do respond in the same way that they have responded.
4. Tell the children what therapy involves, how therapy will proceed and why it proceeds that way. Give them over view of what to do in the next sessions. Remind them that therapy is helpful and that they should not miss the sessions.

- ✓ Psychoeducation in regard to cognitive-behavioral model
  - ❖ Teach the group members about the difference between thoughts, feelings and behavior.
  - ❖ Teach the children/adolescents about the relationship and interaction between thoughts, feelings and behavior.
  - ❖ Briefly describe to the group how cognitive distortion leads to emotional and behavioral problems.
  - ❖ Describe to the group the most common cognitive distortions that can result from trauma exposure (e.g., an inability to tolerate mistakes in oneself or others; a denial of any personal problems resulting from the trauma; all-or-nothing, or black-and-white, thinking; the need to continue survival tactics to avoid further disaster).
- ❖ Teach the children about coping mechanisms
  - ✓ Brain storm the group about how they cope with stressful situation.

- ✓ Briefly describe to the children what copping is and the major types of coping mechanisms: emotion focused coping, problem focused coping and appraisal focused coping. Give example for each type of copping.
- ✓ Teach relaxation exercises: Explain that there are three parts – muscle relaxation, creating an imaginary "Happy Thought", and slow breathing.
- ✓ Discuss sleeping problems in the group; brainstorm the group about how to solve sleeping problems. Provide them some tips to improve their sleeping habit(like regular time to sleep)

- Home works
  - Give a list of PTSD symptoms for the children to study
  - Give the adolescents home work to list dawn their own coping mechanisms (what they do when they are stressed)

Session 6-8: Story telling

Objectives:

- Telling the whole story
- Narrative exposure

Therapeutic Activities

- Telling the general story

5. Have each member of the group tell the whole story of the abuse from the beginning to the end
6. Encourage the process of disclosure in the group, let them feel easy to disclose

7. Ask questions like what, who, where and when to encourage the members not to miss important points
8. Help the children/adolescents sort out what exactly has happened-making pieces come together and form the whole picture.

1. Narrative exposure

This part of therapy is the most scary and painful though important-confronting the feared memories. The clients will get a relief as they confront the feared memories. Here anticipatory anxiety is common that the group members fear what will happen as they confront the memories, however the more they confront the lesser the fear becomes. There is a pattern that anxiety often increases before it starts to be reduced which makes clients escape confrontation. Therefore, the counselor should be skillful in managing the particular clients pace so that there will be appropriate exposure treatment.

1. Have each member tell the story in greater detail. If something becomes too stressful then stop narration and do relaxation exercises.
2. Ask the children to talk about the worst moment of the abuse and their feelings at the time. It helps them have a new perspective on what happened. It also helps to associate their anxiety to the specific events that happened during the abuse rather than generalizing it to other stimulus.
3. Ask them to identify the scariest stimulus that they associate with the trauma Facilitate a group brainstorming with the members in identifying the triggers that elicit emotional and physiological arousal evocative of the trauma (e.g., sights, sounds, smells, physical sensations, tastes, places, persons, weather, thoughts), and the reactions they have to their triggers.

1. Home Works

2. Ask them to practice relaxation exercises every day.

3. Provide the adolescents with subjective unit of distress scale (SUDS) so that they could easily measure the level of stress that they are experiencing at different times.

Session 9-12: Cognitive Restructuring, Self monitoring and Relapse Prevention

Objectives

1. Cognitive restructuring
2. Self monitoring
3. Relapse prevention

Activities

1. Cognitive restructuring

After traumatic experience people may have a range of irrational thoughts and beliefs that cause them distress, anxiety, anger, and arousal. For instance they may think that the world is a dangerous place and that other people are cruel and feel considerable vulnerability as a result. Similarly many people experience feelings of guilt and shame fallowing trauma. They may think that what happened was happened because of their fault; that they were in adequate to cop better. They may think that they were bad or evil for acting in the way they do during the incident. There can be some element of truth in these aspects, however most of the time they are completely untrue or over exaggerated.

The therapist helps the group members recognize unhelpful thoughts and beliefs and replace them with more adaptive and helpful ones. In other words, the therapist challenges irrational

thoughts and beliefs and replace them with more rational and realistic thoughts and beliefs. Exposure therapy helps a lot in this process by modifying irrational thoughts as they arise. Hence to achieve these goals the fallowing activities are performed:

1. Mapping the frequency and intensity of the memories of the sexual or physical abuse and the events that trigger these memories
2. Deal with the attribution of the abuse. Ask the group whom they consider is responsible for the abuse
3. Therapeutically addressing the feelings towards the abuser. Ask how they are acting or would act towards the abuser
4. Help children develop alternative explanation of what happened and develop a positive style of explanation
    1. Focusing on unique experiences and developing meaning out of their experience
    2. Connecting their story to the past and the future

1. Self monitoring

Help the children control their thoughts, feelings and behaviors by teaching them how to use different techniques.

1. Controlling unpleasant PTSD thought
    1. Use mental destructions like focusing on specific place in your surroundings, focusing on pleasant past experience, using mental exercises etc
    2. Distract yourself from unpleasant memory by engaging in different activities like doing something, playing games, watching TV, reading books etc.
    3. Use thought stopping technique where you consciously order yourself from stoping unwanted thought loudly or whispering to yourself.

Training them to use various positive and adaptive self statements that help them reduce scary thought

1. Avoiding inappropriate behavior
    1. Help the children/adolescent establish structure and daily routine
    2. Help adolescents/children strengthen their social interaction

1. Controlling anger

Explain to the group the role of anger as a healthy response to trauma, as well as the healthy and unhealthy ways of expressing anger; elicit from the members the ways that anger expression has helped as well as hurt them.

1. Identifying the triggers and the signs of anger
1. Delay or slow dawn your reaction when you get angry as anger usually disappears after a while
2. When you feel that the anger is escalating remove yourself from the situation for a while
3. Identify the situations that makes you angry and plan your actions accordingly(eg avoid triggers)

1. Relapse Prevention

By this time most of the symptoms are significantly reduced and therapy focuses on what to do if the symptoms relapse. To achieve this goal the fallowing activities would be performed:

1. Review clients' progress and identify any remaining concerns and anticipated difficulties
2. Eliciting group discussion about the future: discuss on what to do if the symptoms relapse.
3. Revise major coping skills
4. Revise self monitoring skills

5. Facilitate a group brainstorming of self-nurturing behaviors (e.g., listen to favorite music, read a book, take a walk, call a friend, watch a favorite video)

Appendix-F

ቀን : _____

ለተጠኚ ቡድን (Experimental Group)

<u>በፈቃድ ላይ የተመሠረተ ስምምነት</u>

(Informed Consent)

እኔ _____(የኮድ ስም) የተባልኩ ቀጨኔ የህፃናት ሳይኪያትሪ/አፕሪፍስ ተጠቃሚ ስሆን በአዲስ አበባ ዩኒቨርስቲ በካወንስሊንግ ሳይኮሎጂ የድረሀ ምረቃ ተማሪ ከሆነው **ከአቶ ሪያድ መሀመድ** ጋር "**የቡድን የምክክር አገልግሎት ወሲባዊ/አካላዊ ጥቃት በደረሰባቸው ልጆች የስነ-ልቦና ችግሮች ላይ ያለዉን ዉጠጋኝ ት**" ለሚተሸ በሚደርገው ጥናታዊ ምርምር ላይ ተሳታፊ ለመሆን ፈቃደኝነቴን በመግለጽ ጥናቱ የሚከይቃቸወን ሀኔታዎች ሚትምፁ

1. በጥናቱ ላይ በፈቃደኝነት ተሳታፊ ለመሆን፣
2. የሚቋርጡልኝን ቅድመ እና ድህረ-ሳከይቆች በአግባቡ ለመሳት፣
3. መፍትሔ ተኮር የአጭር ጊዜ የቡድን የምክክር አገልግሎት ላይ ከባለሞያው ጋር በተስማማው ሰዓትና ቀን ያለሚረጥ የአገልግሎቱ ተጠቃሚ ለመሆን፣

እና ሌሎች ለጥናቱ አስፈላጊ የሆኑ ሀኔታዎችን ለሞሟት በፊርሜ አረጋግጣለሁ ፡

እኔ **አቶ ሪያድ መሀመድ** ከተጠቃሚ _____(የኮድ ስም) ጋር ከላይ በተጠቀሰው ጥናታዊ ምርምር ዙሪያ በቀጨኔ የህፃናት ሳይኪያትሪ/አፕሪፍስ በማኘት ለጥናቱ ስኬታማት የሚስፈልጉትን ከዚህ በታች የተዘረዘሩትን የጥናቱን ስነ-ምግባራዊ ደንቦች ሚትምፁ-

1. ተሳታፊዎች በጥናቱ ለማተፍ ፍቃደኛ በሚኖቸው ልባዊ ምሥጋና በሞቅረብ፤
2. ለጥናቱ ተሳታፊዎች ስለጥናቱ በቂ ገለጻ እና ሚጃ በማጠት፤
3. አንዳንድ የጥናቱ ጥያቄዎች የተሳታፊዎችን ስሜት ሊረብሹ ሰለሚቻሉ በጥንቃቄ እና በአግባቡ በሞቅረብ፤
4. መፍትሔ ተኮር የአጭር ጊዜ የቡድን የምክክር አገልግሎት ሂደቱ በተገቢው እና በጥንቃቄ እንዲካሄድ በሞረግ፤
5. በጥናቱ እና በቡድን የምክክር አገልግሎት ሂደት የሚሉ ሃሳቦችና ሚጃዎች በሚሉ በሚጥር በማዝ፤

በአጠቃላይ ጥናታዊ ምርምሩን በአግባቡ ለማካሄድ ማማማኔን በፊርሜ አረጋግጣለሁ ፡

የጥናቱ ተሳታፊ ስም: _____ **ፊርማ:** _____

(ወይም 'የቤቱ እናት' ስም)

የጥናቱ ባለቤት ስም: _____ **ፊርማ:** _____

ቀን : _____

ለማነጻጸሪያ ቡድን (Control Group)

<u>በፈቃድ ላይ የተመሠረተ ስምምነት</u>

(Informed Consent)

እኔ _____(የኮድ ስም) ቀጨኔ የህፃናት ሜዲካል ኦፕሬፍስ ተጠቃሚ ስሆን በአዲስ አበባ ዩኒቨርስቲ በካወንስሊንግ ሳይኮሎጂ የድረህ ምረቃ ተሜ ከሆነው **ከአቶ ሪያድ መሀመድ** ጋር "**የቡድን የምክክር አገልግሎት ወሲባዊ/አካላዊ ጥቃት በደረሰባቸው ልጆች የስነ-ልቦና ችግሮች ላይ ያለውን ውጤታማነት**" ለሜተሽ በሚደርገው ጥናታዊ ምርምር ላይ ተሳታፊ ለመሆን ፈቃደኝነቴን በመግለጽ ጥናቱ የሚከይቃቸወን ሁኔታዎች ሚከትም፡

6. በጥናቱ ላይ በፈቃደኝነት ተሳታፊ ለመሆን፣
7. የሚቋርበልኝን ቅድመ እና ደህረ-ሜከይቆች በአግባቡ ለመሞላት፣

እና ሌሎች ለጥናቱ አስፈላጊ የሆኑ ሁኔታዎችን ለሞሟላት በፊርሜ አረጋግጣለሁ ፡

እኔ **ሪያድ መሀመድ** ከተጠቃሚ_____(የኮድ ስም) ጋር ከላይ በተጠቀሰው ጥናታዊ ምርምር ዙሪያ በቀጨኔ የህፃናት ሜዲካል ኦፕሬፍስ በመኘት ለጥናቱ ስኬታማት የሚስፈልጉትን ከዚህ በታች የተዘረዘሩትን የጥናቱን ስነ-ምግባራዊ ደንቦች ሚከትም፡-

1. ተሳታፊዎች በጥናቱ ለመሳተፍ ፍቃደኛ በመሆናቸው ልባዊ ምሥጋና በማቅረብ፤
2. ለጥናቱ ተሳታፊዎች ስለጥናቱ በቂ ገለጻ እና መረጃ በመስጠት፤
3. አንዳንድ የጥናቱ ጥያቄዎች የተሳታፊዎችን ስሜት ሊረብሹ ሰለሚችሉ በጥንቃቄ እና በአግባቡ በማቅረብ፤
4. በጥናቱ ሂደት የሚሉ ሃሳቦችና መረጃዎች በሚስጥር በመያዝ፤

በአጠቃላይ ጥናታዊ ምርምሩን በአግባቡ ለማከሄድ መስማማቴን በፊርሜ አረጋግጣለሁ ፡

የጥናቱ ተሳታፊ ስም: _____ **ፊርማ:** _____

የጥናቱ ባለቤት ስም: _____ **ፊርማ:** _____