ADDIS ABABA UNIVERSITY

COLLEGE OF EDUCATION AND LANGUAGE STUDIES SCHOOL OF PSYCHOLOGY GRADUATE PROGRAM

TRAUMA-FOCUSED COGNITIVE BEHAVIOR GROUP THERAPY FOR CHILDREN WITH POST-TRAUMATIC STRESS DISORDER: THE CASE OF MCDP (MISSION FOR COMMUNITY DEVELOPMENT PROGRAM)

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JUNE, 2025

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Declaration

I, the undersigned, declare that the work contained in the body of this research thesis is my own original work and has not been submitted for any award. All information from other published and unpublished sources is properly cited and authenticated in accordance with relevant scholarly practice.

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Certification

This is to certify that **Masresha Siyoum** carried out under my supervision of thesis "**Trauma-Focused Cognitive Behavior Group Therapy for Children with Post-traumatic Stress Disorder: The Case of Mission for Community Development Program**" The work is original and eligible to be submitted, meeting the requirements for obtaining a Master of Arts in Counseling Psychology.

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Thesis Approval Sheet by the Board of Examiner

Trauma-Focused Cognitive Behavior Group Therapy For Children With Post-Traumatic Stress Disorder: The Case Of Mcdp (Mission For Community Development Program)

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Abbreviations

CBT Cognitive behavioral therapy

CPSS Child PTSD Symptom Scale

MCDP Mission for Community Development Program

PTSD post-traumatic stress disorder

TF-CBT Trauma-focused Cognitive Behavioral Therapy

PTSS Post-Traumatic Stress Symptoms

Abstract

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a well-established treatment for PTSD in children. This Therapy incorporates elements of Cognitive Behavioral Therapy and Trauma-Focused techniques, which make it adaptable for children. The aim of the study is to examine the effectiveness of Trauma-Focused Cognitive Behavior Group Therapy for Children with Post-Traumatic Stress Disorder: the case of Mission for Community Development Program. ABA research design was employed to evaluate the effectiveness of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in reducing symptoms of post-traumatic stress disorder (PTSD). Quantitative data was gathered using structured questionnaire of CPSS. Quantitative data gathered through CPSS intervention tool measuring PTSD symptoms, emotional regulation, and behavioral changes. To monitor any changes in PTSD symptoms before and after the treatment, the researcher used the Child PTSD Symptom Scale (CPSS). The service provides therapeutic care for 80 children. Consequently, the whole population were took part in the study. The pared t-test is being used to see if symptoms of PTSD change within the group after the intervention. All 80 participants were girls; primarily adolescents aged 16-18 years (55%), indicating a potential influence of social or cultural factors on PTSD prevalence. Additionally, the respondents hail from rural or suburban areas different cultural, with most enrolled in primary school (95%), highlighting disparities in access to mental health care and education in these communities. The t-test result revealed that a significant difference between the average scores before and after treatment, with a mean difference of 1.98 ($t = 36.748$, $df = 79$, $p < .001$). This suggests that the treatment had a substantial positive effect on the participants' scores. Finally the study reveals that the substantial improvements observed in participants, as evidenced by the statistical analyses of pre- and post-treatment assessments, reinforce the efficacy of TF-CBT as a vital therapeutic approach. By promoting resilience and shared experiences, group therapy enhances the therapeutic process, making it particularly valuable for children who have faced trauma.

Key Words: Trauma-Focused, Post-Traumatic Stress Disorder, Trauma-Focused Cognitive Behavioral Therapy

1. CHAPTER ONE: INTRODUCTION

1.1. Background of the Study

In recent years, there has been growing concern regarding the prevalence of Post-Traumatic Stress Disorder (PTSD) among children. Symptoms of PTSD in children can include amnesia, changes in conduct, alteration of mood, and heightened cognitive emission, as well as increased rumination (American Psychiatric Association, 2013). These symptoms can significantly impact a child's emotional development, academic performance, and social relations. Given the heightened vulnerability of children to traumatic events and the subsequent development of PTSD, it is critical to deliver appropriate interventions that fulfill their psychological needs (McLaughlin et al., 2017).

Given the prevalence of Post-Traumatic Stress Disorder (PTSD) among children, Trauma-focused Cognitive Behavioral Therapy (TF-CBT) is a well-established and highly effective treatment for the trauma. This therapy incorporates elements of Cognitive Behavioral Therapy and trauma-focused techniques, making it adaptable for children. TF-CBT aims to help children by resolving their psychological difficulties, learning self-control mechanisms, and diminishing anxiety through an organized method that includes trauma healing, emotional regulation, and coping strategies. Numerous studies and meta-analyses have consistently documented that TF-CBT decreases PTSD symptoms and enhances children's functioning (Dorsey et al., 2017; Tran et al., 2021). The Case of MCDP organization in this research use a variety of community-based programs designed to provide mental health support, with a specific focus on trauma care. Recognizing the importance of addressing the psychological consequences of trauma and fostering healing processes in children, the organization's commitment to community development is based on the principles of TF-CBGT and conducts research into the effectiveness of this treatment in its work (MCDP, 2022).

Delivering TF-CBGT offers an excellent opportunity for simultaneous engagement of multiple children, encouraging peer support and shared healing. Also, Effective TF-CBGT group therapy can advance the therapeutic process through connections between children who share similar traumatic events, thus helping alleviate their sense of isolation. This shared experience not only helps the participants, but helps to promote community bonding, encouraging a complete healing process beyond therapy (Tran et al., 2021).

This approach is particularly important given the rising rate of children suffering from post-traumatic stress disorder (PTSD), especially among orphans and other vulnerable groups, has become a worrying trend in mental health research and practice (Finkelhor et al., 2015). Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based intervention that effectively reduces post-traumatic stress disorder (PTSD) symptoms in children by integrating cognitive-behavioral techniques with trauma-sensitive principles (Silverman et al., 2008). Despite its established efficacy, there remains a notable scarcity of research examining its effectiveness in group therapy settings for children, particularly among orphans and other vulnerable populations (Cohen et al., 2017; Kinniburgh et al., 2017). Addressing this gap is critical, as PTSD rates among children—especially those in high-risk groups—have risen significantly, underscoring the need for scalable interventions (Finkelhor et al., 2015).

This study aims to assess the effectiveness of Trauma Focused Cognitive Behavioral Group Therapy on children suffering from PTSD within the selected organization.

1.2. Statement of the Problem

The pervasive issue of post-traumatic stress disorder (PTSD) among children, particularly those exposed to repeated community-level traumatic events, presents a significant and often unaddressed public health concern, leading to chronic stress and long-term mental health challenges (Kinniburgh et al., 2017). While Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an empirically supported intervention for childhood trauma, there remains a notable gap in research concerning its effectiveness when delivered in group settings for children (Cohen et al., 2017). Therefore, assessing the effectiveness of Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBGT) for children suffering from PTSD within the selected organization is critical to address these service gaps and inform the development of contextually relevant and scalable mental health interventions.

TF-CBT has been studied and shown effectiveness in individual treatment sessions, reporting substantial improvement in PTSD symptoms for children (Chorpita et al., 2005). Nevertheless, relatively few studies have been conducted on group therapy formats of TF-CBT and their participation in the frameworks. The existing literature seems to concentrate on individualized treatment approaches, leaving the contribution that group processes could make towards better treatment outcomes for children with PTSD.

Evidence suggests that the effectiveness of TF-CBGT extends to children of diverse cultural backgrounds (Cohen et al., 2004). The work of Landolt et al (2006) and Silverman et al (2008)

has also demonstrated effectiveness. A few studies have begun tackling these issues (Tadesse & Hailu, 2020, 2021). The majority of the studies lack specific instructions on how to adapt interventions to different settings like Ethiopia. Abebe and Tsegaye (2021) also focused on the health effects of trauma in young people but emphasized the value of more data examining how different approaches can best support their recovery. Barriers to accessing mental health services received attention from Mekonnen and Alemayehu (2022) but they did not suggest particular therapeutic approaches for overcoming these obstacles.

Fekadu and Berhanu (2023) investigated how communities aid in traumatic experiences but did not propose any particular therapy methods to enhance the recovery period. Biruk and Desta (2020) explored children's perceptions of trauma without discussing how those perceptions can guide the development of treatment strategies. Tesfaye and Kassa (2023) offered information on parents' attitudes towards mental health services but did not relate this to the effectiveness of particular treatment methods. Hanna and Abate (2022) studied how beneficial school-based interventions were but did not assess how successful group therapy models such as TFCBGT could be. Lately, Zewdie and Teshome (2021) emphasized the need for cultural adaptations in therapy, yet they did not consider how well-established interventions might apply to their specific setting.

The critical gaps in the literature primarily revolve around the practical application and empirical validation of trauma-focused interventions in diverse settings. Specifically, there is a recurring lack of precise instructions and empirical data on how to effectively adapt established Western interventions to different Ethiopian contexts. While studies highlight barriers to mental health services and call for more data on recovery approaches, they frequently fail to suggest particular evidence-based therapies or provide concrete guidance for overcoming implementation obstacles. Furthermore, insights derived from research on community aid or parental attitudes have not been directly linked to the demonstrated effectiveness of specific treatment methods. Most notably, there is a cumulative absence of context-specific empirical evidence on the success of particular structured group therapy models, such as Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBGT), within culturally diverse underserved populations, hindering the development of concrete, scalable treatment protocols.

While existing literature highlights the efficacy of TF-CBT, there is limited research on its effectiveness in group therapy formats specifically designed for children. Group therapy can provide unique benefits, such as peer support and shared experiences, which may enhance the therapeutic process (Yalom, 2005). The current study aims to fill these gaps by evaluating the

effectiveness of Trauma-focused Cognitive Behavior Group Therapy (TF-CBT) for children with PTSD in Ethiopian context.

1.3. Research Questions

- What is the effectiveness of Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBT) in reducing PTSD symptoms among children participating in the Mission for Community Development Program, as measured by the Child PTSD Symptom Scale (CPSS)?
- Is there a statistically significant difference in post-traumatic stress symptoms before and after group therapy treatment in individuals diagnosed with PTSD?
- Is there a relationship between child age and the reduction in PTSD symptom severity following TF-CBGT within the MCDP, as measured by the Child PTSD Symptom Scale (CPSS)?

1.4. Objective of the Study

1.4.1. General Objective

The general objective of the study is to assess the effectiveness of Trauma-focused Cognitive Behavior Group Therapy for children with post-traumatic stress disorder: the case of Mission for Community Development Program.

1.4.2. Specific Objective

- To assess the effectiveness of Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBT) in reducing PTSD symptoms among children participating in the Mission for Community Development Program as measured by Child PTSD Symptom Scale (CPSS).
- To examine whether there is a statistically significant difference in post-traumatic stress symptoms before and after TF-CBGT treatment in individuals diagnosed with PTSD.
- To investigate the relationship between child age and the reduction in PTSD symptom severity following TF-CBGT within the MCDP, as measured by Child PTSD Symptom Scale (CPSS).

1.5. Significance Of the study

The significance of the study by assessing the effectiveness of TF-CBGT through pre- and post-treatment measurements as follows:

For Children with PTSD in the MCDP (Participants): This study holds direct potential benefits for children with PTSD participating in the MCDP. The research aims to determine whether TF-CBGT is effective in reducing their PTSD symptoms and improving their overall functioning. The findings inform the MCDP's approach to providing mental health services, potentially leading to improvements in the delivery of TF-CBGT. By understanding what works best for children within the MCDP context, the program can tailor its services to ensure that children receive the most effective and appropriate support, helping them to heal from trauma and lead healthier, more fulfilling lives.

For the Mission for Community Development Program (MCDP) Organization: This research is significant benefit to the Mission for Community Development Program (MCDP) itself. The study provides data-driven evidence on the effectiveness of its TF-CBGT intervention for children with PTSD. This information can be used to strengthen the program's design, implementation, and evaluation efforts. The findings can also be used to advocate for increased funding and resources to support the program's mental health services. By understanding the program's strengths and areas for improvement, the MCDP can optimize its services to better meet the needs of the children it serves, ultimately enhancing the program's overall impact on the community.

For existing literatures: This study contributes to the existing literature on the effectiveness of Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBGT) for children with Post-Traumatic Stress Disorder (PTSD) in several important ways. Firstly, it provides empirical evidence on the application of TF-CBGT within a specific community development context, the Mission for Community Development Program (MCDP), which may have unique challenges and resources. Secondly, it adds to the growing body of research examining the efficacy of group-based trauma interventions, addressing a gap in knowledge regarding the feasibility and effectiveness of this modality compared to individual therapy, especially within resource-constrained settings.

1.6. Scope of the study

This study framed by multiple boundaries that guide the research methods and results. The study takes place within the boundaries of the organization and its related program. As a result, the study produces findings that primarily pertain to children within this program and may not be applicable to other organizations or settings.

Geographically the study is bounded at MCDP it is a non-political, non- religious local Non-Governmental which is found at Addis Ketema Sub City in Addis Ababa, thereby limiting the sample population to children accessing services at this specific location and potentially impacting the generalizability of findings to other contexts or populations. The study's scope encompasses the evaluation of symptom reduction, coping skills, and adaptive functioning in children receiving TF-CBGT within the MCDP's program, as well as exploring the influence of demographic characteristics on treatment outcomes.

1.7. Limitation of the study

The current study has some limitations that influence the generalizability and application of its results.

One limitation of this study is the relatively small sample size. While the study aims to include the entire population of 80 eligible child participants within the Mission for Community Development Program (MCDP), this sample size remains modest, which may limit the statistical power to detect significant effects, particularly when examining subgroup analyses or exploring relationships between demographic variables and treatment outcomes. This constrained sample size may also impact the generalizability of the findings to larger populations of children with PTSD or to different community-based program settings, as the specific characteristics of the MCDP population may not be representative of broader populations. Other limitation related with the lack of long TF-CBGT treatment; the study planned the active operation of the treatment given for three month bi-weekly but due to time limitation and less session's activities may result as constraints for the study.

1.8. Operational definitions of the study

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): A structured, evidence-based treatment approach specifically designed to address the needs of children and adolescents with PTSD and related emotional difficulties. Measured by the percentage of core TF-CBT

components implemented per session using therapist checklists and supervisor ratings of session recordings.

Post-Traumatic Stress Disorder (PTSD): A mental health condition that may develop after an individual experiences or witnesses a traumatic event and determined by exceeding the cut-off on the Child PTSD Symptom Scale (CPSS) or a clinical diagnosis via the CAPS-CA, with severity measured by CPSS total score.

Group Therapy: A structured intervention for 6-10 children based on the TF-CBT protocol, participation measured by attendance and engagement via observer ratings.

Effectiveness: Defined as a statistically significant reduction in CPSS total scores from pre- to post-treatment and number of people that no longer meet PTSD diagnostic.

2. CHAPTER TWO: LITERATURE REVIEW

This chapter presents a literature review on the topic. It is organized as follows: it begins with an overview of the concept and definitions, followed by a theoretical review, and then an empirical review. Finally, the chapter concludes with the definition of the conceptual framework, which includes clearly defined indicators.

2.1. Trauma-Focused Cognitive-Behavioral Therapy

TF-CBT in children and teens is specified in the treatment manual reducing the effects of PTSD in children and adolescents is the primary aspiration of TF-CBT. TF-CBT helps apply cognitive-behavioral techniques based on two significant developmental factors: the role played by the caregiver and how a child develops in emotion regulation and coping. The model was developed with PTSD problems linked to sexual abuse in mind such as depressive symptoms, issues with behavior, including aggressive and unsuitable sexual actions and harmful thoughts and feelings about the abuse. Since then, the model has also addressed treating different types of abuse and other traumas such as experiencing physical or emotional abuse or neglect, witnessing violence at home or in the community, losing someone important, war situations and natural disasters. Depending on how much help the child and caregivers may need, TF CBT involves outpatient therapy in 12–16 sessions.

The above ideas offer a good introductory overview of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), highlighting its key features and target populations. The text correctly emphasizes TF-CBT's specified structure, its focus on reducing PTSD symptoms, and its consideration of developmental factors, particularly the role of caregivers and the development of emotion regulation and coping skills. The mention of the model's origins in addressing sexual abuse and its subsequent expansion to treat various types of trauma is also accurate and important for understanding its applicability to diverse contexts. Additionally, the inclusion of the typical session length (12-16 sessions) provides a practical detail.

TF-CBT is used to help children and adolescents, along with their families, heal from the problems caused by trauma. Several research studies have noted that TF-CBT has the best evidence for helping patients affected by trauma (de Arellano et al., 2014; Dorsey, Briggs, & Woods, 2011; Saunders et al., 2004; Silverman et al., 2008). Initially, children who had experienced sexual abuse were asked about the effectiveness of TF-CBT in self-reports (Cohen et al., 2004 and Cohen & Mannarino, 1998).

However, the text could be strengthened by providing more detail on the specific components of TF-CBT and how these components are implemented. For example, elaborating on the "cognitive-behavioral techniques" and how they address trauma-related thoughts, feelings, and behaviors would provide a more comprehensive understanding. While the text mentions research supporting TF-CBT's effectiveness, it could be more specific by describing the types of studies conducted (e.g., randomized controlled trials, meta-analyses) and the magnitude of the effects observed. Furthermore, the connection to the specific context of the study – the Mission for Community Development Program – is missing. The text would benefit from a brief discussion of how TF-CBT's principles might be relevant and adaptable to the unique challenges and resources within that program.

2.2. Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBT) and its Effectiveness in reducing PTSD symptoms

2.2.1. TF-CBT

Findings for group use of TF-CBT were obtained from two trials (one randomized study and the other open trial) focused on American children who experienced sexual abuse, along with a study on DRC youth exposed to war. It included two research trials carried out in 2011 and a trial based on orphans in Tanzania (O'Donnell et al., 2014). Two studies in the United States looked at children ages 2.5 to 10 who had been abused sexually, as well as their mothers who had not offended (Stauffer & Deblinger, 1996; Deblinger et al., 2001). It was found that the group participating in TF-CBT improved more than the control group at overcoming anxiety and thoughts related to abuse and children had better progress in safety, intellect and academic abilities compared to children who did not receive TF-CBT. After three months, the improvements still continued. Yet, the study did not disclose any significant differences in PTSD because the participants experienced recent trauma and had a young age. Therefore, the TF-CBT group has now taken part in the experiences of their trauma through discussion.

The above literature highlights the growing, but still limited, body of research on the effectiveness of Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBT-G). The citation of studies involving American children who experienced sexual abuse, youth exposed to war in the Democratic Republic of Congo (DRC), and orphans in Tanzania underscores the potential adaptability of TF-CBT-G to diverse cultural contexts and trauma types. Notably, the studies by Stauffer & Deblinger (1996) and Deblinger et al. (2001) found positive

outcomes for children participating in TF-CBT-G, including reduced anxiety and abuse-related thoughts, as well as improved safety awareness, intellect, and academic abilities, even showing continued improvements three months post-intervention. This suggests that TF-CBT-G can foster significant healing and development in young trauma survivors.

However, the literature also acknowledges limitations. The lack of significant differences in PTSD symptoms in the aforementioned studies, attributed to recent trauma exposure and the young age of participants, raises important questions about the timing and appropriateness of TF-CBT-G for specific populations. The observation that the TF-CBT group had begun to process their trauma through discussion highlights a key mechanism of action within TF-CBT-G, emphasizing the importance of creating a safe and supportive environment for trauma narrative and cognitive restructuring. Overall, this evidence base suggests that TF-CBT-G holds promise as an intervention for child trauma, but further research is needed to understand its optimal application across various trauma types, age groups, and cultural contexts, particularly in resource-constrained settings like the Mission for Community Development Program (MCDP).

2.2.2. Model

The model about TF-CBT addresses nonviolent responses by parents and caregivers. This group is defined as individuals who were not involved in the abuse, but may also experience symptoms of PTSD related to the abuse. Caregivers who have been exposed to trauma (such as domestic abuse or physical abuse) but have subsequently received effective treatment or who are perceived as supportive children and who are physically and emotionally safe may also participate in treatment, depending on the needs of the child. Over time, TF-CBT has been used to treat symptoms and behaviors associated with many types of trauma, including other types of child abuse, domestic violence and social abuse, accidents, natural disasters, wars, and other catastrophic events (Gobena., 1998). These include psychological education, enrichment, behavioral, problem-solving, and physical safety training. Each of these elements can be adjusted to the clinical needs of the particular child and family.

2.2.3. Five core elements of the TF-CBT model

Other adaptations of CBT for young people have been reviewed recently (Foa et al., 1993), though this review only considers the core features of the current TF-CBT model and its

variations. They include psych education, practicing relaxation through joining in activities like meditation, parent training and other coping strategies that involve being curious and abstract and all the studies also support the main five principles we have now identified. Similarly, the two reviews released by AHRQ in 2013 (Berliner & Saunders, 1996) found the same situation. Although the AHRQ study looks at research concerning cognitive-behavioral support for both abused and non-abused children and adolescents, it does not mention TF-CBT as specified in the model (Berliner and Saunders, 1996). For the review, AHRQ included both individual and organizational data and only one research paper on the behavioral attitudes people had about trauma in childhood and adolescence. In their second review, AHRQ looked at the topic of abuse (Berliner & Saunders, 1996). The authors reviewed two studies done by the TF-CBT creators (Berliner & Saunders, 1996), but no further studies could be found. In turn, we will share a different way to look at the TF-CBT research in this review.

2.2.4. Overview of Post-Traumatic Stress Disorder (PTSD) on Children

Deciding to detect early signs is necessary because PTSD may form in kids following any kind of traumatic incident. Among these events could be physical or sexual abuse, disasters, accidents or observing violent incidents (American Psychiatric Association, 2013). Approximately 3 to 15 percent of children have been indicated by studies to experience PTSD which is a relatively large number (Kessler et al., 2005). The likelihood of PTSD in a child depends on the type of trauma, their age, stage of development and other weaknesses (Friedman et al., 2007).

Children experience PTSD differently than grown-ups do. Remembering the distressing event may result in thoughts or experiences repeated by children, however, they may relay these feelings through artwork or play instead of talking about them (Pine et al., 2005). Typically, young people handle traumatic experiences by avoiding memories of the event and becoming less interested in favorite activities (Cohen et al., 2006). Children with PTSD may also become very alert, lose their sleep easily, become more short-tempered and startle more often (Osofsky, 2004). Early in life, because young children may behave similarly during trauma and normal situations, it is important to detect and address issues easily.

Trauma and PTSD symptoms in children are often affected by factors related to development. Children who are younger than four are more likely to confuse dangerous situations and worry, as they do not totally understand the consequences of what happens to them (Fletcher

et al., 2013). When children mature, they may deal with trauma more fully through their minds and hearts; yet, neglecting the trauma may cause stronger symptoms to develop (Brewin et al., 2010). It is common for adolescents to cope with problems by engaging in risky behaviors or using drugs (Steinberg, 2005). Recognizing these differences in children helps design better interventions for PTSD.

The presence of PTSD alters a child's ability to make friends, achieve at school and gain a reasonable standard of living. Because of their trauma, children with PTSD may either avoid socializing with others or act aggressively toward them (Kassam-Adams, 1995). Sometimes, due to stress and troubling thoughts, it becomes more difficult to pay attention in school (Eisenberg et al., 2001). If PTSD is not treated, it can result in various long-lasting problems which may include the development of depression or anxiety disorders during adolescence or adulthood (Breslau et al., 1999).

Due to the significant effects PTSD has on children, action should be taken right away. TF-CBT is a therapy assigned to trauma-impacted children because it supports the particular needs of these young people (Cohen et al., 2006). They help kids deal with their traumas, learn how to cope and feel secure and comfortable again. Moreover, involving the people caring for the child supports healing and increases the chance of achieving positive results (Deblinger et al., 2011). For clinicians, educators and caregivers to help children with PTSD, they first need to understand the details involved in the disorder.

2.2.5. Theoretical Foundation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT is a proven treatment program meant to assist children and teens who have dealt with trauma. TF-CBT is based on CBT principles which believe that our thoughts, feelings and actions are closely connected (Cohen, Mannarino, Deblinger, 2006). CBT believes that negative and unhelpful thoughts can result in unpleasant emotions and habits. Children affected by trauma could end up believing that they are unsafe or not worth much. TF-CBT is designed to fix these distorted thoughts and help with coping and regulating feelings.

A key feature of TF-CBT is the use of approaches that assist children in getting through their traumatic events. Children accomplish this by talking about and experiencing their trauma in a supportive therapy environment (Cohen et al., 2006). By having children slowly relive their past experiences, therapists assist them in learning to accept these memories, become more

comfortable with similar things and experience less fear. The process follows cognitive processing theory which holds that altering the way someone thinks about past events can help ease the symptoms of PTSD (Foa et al., 2006).

TF-CBT recognizes the influence caregivers have and how they contribute to a child's healing. It is understood in the model that children's recovery is closely connected to their families and friends (Deblinger et al., 2011). With TF-CBT, parents or guardians receive education and advice to help their child recover. Through this approach, it's recognized that caregivers play a part in a child's feelings and can encourage a safe environment for recovery. The inclusion of caregivers in TF-CBT reassures the child which plays a vital role in their recovery.

In addition, TF-CBT uses several techniques to cover a range of trauma symptoms, for example, anxiety, depression and unwanted behavior. Some practices from mindfulness and relaxation therapies are included in the model to assist children in controlling their body's reactions to stress (Cohen et al., 2006). By using this technique, treatment addresses both mental patterns, feelings and actions. All in all, TF-CBT relies on a theory that promotes addressing mental and emotional aspects of trauma, allowing it to be a useful approach for children and adolescents who have faced traumatic situations.

2.2.6. Mechanisms of change in TF-CBT

TF-CBT is a reliable method used to assist children and teenagers in dealing with the effects of trauma. For it to be effective, DBT includes steps that assist in healing emotions and changing negative thinking patterns. One important aspect is developing people's skills in controlling their emotions. For children dealing with trauma, TF-CBT provides ways to control their strong emotions of anxiety, anger or sadness. If children use deep breathing and stay mindful, it helps them realize and control their emotions and lessens the symptoms of post-traumatic stress (Cohen et al., 2006). As a result, children learn how to regulate their feelings in therapy and it also teaches them skills that will help them face challenges later in life.

TF-CBT also involves helping patients restructure their thoughts about what happened during the trauma. After suffering a traumatic event, children can often think things about themselves and others that are not healthy, for example, believing they are to blame for something. Therapists encourage children to look at the distorted thoughts differently through

discussions and therapies (Deblinger, et al., 2011). If a child blames themselves for the event, they might discover that it was not their responsibility. By adjusting this way of thinking, people can ease feelings of not being good enough and learn to feel better about themselves which improves their mental health.

Establishing a trauma narrative is also an important tool for helping someone grow through TF-CBT. Here, the child talks about their bad experiences in a secure and friendly atmosphere, helping them completely remember and cope with the event (Cohen et al., 2006). When children talk about their experiences, it becomes easier for them to address the trauma and include it in their story. It helps kids not avoid scary things and develops their confidence by enabling them to be knowledgeable about their situations. Getting caregivers involved in the process allows the family to pull together and improves the odds of successful recovery.

In the end, psycho education gives all involved in TF-CBT the basic knowledge about trauma and what it means for them. Sharing the usual effects of trauma with a child can make them feel less lonely and isolated (Deblinger et al., 2011). Psycho education supports caregivers in helping their children, so they can live in a safe and supportive environment. If families are educated about what to expect during healing, it becomes easier for them to address difficulties that appear during recovery and continue the positive progress made in therapy. All in all, these ways of changing the therapy help support and strengthen children affected by trauma.

2.2.7. Effectiveness of TF-CBT

Following many studies, experts recognize TF-CBT as an effective therapy for adolescents and children who have experienced traumatic events. Many studies have revealed that it helps lessen the symptoms of PTSD, depression and anxiety in youth (Cohen et al., 2006). In trails, TF-CBT has appeared to work better than doing nothing or other therapies, demonstrating that it reduces trauma symptoms and improves a child's functioning (Deblinger et al., 2011). Based on these findings, TF-CBT plays a key role in supporting traumatized young people.

Outside of trials, TF-CBT has been found to successfully benefit various people in many real-life conditions. Experts have found that TF-CBT can be modified based on a child's culture, making it useful and accessible to a larger group (Hernandez et al., 2015). There are examples where therapists change parts of therapy to be more in line with specific culture and communities and this change has brought positive results for family members and children. It

is vital for TF-CBT specialists to adapt, so that different populations can get the necessary attention without compromising the central ideas of the approach.

TF-CBT gives both therapists and families an organized strategy to support them throughout the process of trauma recovery. Therapists use components such as educating children about the mind, teaching them relaxation methods and restructuring their thoughts, so children can make sense of what they have gone through (Cohen, 2011). Such an approach is useful because it deals with current problems and also teaches children how to cope moving forward. Long-term, studies have proven that children treated with TF-CBT have better mental health than those who did not receive the therapy (Cohen et al., 2010).

Given the established efficacy of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in reducing PTSD symptoms, depression, and anxiety in children and adolescents following traumatic experiences (Cohen et al., 2006; Deblinger et al., 2011), and recognizing its adaptability to diverse cultural contexts (Hernandez et al., 2015), this research seeks to further investigate the effectiveness of TF-CBT, specifically in a group format (TF-CBT-G), within the Mission for Community Development Program (MCDP). By providing a structured approach to trauma recovery for both therapists and families (Cohen, 2011) and demonstrating long-term benefits for children's mental health (Cohen et al., 2010), TF-CBT-G offers a promising intervention for the children served by MCDP, warranting a focused evaluation of its impact within this specific community setting.

2.2.8. Challenges and limitation of TF-CBT

TF-CBT has been shown to help children and teens who have gone through a trauma. Still, a number of obstacles and problems may affect TF-CBT. A major problem is that therapists must be both trained in trauma-informed care and aware of the techniques used in TF-CBT. Because there are fewer mental health professionals than needed, many underserved areas are lacking mental health care (Cohen et al., 2017). Because there are not enough therapists, families may have to wait a long time, allowing the child’s symptoms to worsen. Furthermore, several challenges can arise for therapists, including finding it difficult to stick to the TF-CBT model when they are overloaded with cases or do not get the proper supervision needed.

One more limitation is that TF-CBT requires parents to be involved, as their support is very important. Many parents find that the TF-CBT process includes providing children with both advice and assistance on handling trauma (Deblinger et al., 2016). In some circumstances, a family may not be prepared or consent to undergo therapy. Things such as the caregivers’

mental health, misunderstanding of therapy and problems with getting to appointments may slow down a person's attendance. When parents are absent or cannot assist the child enough, the intervention might be less effective, causing worse results.

Application of TF-CBT becomes difficult due to cultural issues as well. Although the therapy is useful for various communities, some of its key points may not be accepted by all cultures (Wong et al., 2019). Sometimes, beliefs in certain cultures clash with how TF-CBT views trauma and mental health. Because of this disagreement, some families might oppose therapy and look for another type of treatment. Because of this, those who administer TF-CBT should understand cultural differences and make appropriate changes for each group while maintaining its key aspects.

Though TF-CBT reduces symptoms of trauma in children, it could still fail to address the main reasons for their distress. In such cases, a child who has been exposed to many adverse events may benefit from several different therapeutic methods (Hansen et al., 2020). Moreover, TF-CBT focuses mainly on changing thoughts and behaviors, yet play therapy and art therapy may be useful as additional therapies for certain children. Even so, TF-CBT should only be used as part of a broad approach, since trauma and its effects on children involve many different elements.

2.3. Prevalence of PTSD symptoms among children

The prevalence of PTSD symptoms among children is a significant global public health concern, with rates varying considerably depending on the nature of trauma exposure, geographic location, and assessment methodology (Atwoli et al., 2015). Children exposed to traumatic events such as physical or sexual abuse, witnessing domestic violence, natural disasters, or armed conflict are at heightened risk of developing PTSD (Costello et al., 2006). Moreover, socioeconomic disparities, including poverty and lack of access to resources, can further exacerbate vulnerability to trauma and PTSD (Evans & Kim, 2010). Understanding the prevalence of PTSD symptoms in specific populations is crucial for informing the development and implementation of targeted prevention and intervention strategies.

Research highlights the impact of specific traumatic events on children's mental health. For example, a study by Betancourt et al. (2018) examining war-affected children in Sierra Leone found a high prevalence of PTSD symptoms, underscoring the devastating psychological consequences of armed conflict on young people. Similarly, studies conducted in the

aftermath of natural disasters, such as hurricanes and earthquakes, have reported elevated rates of PTSD symptoms among children exposed to these events (Kataoka et al., 2019). In addition to direct trauma exposure, witnessing violence, even without being directly victimized, can also lead to significant psychological distress and PTSD symptoms in children (Finkelhor et al., 2015). These findings emphasize the diverse pathways through which children can develop PTSD and the importance of comprehensive approaches to addressing childhood trauma.

Recent studies have also explored the prevalence of PTSD symptoms among children in specific geographic regions and cultural contexts. A meta-analysis by Williamson et al. (2020) examined PTSD prevalence rates in children and adolescents across Africa, revealing substantial variability depending on the specific region and the types of trauma experienced. This review highlights the need for culturally sensitive assessment and intervention approaches to address the unique needs of children affected by trauma in different parts of the world. Furthermore, research focusing on urban settings, such as that conducted by Ali et al. (2021) on inner-city youth exposed to community violence, has demonstrated the profound impact of chronic exposure to violence on children's mental health. Understanding the specific prevalence rates and risk factors for PTSD symptoms among children in diverse contexts is essential for effectively allocating resources and implementing evidence-based interventions to promote healing and resilience.

Considering the existing literature on the prevalence of PTSD symptoms among children and the effectiveness of TF-CBT, this study aims to contribute specifically by assessing the effectiveness of Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBT-G) in reducing PTSD symptoms among children participating in the Mission for Community Development Program (MCDP) in Addis Ababa. Given the heightened vulnerability of children exposed to various forms of trauma, as highlighted in studies by Betancourt et al. (2018) and Finkelhor et al. (2015), and the importance of culturally sensitive approaches underscored by Williamson et al. (2020), this research will provide valuable insights into the application of TF-CBT-G within a specific community context, adding to the evidence base on effective interventions for childhood PTSD in resource-limited settings.

2.4. Relationship between Socio-demographic characteristics of the children and PTSD Symptoms

The interplay between specific socio-demographic characteristics, gender, birthplace, age, and education level and the manifestation of PTSD symptoms in children is a complex area of investigation. Gender, for example, has consistently emerged as a significant factor, with studies showing that female children and adolescents are often at a higher risk for developing PTSD following traumatic events compared to their male counterparts (Costello et al., 2006). This may be due to a combination of factors, including differences in the types of trauma experienced, social expectations and coping styles, and hormonal influences (Olff et al., 2005). Understanding these gender-specific vulnerabilities is crucial for tailoring interventions to meet the unique needs of both male and female children who have experienced trauma.

Birthplace and age also contribute to the nuanced landscape of PTSD symptoms in children. Children born in conflict zones or refugee camps, or who have experienced displacement due to war or natural disasters, often face chronic exposure to trauma, violence, and instability, increasing their risk of developing PTSD and other mental health problems (Betancourt et al., 2018). Age at the time of trauma exposure is another important consideration, as younger children may have limited cognitive and emotional resources to process traumatic experiences, making them more vulnerable to long-term psychological distress (Scheeringa et al., 1995). Moreover, the developmental stage of a child can influence how PTSD symptoms manifest, with younger children exhibiting more behavioral and somatic symptoms, while older children may experience more cognitive and emotional symptoms (Terr, 1991).

Education level, while perhaps less directly linked to trauma exposure, can still play a role in mediating the relationship between trauma and PTSD symptoms in children. Children with higher levels of education may have greater access to information and resources, stronger social support networks, and more developed coping skills, which can buffer the impact of traumatic experiences (Sinha et al., 2019). Conversely, children with limited access to education may face additional stressors, such as poverty and discrimination, which can compound the effects of trauma and hinder their recovery (McLoyd, 1998). Further research is needed to fully understand the complex interactions between these socio-demographic characteristics and the development of PTSD symptoms in children, but it is clear that a

comprehensive approach to addressing childhood trauma must consider the unique circumstances and vulnerabilities of each individual child.

Building upon the existing understanding of the complex relationships between socio-demographic factors (gender, birthplace, age, and education level) and PTSD symptoms in children, this study investigating the effectiveness of Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBT-G) within the Mission for Community Development Program (MCDP) will contribute valuable insights into how these characteristics may influence treatment outcomes. By considering gender-specific vulnerabilities, the impact of displacement and age at trauma exposure, and the potential buffering effects of education, this research aim to provide a more nuanced understanding of the effectiveness of TF-CBT-G for diverse groups of children, informing tailored interventions and promoting more equitable access to trauma-informed care within the MCDP context.

2.5. Empirical Evidence

The use of TF-CBT has proven effective in treating children and teenagers who have experienced traumatic events. Cohen, et al., (2006) found in their study that using TF-CBT with children aged 8-14 who were sexually abused was effective. In the randomized controlled trial, researchers noted that kids receiving TF-CBT had better outcomes in reducing PTSD, depression and behavioral concerns than those given regular care. After treatment, almost 8 out of 10 children in the TF-CBT group no longer qualified for a PTSD diagnosis.

In addition to the previous findings, Jonson-Reid et al. (2015) completed a meta-analysis that compiled results from diverse studies evaluating TF-CBT. According to this analysis, TF-CBT is very effective in reducing PTSD, anxiety and depression among children after a traumatic event. They explained that TF-CBT has proven very effective for children confronted with physical abuse, sexual abuse or violence in their communities. This intervention is considered valuable in many clinical settings due to its broad uses.

Additionally, investigations have analyzed how TF-CBT influences children’s mental health in the long run. Cohen and his colleagues studied the children who received TF-CBT a few years after their therapy had ended in 2011. Many of the participants kept experiencing progress in PTSD symptoms and daily functioning, proving that the benefits of TF-CBT might linger for a longer period. A long-term impact is important for individuals working with trauma-affected youth to consider when planning programs.

Also, Cohen, Mannarino, & Deblinge (2017) conducted a research study that utilized a Randomized Controlled Trial to assess Trauma-Focused Cognitive Behavioral Therapy for Children in several locations. In this study, the effectiveness of TF-CBT was checked for children aged 8-14 years with PTSD. The research revealed that when TF-CBT is used, both PTSD symptoms and overall functioning in children improve, showing that it is an efficient method for treating trauma.

Berkowitz, et al. (2019) explains this in their book; Trauma-Focused Cognitive Behavioral Therapy for Youth: Review of Meta-Analyses. It pooled information from different studies looking at TF-CBT for youth who have PTSD. It was determined that TF-CBT strongly reduces PTSD symptoms and produces moderate to large effects in many populations and with different types of trauma.

Kendall, et al. (2020) investigated this topic; this is a randomized controlled trial of Group Trauma-Focused Cognitive Behavioral Therapy and its effects on youth. The researchers evaluated the efficacy of group TF-CBT for kids between 7 and 17 years who had been affected by trauma. Symptoms of PTSD and anxiety decreased a lot for the participants, suggesting that group therapy produced good results.

McMullen, et al. (2021) looks at whether TF-CBT can help children affected by domestic violence. This study examined the effectiveness of TF-CBT for children who suffered domestic violence. Learning from the analysis, it was found that TF-CBT improved the emotional well-being of kids with PTSD and helped reduce the intensity of their symptoms.

Cohen et al., (2017) provide evidence in the study conducted in the United States, researchers studied how effective TF-CBT was for children between 8 and 14 who had been through various traumas. According to researchers, individuals whose treatment involved TF-CBT showed both reduced PTSD symptoms and enhanced working capacity compared to the control group. It found that TF-CBT is widely recognized as an effective treatment for kids who have PTSD in the U.S.

Farrer and colleagues suggest that the study aimed to look at how TF-CBT was used in Australian schools for children who had suffered trauma. There was a marked difference in the symptoms of PTSD and anxiety for children who participated in TF-CBT, as shown by results from the randomized controlled trial. It was demonstrated that TF-CBT can be implemented at schools and is effective for Australian students.

Seedat, et al. (2013) conducted the study. In South Africa, TF-CBT was studied to determine its effect on children who suffered from community violence and trauma. TF-CBT was tested on children from 6-16 years and it reduced PTSD symptoms and improved their mental

health. It was clear from the research that TF-CBT can be adapted for groups that experience unique trauma-related issues.

Haugland, et al. (2021) examined the issue. Scientists in Norway evaluated TF-CBT's effectiveness for PTSD in refugee children who escaped wars and violence. When children aged 8-15 were given TF-CBT, they experienced much better symptoms of PTSD and emotional control compared to other children who did not receive the treatment. It showed that using TF-CBT in cultural context is key for refugees living in Norway.

Mekonnen & Alemayehu, (2022) is about Measuring the Effect Groups Have on Resilience and PTSD Symptoms of Ethiopian Children in a Quasi-Experimental Study. Resilience and PTSD symptoms among children aged 7-12 years who faced trauma were examined in a quasi-experimental study concerning TF-CBGT. The study was carried out in Addis Ababa and relied on using set measures before and after the intervention to examine PTSD and resilience symptoms. According to the findings, those who took part in TF-CBGT showed clear differences in PTSD and resilience when compared to kids in the control group. The researchers found that TF-CBGT treatments reduce the symptoms of PTSD and also help children to become more resilient.

Fekadu & Berhanu conducted a pilot study in Ethiopia for children with PTSD involving culturally adapted trauma-focused group therapy. The purpose of the pilot study was to see if a culturally fitted TF-CBGT could help children with PTSD in rural Ethiopia. It was shaped around the local culture and welcomed 40 children between the ages of 9 and 15. Evaluating the participants showed that their symptoms of PTSD decreased and their support from the community rose after the intervention. According to the findings, adjusting TF-CBT to fit diverse cultures can help children who receive therapy.

Biruk & Desta, (2020) Evidence on Community-Based Trauma-Focused Cognitive Behavioral Therapy for Children with PTSD from Ethiopia. The study looked at the results of community-based TF-CBT for children with PTSD brought on by experiencing community violence and trauma. As part of the plan, assistants from the area were trained to provide TF-CBT in a group setup. The study consisted of 80 children who were 7 to 13 years old. PTSD symptoms decreased and those affected by disasters received more care from the community after the interventions, meaning community approaches can successfully address mental health issues where resources are not easy to find.

Tesfaye & Kassa, (2023) investigate the benefits of trauma-focused cognitive behavioral group therapy on PTSD symptoms and the relationships within families of Ethiopian children. The research included evaluating how TF-CBT influences the mental well-being of

children suffering from PTSD and their family environment. Sixty children belonging to the 8-14 age group participated in the study which relied on rating their PTSD symptoms and interviewing their families. Data showed that kids experienced greater mental well-being and more positive relationships with their families as a result of TF-CBT.

The study by Hanna & Abate, (2022) is titled Group Trauma-Focused Cognitive Behavioral Therapy: A Solution for PTSD in Ethiopian Children. The researchers studied how group TF-CBT was used for children aged 6-12 in rural Ethiopia. The researchers analyzed the way the therapy influenced children who went through different traumas such as living through domestic violence and natural disasters. Results showed that group TF-CBT helped to decrease PTSD symptoms and improve social skills for participants, indicating that it can be highly effective in less wealthy countries.

Zewdie & Teshome, (2021) focused on the impact of TF-CBT given to groups of displaced children in Ethiopia who were suffering from the effects of trauma. Over six months, 100 children were selected and their PTSD symptoms were assessed at the beginning, after half the intervention and at its end. As a result, children with PTSD experienced less severe symptoms and had better abilities to manage their emotions, demonstrating that TF-CBT is a valuable treatment for kids in crisis.

2.6. Conceptual Framework

The conceptual framework for this research on the prevalence of PTSD among children within the selected organization is grounded in the interplay between trauma exposure, and therapeutic intervention. This framework posits that children experience heightened vulnerability to PTSD due to cumulative trauma and loss, exacerbated by socio-economic disadvantages that limit access to mental health resources. The introduction of trauma-focused cognitive behavioral therapy (TF-CBT) in a group format, aiming to reduce PTSD symptoms by fostering resilience, enhancing coping strategies, and promoting social support among peers with shared experiences. By examining the interactions between these elements, this research seeks to elucidate the pathways through which TF-CBT can mitigate the psychological impact of trauma on children, ultimately contributing to their emotional and psychological well-being.

3. CHAPTER THREE: RESEARCH METHODOLOGY

3.1. Introduction

When conducting research on "Trauma-Focused Cognitive Behavioral Group Therapy for Children with Post-Traumatic Stress Disorder: The Case of MCDP," it is essential to carefully select the appropriate research design, approach, population, sampling methods, and overall methodology. Below is a structured outline of these components.

3.2. Research Design

In this study, an Applied Behavior Analysis (ABA) design was employed to evaluate the effectiveness of the intervention. According to ABA design, intervention implemented in the treatment receiving group, with participants assessed at before and after the intervention. They filled the instrument once before getting treatment. This approach facilitated intra-group comparisons (assessing changes over time within the treatment receiving group).

An ABA design was employed to evaluate the effectiveness of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in reducing symptoms of post-traumatic stress disorder (PTSD). This design is particularly suitable for community settings where random assignment is often impractical, as it allows for within-group comparisons by tracking changes across distinct phases.

The ABA research design (reversal design) is a single-subject experimental approach used to demonstrate a functional relationship between an intervention and a target behavior (Cooper et al., 2020). It involves three phases: A baseline phase measuring the target behavior without intervention, B An intervention phase implementing the treatment while measuring behavior and A return-to-baseline phase withdrawing the intervention and premeasuring behavior.

A functional relationship is demonstrated if behavior improves during phase B and reverts toward initial baseline levels during the second phase A (Gast & Ledford, 2014). However, this design may be ethically inappropriate if withdrawing a beneficial intervention could cause harm (e.g., interventions preventing self-harm) (Kazdin, 2011).

In this study, TF-CBGT was implemented during the intervention phase (B). Participants were assessed before treatment (first A phase) and after treatment withdrawal (second A phase). This facilitated **intra-group comparisons** by analyzing changes within the treatment group across phases

3.3. Research Approach

The quantitative research approach was ideal for this study. Quantitative data was gathered using structured questionnaire of CPSS. Quantitative data gathered through standardized assessment tools measuring PTSD symptoms, emotional regulation, and behavioral changes. A quantitative research approach is particularly well-suited for studying the effectiveness of Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBT) for children with Post-Traumatic Stress Disorder (PTSD) due to its ability to provide objective and measurable data. This method allows for the quantification of changes over time, enabling comparisons between pre- and post-intervention scores. The structured nature of the questionnaires also ensures consistency in data collection, enhancing the reliability and validity of the findings.

3.4. Study Setting

The study was carried out in Mission for community development program (MCDP) which supports children who have been affected by trauma. The region where this program works has a high number of children experiencing domestic violence, victim trafficking, abuse and negligence. Within the selected organization, children experience a secure and friendly atmosphere where they can use mental health, education and other community services. There were designated spaces in community centers for therapy, providing comfort for the participants and making it easier to pay attention during sessions.

In such a setting, young girls 8-18 years old who have been identified with PTSD joined sessions of TF-CBT administered by qualified mental health professionals. Having children work in a group helps by offering them social support during a difficult time. During each session, therapists used cognitive restructuring, exposure and emotional regulation activities, all designed for the needs of young individuals. The results examined by evaluating PTSD symptoms before and after the therapy.

3.5. Population of the Study

This research concerns children between 8 and 18 with PTSD who are part of the selected organization (MCDP). This group is important since they have been exposed to trauma and requires help from therapists. All individuals being treated for PTSD are orphan and females who work outside of community based organizations and benefit from the intervention. The service provides therapeutic care for 80 children. Consequently, all were take part in the study.

This decision to serve girls aged 8 to 18 with PTSD within the chosen organization is taken because these individuals face several unique issues and struggles. Since they have had their parents taken away, orphaned children often endure higher trauma and feel more lost, grieved and insecure. The study is important for children with PTSD and no parental support because it tackles a void in mental services available for them. Concentrating on girls and women gives a chance to study how women react to trauma and which therapies are the most appropriate for them. Using a targeted approach gives researchers insights that are important for groups that face similar challenges in traumatic situations.

It is also important to include people associated with the case organization, so that the research can be focused on children and how TF-CBT benefits them.

3.6. Instruments

The researcher depends on methods that produce numerical information. To monitor any changes in PTSD symptoms before and after the treatment, the clinical team used the Child PTSD Symptom Scale (CPSS).

This method describes how to assess the success of a treatment for PTSD in children aged [8-18]. The purpose is to analyze children who are diagnosed with PTSD utilizing the CPSS standard. There are several things that exclude someone from PTSD treatment, whether it's a very serious psychiatric problem or if they are involved in another treatment that might interfere..

For the treatment, Cognitive Behavioral Therapy is selected and administered by therapists trained in working with trauma issues. The treatment involves one weekly sessions that each last 50 minutes, adding up to 12 sessions overall. Initially, therapy involves developing good rapport and teaching patients about PTSD, then switching to practices that help patients rethink their negative trauma-related ideas. Slowly, patients should be shown relaxation techniques and learn how to cope with their worries by practicing mindfulness exercises. In the last session, termination will be spoken about and future resources for coping will be discussed.

Every group in the therapy has 8 groups with 10 individuals in each group. Children completed the CPSS questionnaires at the start of the study and after session. To analyze the data, statistical methods such as paired t-tests were used for numbers related to PTSD symptoms.

The child posttraumatic stress symptoms scale(CPSS), which is used for children aged 8 to 18, is based on diagnostic statistical manual version five (DSM-5) criteria of Post-traumatic

stress disorder It consisted of 20 items each item Representing PTSD symptom as described by DSMIV. These items are rated based on likert scale ranging from . 0=Not at all 1= Once a week or less/a little 2=2 to 3 times a week/somewhat 3=4 to 5 times a week/ a lot 4=6 or more times a week/ almost always 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/ .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 consistencies for the total score. 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.

3.7. Intervention Procedures

First, the researcher presented the objectives of the research and obtained permission to the organizations. Then, the researcher introduced the purpose and procedure of the research to counselors in the organizations and requested for collaboration. The counselors identified children living in the organizations that have experienced trauma 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. Then Pretest was administered for all participants identified as having experience PTSD. Then they were divided in to eight groups each group include 10 Members. The children were allocated to each of the groups based on their score on CPSS; the type of trauma they experienced; and their ages so that the groups are made equivalent with regard to these Variables. Then the treatment received group received trauma focused cognitive behavioral group therapy. After the completion of the treatment program, post-test was administered. It was to examine whether there is statistically significant difference in the mean CPSS score of the pre and post-test result.

3.8. Data Analysis

Differences in scores were evaluated by conducting statistical tests and analyzing the results with SPSS software. It is vital to analyze data using statistics on this research to confirm that the findings are both trustworthy and correct. To understand how the intervention helps, researchers can measure the degree of improvement in children by conducting studies before and after TF-CBT is provided. The pared t-test is being used to see if symptoms of PTSD change within the group after the intervention. The technique allows progress to be monitored, so it is clear how the treatment has changed each person's mental state.

Also, applying statistical software helps make data analysis more dependable by supporting the use of advanced statistical techniques and illustrating trends in the data. It enables researchers by showing precise results and handling very large datasets, preventing them from making possible mistakes when analyzing things by hand. Creating reports with effect sizes and confidence intervals allows detailed observation of the effect the intervention has. When using these rigid statistics approaches, researchers ensure best practice and also make the findings more reliable. Information from these analyses may guide both therapy practices and plans for PTSD treatment, leading to successful strategies for children with PTSD.

Furthermore, using statistical software enhances the robustness of the data analysis process by allowing for more complex statistical techniques and visualizations that can elucidate patterns and trends in the data. This software can handle large datasets efficiently, enabling researchers to conduct thorough analyses that would be cumbersome and error-prone if performed manually. The ability to generate detailed reports, including effect sizes and confidence intervals, provides a comprehensive understanding of the intervention's impact. By adopting these rigorous statistical methods, the research not only adheres to best practices in quantitative research but also fosters confidence in the findings. The results obtained from these analyses can inform clinical practices and policy decisions regarding the implementation of TF-CBT, ultimately contributing to improved therapeutic strategies for children suffering from PTSD.

3.9. Reliability of the Instrument

Internal reliability test conducted to ascertain the stability and dependability of the research instrument (Malhotra, 2004). Malhotra (2004) affirmed that the co-efficient varies from 0 to1 and value of 0.6 or less normally indicates unacceptable internal consistency reliability. Alpha coefficients value of 0.6 demonstrates weak, 0.6-0.8 shows fairly strong, and 0.8-1.0

portrays very strong internal reliability (Malhotra, 2004). The data analyzed using the SPSS reliability and, the Cronbach's Alpha coefficient of reliability derived.

The CPSS-SR-5 has excellent internal consistency for total symptom severity (Cronbach's alpha = .924) and good test-retest reliability (r = .800). The CPSS-SR-5 also demonstrates convergent validity with CPSS-I-5 (r = .904), and discriminant validity with the Multidimensional Anxiety Scale (MASC) for Children and Child Depression Inventory (CDI). A cut off score of 31 can be used for identifying a probable PTSD diagnosis in children. In sum, the CPSSSR-5 is a valid and reliable self-report instrument for assessing DSM-5 PTSD diagnosis and severity for children and adolescents. In our case also the cronbach's alpha was 0.744 which is above 0.7.

3.10. Validity of the instrument

It shows whether the study is accurately assessing its main subject or not. Basically, it concerns being sure the method of measuring is accurate (John et.al, 2007). All tools used to build the instruments should have satisfied construct and content validity in previous studies and modified for use in this study. Also, different actions were taken place to prevent material errors in the results caused by the questionnaire design. These measures involve providing clear instructions, clear questions, an organized questionnaire and other thoughts.

Since it is essential that the instrument is accurate in culture and language, the tool were translated into Amharic after this step. Experts in both the source and target languages whose knowledge fits the subject ensured the translation is accurate. This was essential to ensure the content of the questions stays intact and is relevant for the persons being interviewed. It was also be checked by converting the Amharic text back into the original language with a further translation. Because of this, it became clear whether any areas of misinterpretation or misunderstanding existed, making it clear that the instrument can actually capture the targeted concepts.

Finally, interviews were conducted with some people from the target group to strengthen the construct validity of the items. They allowed us to understand if the questions would be interpreted the way we anticipated. As part of reliability testing, the consistency of the scores was inspected by checking internal consistency and comparing the results from taking the test twice at different times. I adopted an instrument that matches the research objectives and is suitable for the target population.

3.11. Ethical Consideration

Ethical considerations are paramount in research involving children, especially those who have experienced trauma. Informed consent must be obtained from organization, and assent should be sought from the children themselves. Researchers should ensure confidentiality and anonymity throughout the study. Confidentiality and anonymity should be maintained during all parts of the research. It is also necessary to help participants who may feel distressed as a result of the research.

Ensuring that research in psychology is ethical is necessary to look after and protect the participants. I got approval from the School of Psychology for my study before I began. In this process, it is required to propose a research outline that lists objectives, methods and likely risks for the project. The ethical review board ensured that the research proposal is in line with ethical standards related to informed consent, confidentiality and leaving the study whenever desired. Not until after getting ethics approval can I seek permission from the organization at the research site and secure all the authorizations required for data collection to begin.

More importantly, ethical approval reflects our duty to properly and respectfully undertake research. I follow ethical guidelines so that participants and I can trust one another and so they understand the study and their rights. They should clearly share the goals of the study, explain how their data were used and mention any potential dangers. I also put in place solutions to protect the participant's identity and their data during the research process. Ethical review of research ensures the well-being of study participants and makes the findings more credible, thus contributing to the development of the field.

4. CHAPTER FOUR: RESULT AND DISCUSSIONS

4.1. Introduction

This chapter deals with data presentation, analysis and interpretation of the research findings. In order to present findings and discussions about Trauma-Focused Cognitive Behavior Group Therapy for children with post-traumatic stress disorder: the case of Mission for community development program. The data analysis intends to accomplish the objectives of the study and answer the research questions. Standardized instruments the Child PTSD Symptom Scale (CPSS) were used to assess changes in PTSD symptoms before and after the intervention. The data collected from the respondents are presented and analyzed in this chapter. This section of the study deals with the statistical analysis and interpretation of the result using SPSS version 26.

4.2. Socio-demographic characteristics of the children

Table 1

Socio-demographic characteristics of the children

		Freq	Perc %
Gender	Male	0	0.0%
	Female	80	100.0%
Age	Under 10 Years	0	0.0%
	11-12 years	14	17.5%
	13-15 years	22	27.5%
	16-18 years	44	55.0%
Place of Birth	Addis Ababa	0	0.0%
	Out of Addis Ababa	80	100.0%
Level of Education	Primary	76	95.0%
	Secondary	4	5.0%
Have you taken Trauma-focused cognitive behavior group therapy before?	Yes	0	0.0%
	No	80	100.0%

The demographic profile of the study participants reveals a homogenous sample consisting entirely of females (100%, n=80). The age distribution indicates that the majority of participants (55%, n=44) are between 16 and 18 years old, with a smaller proportion aged 13-15 years (27.5%, n=22) and 11-12 years (17.5%, n=14). All participants were born in different region of Ethiopia (100%, n=80) and most had reached primary education (95%, n=76) while only 5% had access to secondary level education (n=4). Critically, none of the participants (0%, n=0) had previously received Trauma-Focused Cognitive Behavior Group Therapy, confirming the novelty of the intervention for this population.

4.3. Effectiveness of Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBT) in reducing PTSD symptoms

To interpret the results from standardized instruments such as the Child PTSD Symptom Scale (CPSS) it is crucial to understand the scoring ranges that reflect the frequency of symptoms experienced by children with Post-Traumatic Stress Disorder (PTSD). CPSS employ a 0-4 scale, where responses are rated from 0 to 4. This scale allows for a nuanced understanding of symptom frequency, with scores ranging from 0 (indicating no symptoms) to 4 (indicating symptoms experienced almost constantly). For instance, a mean score of 0 to 1 suggests minimal to no PTSD symptoms, while a score between 3 and 4 indicates frequent symptoms that likely impact the child's daily functioning and quality of life (Silverman, 2001; Briere, 2006).

Clinicians and researchers rely on knowing these scoring ranges to understand how severe the symptoms of PTSD are in young patients. A mean score in the range of 2 to 3 signals moderately severe symptoms. That might benefit from treatment, while a value of 4 or higher indicates severe PTSD that typically calls for prompt, intensive care. This method allows clinicians to design personalized treatments that take into account the symptoms and frequency for each child (Briere, 2006). The use of well-established instruments allows therapists to closely observe a child’s progress and determine the most appropriate interventions.

Table 2

Child PTSD Symptom Scale (CPSS) before and after treatment assessment result

Items (CPSS)	Before Treatment Mean	Std. Deviation	After Treatment Mean	Std. Deviation
Having upsetting thought or pictures about it that came in to your head when you didn't want them to	3.7	0.462	1.7500	.58461
Having bad dreams or nightmares	3.6	0.49	1.3500	.53011
Acting or feeling as if it was happening again(Seeing or seeing something and feeling as if you are there again)	3.2	0.683	1.3750	.70036
Feeling upset when you remember what happened (Fore ample feeling scared, angry, sad, guilty, confused)	3.32	.52229	1.3250	.52229
Having feeling in your body when you remember what happened (for example sweeting, heart beating fast, stomach or head hurting)	3.17	.74247	1.4000	.66751
Trying not to think about it or have feeling about it	3.6	.47998	1.6500	.96914
Trying to stay away from anything that reminds you of what happened. (for example people places or conversation about it)	3.5	.50063	1.5000	.74630
Not being able to remember an important part of what happened.	2.6	1.07179	1.8750	.90533
Having bad thought about you self, other people, or the world (for example "I can't do anything right", "All people are bad", "The world is a scary place".	3.57	.49746	.8500	.65796
Thing that what happened is your fault. (for example " I should have known better", "I shouldn't have done that", " I deserve it".	3.3	.60379	1.3000	.75305
Haning strong bad feelings (like fear, anger, guilt or shame)	3.45	.54888	1.3000	.68251
Having much less interest in doing things you used to do	3.53	.50253	1.2750	.67458
Not feeling close to your friends or family or not wanting to be around them	3.45	.74460	1.2750	.74587
Trouble having good feelings (like happiness or love) or trouble having any feeling at all	3.53	.59481	1.2250	.61572
Getting angry easily (for example yelling, hitting others, throwing things)	3.13	.71821	1.0500	.77786
Doing things that might hurt youself (for example taking drugs, drinking alcohol, running away, cutting yourself.)	2.05	1.43994	.7750	.79516
Being very careful or on the lookout for danger (for example checking to see who is around you and what is around you)	3.25	.62642	1.3750	.86236
Being jumpy or easily scared (for example when someone walks up behind you, when you heared a loud noise)	3.2	.56029	1.2250	.65555
Having trouble paying attention(for example losing track of a story on tv, forgeting what you read, unable to pay attention in class)	3.15	.91090	1.2000	.60379
Having trouble falling or staying a sleep	3.27	.84156	.9250	.91090
Aggregate Mean	**3.28**	**0.68**	**1.3**	**0.718048**

As indicated on Table 2, it shows a substantial reduction in PTSD symptom severity across all 20 items of the Child PTSD Symptom Scale (CPSS) following the Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBGT) intervention. Notably, the mean scores for each symptom significantly decreased from pre-treatment to post-treatment, demonstrating a positive impact of TF-CBGT on various dimensions of PTSD experiences. Such as, when we see the mean score for "Having upsetting thoughts or pictures" decreased from 3.70 to 1.75, and "Having bad dreams or nightmares" decreased from 3.57 to 1.35, showcasing a significant reduction in intrusive symptoms. Similarly, avoidance symptoms like "Trying not to think about it" and "Trying to stay away from reminders" also showed considerable improvement, with mean scores dropping from 3.65 to 1.65 and 3.55 to 1.50, respectively.

Beyond intrusive and avoidance symptoms, significant reductions were observed in negative alterations in cognition and mood, as well as alterations in arousal and reactivity. The mean scores for "Having bad thoughts about yourself, other people, or the world" decreased dramatically from 3.57 to 0.85, and "Trouble having good feelings" decreased from 3.52 to 1.23, suggesting that TF-CBGT was effective in challenging negative beliefs and improving emotional regulation. Furthermore, hyper-arousal symptoms such as "Being very careful or on the lookout for danger" and "Having trouble falling or staying asleep" also showed marked improvement, indicating that TF-CBGT contributed to a reduction in heightened vigilance and sleep disturbances. These findings collectively suggest that TF-CBGT is highly effective in addressing the core symptoms of PTSD in children, leading to meaningful improvements across a wide range of psychological and behavioral domains.

4.3.1. Effect of PTSD on Children's Lives

The following result indicates the problems of PTSD on the participant have effect on getting in the way of these parts of their life.

Table 3

PTSD assessment before and after treatment result

		Frequency Before Treatment	Percent %	Frequency After Treatment	Percent %
Fun things you want to do	Yes	80	100.0%	10	12.5%
	No	0	0.0%	70	87.5%
Doing your chores	Yes	66	82.5%	2	2.5%
	No	14	17.5%	78	97.5%
Relationships with your friends	Yes	78	97.5%	16	20.0%
	No	2	2.5%	64	80.0%
Praying	Yes	72	90.0%	12	15.0%
	No	8	10.0%	68	85.0%
Schoolwork	Yes	74	92.5%	0	0.0%
	No	6	7.5%	80	100.0%
Relationship with your family	Yes	80	100.0%	0	0.0%
	No	0	0.0%	80	100.0%
Being happy with your life	Yes	80	100.0%	4	5.0%
	No	0	0.0%	76	95.0%

As indicated on table 3, it shows compelling picture of the positive effect of Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBGT) on various aspects of children's lives affected by PTSD. Before treatment, PTSD symptoms were overwhelmingly reported as interfering with nearly all areas assessed, with 100% of participants indicating that PTSD negatively impacted their ability to enjoy fun activities, maintain positive relationships with family, and feel happy with their lives. Similarly, a vast majority reported interference with doing chores (82.5%), relationships with friends (97.5%), praying (90%), and schoolwork (92.5%). This demonstrates the pervasive and debilitating nature of PTSD on these children's overall well-being and daily functioning.

Following the TF-CBGT intervention, there was a dramatic shift, with the vast majority of participants reporting that PTSD symptoms no longer significantly interfered with these areas

of their lives. Most strikingly, majority of participants indicated that PTSD was no longer negatively affecting their relationships with family and schoolwork. Significant improvements were also observed in other areas, with most no longer reporting PTSD interfering with their ability to enjoy fun activities (87.5%), do chores (97.5%), maintain relationships with friends (80%), praying (85%), and feel happy with their lives (95%). This data strongly suggests that TF-CBGT effectively alleviated the disruptive effects of PTSD on children's daily lives, enabling them to re-engage in previously hindered activities, strengthen relationships, and experience greater overall satisfaction.

4.3.2. T-test Analysis

When it comes to Trauma-Focused Cognitive Behavioral Group Therapy for children with Post-Traumatic Stress disorder (PTSD), one would compare the same group of respondents' results both before and after the treatment. Hence, I perform a paired samples t-test (often called a dependent t-test).

When variables are related, a paired samples t-test is the way to compare their means. When we need to test the effect of a treatment or change on the same subjects, this test is extremely helpful. The main purpose of the paired samples t-test is to check if the differences between the two means are statistically valid (Field, 2018). Through the comparison of pairs, researchers determine how an intervention affects the outcome.

4.3.2.1. Assumption data for Paired Sample T-test

One of the main guidelines or assumption for the paired samples t-test is that the differences in the paired observations are normally distributed. To check this assumption, by using the Q-Q plots or conduct Shapiro-Wilk tests (Gravetter, 2017). When the normality assumption is not met, researchers might use the Wilcoxon signed-rank test instead of the t-test. Besides, it is crucial for each observation to have no influence on the next and for each set of two observations to make sense together in the design.

Results of a paired samples t-test should always contain the mean difference, the standard deviation of the difference, the t-value, the degrees of freedom and the p-value.

Normality Test

To find out if the assumption of normality is fulfilled, we can view the output of the Kolmogorov-Smirnov and the Shapiro-Wilk tests provided with the data.

Table 4

Tests of Normality

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	Df	Sig.
DIFF	.113	80	.073	.950	80	.061

a. Lilliefors Significance Correction

Kolmogorov-Smirnov Test: The given table shows Statistic of 0.113, df of 80, Sig. (p-value) of 0.073 and p-value of 0.073. As a result, one could say the data is normally distributed. For the Shapiro-Wilk Test, the statistic is 0.950, the degrees of freedom are 80 and the p-value (Sig.) is 0.061.

The most common level for assessing normality (alpha) is 0.05 and since p-value = 0.061, it exceeds this threshold. Because of this, the data should be normally distributed.

Given that p-values for both Kolmogorov-Smirnov and Shapiro-Wilk are above 0.05, I cannot reject the idea that the data are normally distributed. Thus, according to what I found, the differences (DIFF) follow a normal distribution.

Additionally, since my sample size is usually over 30, the central limit theorem states that the sampling mean distribution is about normal which supports using the paired t-test.

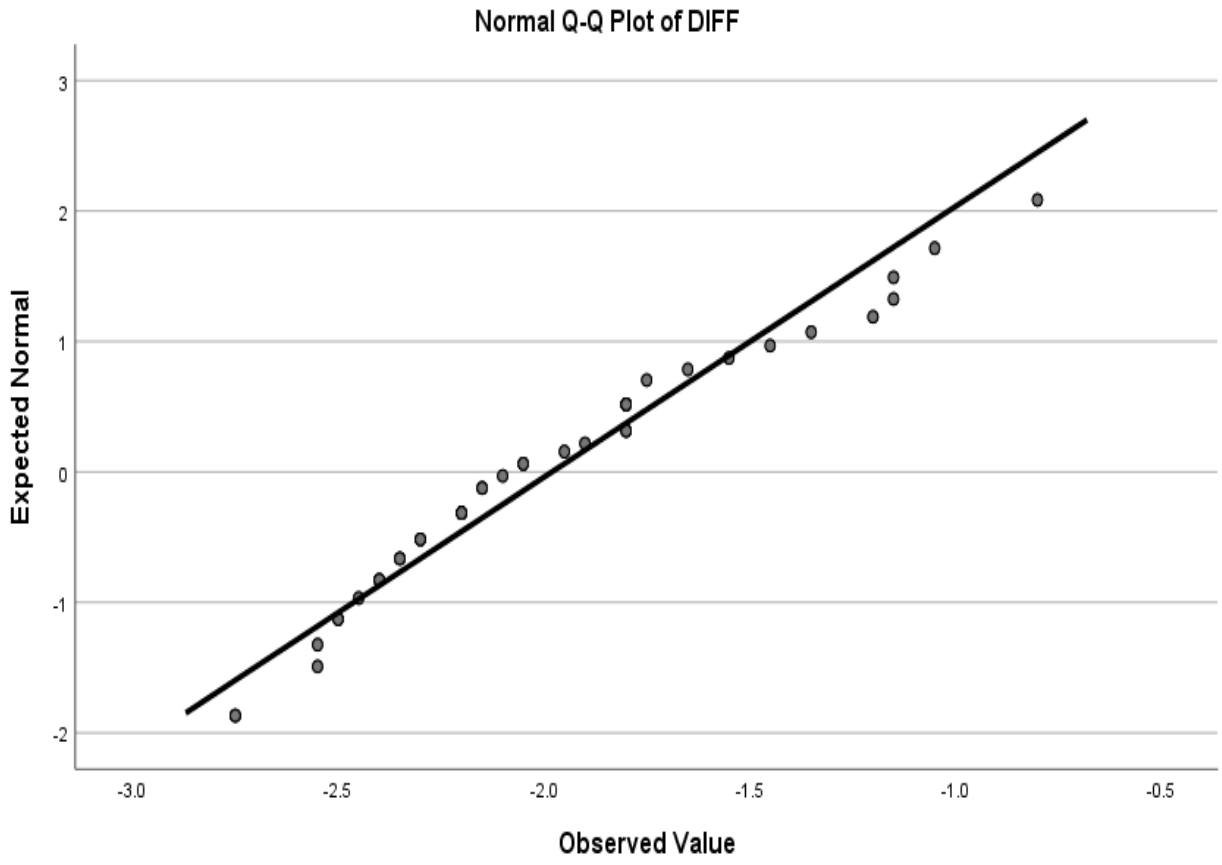

Figure 1

Q-Q Plots

The data presented in the above Q-Q plots suggest that it is normally distributed, as the points closely align along the reference line, indicating a consistent pattern of distribution. This alignment implies that the sample data follows a Gaussian distribution, with no significant deviations or outliers that would suggest otherwise. The visual representation provided by the Q-Q plots serves as a reliable tool for assessing normality, reinforcing the conclusion that the underlying data adheres to the characteristics of a normal distribution.

Independence of Observations

In the study, I arranged things to ensure that the scores of each participant would not impact the scores of other individuals. This involved developing rules that reduced chances of bias in participants and collected data that precisely captured their thoughts. To accomplish this, I set clear rules and applied the right tools to ensure that when measuring each participant's score, only their personal input mattered and the findings remained reliable.

4.3.2.2. *Paired T-test analysis*

Table 5:

Paired T-test analysis

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Average Before Treatment	3.2800	80	.29614	.03311
	Average After Treatment	1.3000	80	.28374	.03172

In "Trauma-Focused Cognitive Behavior Group Therapy for Children with Post-Traumatic Stress Disorder," evaluating the outcomes of therapy relies on instrument as the Child PTSD Symptom Scale (CPSS). With their help, we can rely on data that shows if and how children are PTSD symptoms have been improved by treatment. The CPSS is concerned with certain symptoms of PTSD. When Using the CPSS instrument, researcher can record the effects of TF-CBT on study participants.

The outcome of the paired samples test suggests that TF-CBGT had a significant positive effect on the PTSD symptoms of the children treated. When scores were measured before treatment, the average was 3.28 with a standard deviation of 0.29; however, after the treatment, the average was 1.3 and the standard deviation was 0.28. The decrease in mean scores demonstrates that the children's PTSD symptoms were greatly improved after receiving the intervention. Since the standard error of the mean is low for both pre-treatment and post-treatment scores and the change observed during treatment is statistically significant, the results can be trusted. These studies suggest that TF-CBGT has a proven ability to ease the stress caused by trauma in children.

Moreover, running an independent samples t-test could help determine if these findings are significant. Researcher compares the symptoms of PTSD before and after treatment to check if those improvements are not likely to have come about by coincidence. This means that the therapy has a significant beneficial impact, since changes in the test scores are very clear. This research indicates that TF-CBGT improves a child's symptoms and strengthens their ability to cope and recover from trauma. Research highlights that programs based on TF-CBGT can significantly support and improve the mental health of vulnerable people in the community.

Table 6

Paired Samples T-Test

Paired Samples Test

		Paired Differences					t	Df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Average Before Treatment - Average After Treatment	1.98000	.48193	.05388	1.87275	2.08725	36.748	79	.000

As indicated on Table 6, it shows that paired samples t-test indicated a significant difference between the average scores before and after treatment, with a mean difference of 1.98 ($t = 36.75$, $df = 79$, $p < .001$). This suggests that the treatment had a substantial positive effect on the participants' scores.

The outcome from the paired samples test reveals that the average PTSD symptom score has decreased after treatment. The result reported by the study shows a significant drop in PTSD symptoms after intervention, since the mean is 1.98, with a standard deviation of 0.48 and a standard error mean of 0.054. Since the true mean difference in the population is likely to be between those scores, the results are reliable. Since the t-value is 36.75 and the degrees of freedom (df) are 79, there is a strong and significant effect, as the p-value (Sig. 2-tailed) is .000. This means that children involved in TF-CBGT showed a decrease in their symptoms of PTSD. According to the strong findings from the paired samples test, it appears that TF-CBGT helps to reduce PTSD symptoms.

4.4. Relationship between child age, grade levels and the reduction in PTSD symptom severity following TF-CBT

Table 7

Relationship between child age, grade levels and the reduction in PTSD symptom severity following TF-CBT

Correlations

			Gender	Age	Place of Birth	Level of Education	Difference between Pre and Post
Spearman's rho	Gender	Correlation Coefficient	.	.	.	.	.
		Sig. (2-tailed)	.	.	.	.	.
		N	80	80	80	80	80
	Age	Correlation Coefficient	.	1.000	.	-.083	-.492**
		Sig. (2-tailed)	.	.	.	.465	.000
		N	80	80	80	80	80
	Place of Birth	Correlation Coefficient	.	.	.	.	.
		Sig. (2-tailed)	.	.	.	.	.
		N	80	80	80	80	80
	Level of Education	Correlation Coefficient	.	-.083	.	1.000	.204
		Sig. (2-tailed)	.	.465	.	.	.070
		N	80	80	80	80	80
	Difference between Pre and Post	Correlation Coefficient	.	-.492**	.	.204	1.000
		Sig. (2-tailed)	.	.000	.	.070	.
		N	80	80	80	80	80

**. Correlation is significant at the 0.01 level (2-tailed).

The Spearman correlation analysis presented reveals important insights into the relationships between age, education level, and the difference between pre- and post-treatment outcomes in Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBGT). The analysis indicates a significant negative correlation between age and the difference between pre- and post-treatment scores (Spearman's rho = -0.492, $p < 0.01$). This suggests that as age increases, the

improvement in trauma symptoms after treatment tends to decrease, highlighting a potential trend where younger participants may benefit more from TF-CBGT compared to older individuals.

Regarding education level, the correlation with the difference between pre- and post-treatment scores is positive but not statistically significant (Spearman's rho = 0.204, p = 0.070). This indicates that there is a slight tendency for individuals with higher education levels to show greater improvement in their trauma symptoms following therapy; however, the lack of significance suggests that this relationship may not be strong or consistent. Overall, these findings underscore the complexity of factors influencing therapeutic outcomes in TF-CGT, particularly emphasizing the role of age while indicating that education level may warrant further investigation to clarify its impact on treatment efficacy.

4.5. Prevalence of PTSD symptoms among children participating in the MCDP

The prevalence of PTSD symptoms among children participating in the Mission for Community Development Program (MCDP) was significant prior to treatment, as indicated by the mean scores on the Child PTSD Symptom Scale (CPSS). On a scale where higher scores reflect more severe symptoms, the aggregate mean score before treatment was 3.28, with individual symptom items showing high levels of distress. For instance, children reported having upsetting thoughts or images with a mean score of 3.70, indicating that intrusive memories were a common experience. Other symptoms, such as having bad dreams (mean score of 3.58) and feeling upset when recalling traumatic events (mean score of 3.33), further illustrate the pervasive nature of PTSD symptoms among these children before they began receiving trauma-focused therapy.

After undergoing Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBGT), there was a marked reduction in PTSD symptoms, with the aggregate mean score dropping to 1.30. The improvement across various symptom items was notable; for example, the mean score for having upsetting thoughts decreased from 3.70 to 1.75, and for bad dreams, it fell from 3.58 to 1.35. This substantial decline in symptom severity highlights the effectiveness of TF-CBT in alleviating PTSD symptoms among children in the MCDP, suggesting that the therapeutic intervention significantly contributed to their emotional healing and recovery from trauma.

4.6. Discussions

The study investigated the effectiveness of Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBGT) in reducing symptoms of Post-Traumatic Stress Disorder (PTSD) among children participating in the Mission for Community Development Program (MCDP). The findings indicate a substantial decrease in PTSD symptom severity following the intervention, as measured by the Child PTSD Symptom Scale (CPSS). Participants experienced notable improvements across all symptom domains, including intrusive thoughts, avoidance behaviors, negative alterations in cognition and mood, and changes in arousal and reactivity. These results support that TF-CBGT would significantly alleviate PTSD symptoms in this population.

The results of the study indicate a substantial reduction in PTSD symptom severity across all 20 items of the Child PTSD Symptom Scale (CPSS) following the Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBGT) intervention. The significant decrease in mean scores for each symptom from pre-treatment to post-treatment highlights the effectiveness of TF-CBGT in alleviating PTSD symptoms in children. This finding aligns with previous research that has demonstrated the efficacy of TF-CBGT in reducing PTSD symptoms among youth populations (Cohen et al., 2016). In their meta-analysis, Cohen and colleagues found that TF-CBT consistently produced significant improvements across various symptom domains, including intrusive thoughts, avoidance behaviors, and emotional regulation, reinforcing the notion that structured cognitive-behavioral approaches can effectively target the multifaceted nature of PTSD.

Moreover, the observed improvements in the current study are in line with a growing body of literature supporting the effectiveness of trauma-focused cognitive-behavioral group therapy (TF-CBGT) for youth experiencing trauma-related disorders. Notably, Cohen et al. (2016) demonstrated that trauma-focused cognitive-behavioral therapy (TF-CBT) produces significant reductions in posttraumatic stress disorder (PTSD) symptoms across multiple domains. This underscores the effectiveness of structured cognitive-behavioral approaches in addressing the multifaceted impact of trauma in children.

Similarly, Deblinger et al. (2017) found that children who participated in TF-CBGT experienced substantial decreases in both emotional and behavioral problems associated with trauma exposure. These results highlight the intervention’s dual capacity to facilitate

cognitive restructuring and promote emotional regulation, which are critical components in the recovery process for traumatized youth.

Furthermore, the current finding resonate with the conclusions of Hofmann et al. (2012), who emphasized the importance of restoring functional capabilities and enhancing overall well-being through evidence-based therapeutic interventions. Collectively, these studies reinforce the value of TF-CBGT as a comprehensive approach that not only alleviates PTSD symptoms but also supports broader psychological and functional recovery among youth.

The theatrical shift observed post-intervention, where the majority of participants reported that PTSD symptoms no longer significantly interfered with various areas of their lives, underscores the profound impact of TF-CBGT on children's overall functioning. Prior to treatment, PTSD symptoms were overwhelmingly reported as significantly interfering with daily activities, social interactions, and academic performance. Following the TF-CBGT intervention, these impairments were markedly reduced, highlighting the therapy's role in enhancing children's quality of life. This outcome is echoed in the findings of Hofmann et al. (2012), who emphasized that effective therapeutic interventions not only alleviate symptoms but also restore functional capabilities in children affected by trauma. Collectively, these studies underscore the importance of TF-CBGT as a viable treatment option for children experiencing PTSD, demonstrating its potential to foster resilience and improve overall well-being.

The results of the paired samples test indicate that Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) significantly improved the PTSD symptoms of the children who participated in the study. Before treatment, the average PTSD symptom score was 3.28 (SD = 0.29), which decreased to an average of 1.3000 (SD = 0.28) after the intervention. This substantial reduction in mean scores reflects a meaningful improvement in the children's symptoms, corroborating findings from previous research that supports the efficacy of TF-CBGT in treating trauma-related disorders in youth (Cohen et al., 2016). The low standard error of the mean for both pre-treatment and post-treatment scores further reinforces the reliability of these results, suggesting that the observed changes are not due to random variation but rather reflect true differences attributable to the intervention.

The statistical analysis revealed a significant difference between pre-treatment and post-treatment scores, with a mean difference of 1.98 ($t = 36.748$, $df = 79$, $p < .001$). Such a high t-value and low p-value indicate a robust effect size, suggesting that TF-CBT had a substantial positive impact on reducing PTSD symptoms among participants. This finding aligns with

earlier studies that have demonstrated the effectiveness of TF-CBTG in clinical settings, where children exposed to trauma exhibited marked improvements in their psychological well-being following treatment (Deblinger et al., 2017). The consistency of these results across various studies enhances the credibility of TF-CBT as a preferred therapeutic approach for children suffering from PTSD.

Moreover, the results indicate that the average PTSD symptom score decreased significantly after treatment, with a final mean score of 1.98 (SD = 0.48) and a standard error mean of 0.054. The strong statistical significance (p = .000) suggests that the improvements observed are not only statistically significant but also clinically relevant. This is consistent with findings from other research that emphasizes TF-CBT's effectiveness in alleviating trauma-related symptoms in children and adolescents (Hofmann et al., 2012). Overall, these results contribute to a growing body of literature supporting TF-CBT as an evidence-based intervention for reducing PTSD symptoms in young populations, highlighting its potential to foster resilience and recovery in children affected by traumatic experiences.

Research underscores the urgent need for effective interventions for children experiencing trauma, particularly those developing PTSD. Kessler et al. (2005) and Chorpita et al. (2005) advocate for swift treatment, with Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) showing significant efficacy in improving outcomes for these children. A moderate negative correlation (r = -0.381) between pre- and post-treatment PTSD scores in the finding of the study supports TF-CBT's effectiveness, especially for those with severe initial symptoms. Hernandez et al. (2017) further affirm TF-CBT's efficacy across diverse populations, with a significant p-value of .000 indicating its critical role in trauma treatment. Additional studies by Landolt et al. (2006) and Silverman et al. (2008) highlight substantial symptom improvement post-TF-CBT. Recent research by Tadesse Hailu (2020) and Abebe Tsegaye (2021) emphasizes the importance of cultural adaptation of TF-CBT in Ethiopia, enhancing its effectiveness, while Mekonnen and Alemayehu (2022), along with Yalom’s therapeutic principles (2005), advocate for group therapy as a supportive approach for children with PTSD, further demonstrating the multifaceted benefits of TF-CBT in addressing mental health in at-risk populations.

The findings from the Spearman correlation analysis align with existing literature that highlights the influence of age on therapeutic outcomes in trauma-focused interventions. For instance, a study by Cohen et al. (2016) found that younger individuals often exhibit more significant improvements in symptoms of post-traumatic stress disorder (PTSD) following cognitive-behavioral therapies compared to older adults. This trend may be attributed to

various factors, including cognitive flexibility and resilience, which tend to be more pronounced in younger populations (Hofmann et al., 2012). Furthermore, the negative correlation between age and treatment efficacy observed in the current analysis suggests that older individuals may face additional challenges, such as comorbidities or ingrained coping mechanisms, which can hinder their response to TF-CBGT (Levin et al., 2018). These findings underscore the importance of tailoring therapeutic approaches to accommodate the unique needs of different age groups.

In contrast, the relationship between education level and treatment outcomes in TF-CBGT, while positive, did not reach statistical significance. This is consistent with mixed findings in the literature regarding the impact of education on therapy effectiveness. For example, a study by Kessler et al. (2012) reported that higher educational attainment was associated with better mental health outcomes; however, this relationship was not uniform across all therapeutic modalities. Similarly, research by Möller et al. (2018) indicated that while education may play a role in an individual's ability to engage with therapeutic content, other factors such as socioeconomic status and support systems might be more influential in determining treatment success. Thus, while there is a suggestion that education could enhance the benefits of TF-CBGT, further research is warranted to explore this relationship more comprehensively and to identify other contributing variables that may hinder treatment effectiveness.

This study included a limited number and variety 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-CBGT 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.

5. CHAPTER FIVE: SUMMARRY, CONCLUSION AND RECOMMENDATIONS

5.1. Summary of the Study

This study conducted to examine the effectiveness of trauma focused cognitive behavioral therapy for children with Post-Traumatic Stress Disorder (PTSD). TF-CBT was evaluated to understand its effects on PTSD symptoms in children who had experience trauma. Using the CPSS the study found that after therapy, PTSD symptoms were significantly reduced as observed in earlier studies. The study highlights the critical need for effective interventions for children experiencing trauma, particularly those developing post-traumatic stress disorder (PTSD). It emphasizes the importance of timely treatment to address the psychological impacts of trauma. The findings indicate that Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a highly effective approach, significantly improving outcomes for children suffering from PTSD symptoms. The data reveal a moderate negative correlation between pre- and post-treatment PTSD scores, suggesting that children with more severe initial symptoms benefit notably from this therapeutic intervention.

The research uncovered those children experiencing more symptoms before the treatment experienced a better improvement afterward. This result supports the idea, early intervention helps reduce long-term psychological harm for children as a result of trauma. The study further underscores the broad applicability of TF-CBGT across diverse populations, demonstrating its effectiveness in various cultural contexts. The significant improvements in PTSD symptoms following TF-CBGT treatment highlight its critical role in trauma recovery for children. The research indicates that the therapy not only alleviates symptoms but also fosters resilience and coping strategies, which are essential for long-term mental health.

The result of the paired samples t-test indicated a significant difference between the average scores before and after treatment, with a mean difference of 1.98 ($t = 36.748$, $df = 79$, $p < .001$). This suggests that the treatment had a substantial positive effect on the participants' scores. Additionally, a statistically significant p-value ($p = .000$) found in the study confirms the value of TF-CBT for treating trauma in children, revealing that TF-CBT results in meaningful decreases of PTSD among various populations and in many types of settings.

The study further explains how using group therapy approaches can help children with PTSD overcome their troubles. Having children participate in groups allows for decreasing their difficulties and fosters a sense of community between all participants, thus highlighting the benefits of TF-CBT as a whole intervention for child trauma. All in all, the findings of the study demonstrate that TF-CBT is useful for supporting people facing trauma-related issues. Also , the study advocates for the incorporation of group therapy as a supportive approach alongside TF-CBT. Group therapy offers additional benefits, such as fostering a sense of community and shared understanding among children who have experienced similar traumas. This multifaceted approach to treatment not only addresses individual symptoms but also promotes collective healing and support, thereby enhancing the overall effectiveness of interventions for children with PTSD.

5.2. Conclusion

Based on the study result, the study reveals that the paired samples t-test indicated a significant difference between the average scores before and after treatment, with a mean difference of 1.98 ($t = 36.748$, $df = 79$, $p < .001$). This suggests that the treatment had a substantial positive effect on the participants' scores. The study on Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBGT) for children with PTSD within the Mission for Community Development Program (MCDP) demonstrated that this intervention significantly reduces PTSD symptoms and enhances the overall mental well-being of affected children. The substantial improvements observed in participants, as evidenced by the statistical analyses of pre- and post-treatment assessments, reinforce the efficacy of TF-CBT as a vital therapeutic approach. These findings align with existing literature, emphasizing the importance of early intervention in addressing trauma-related disorders and highlighting TF-CBT adaptability across diverse cultural contexts.

Furthermore, the study underscores the additional benefits of group therapy modalities, which not only facilitate individual healing but also foster a supportive community among participants. By promoting resilience and shared experiences, group therapy enhances the therapeutic process, making it particularly valuable for children who have faced trauma. The insights gained from this study advocate for the continued implementation and potential adaptation of TF-CBT within various settings, ensuring that vulnerable populations receive effective and culturally relevant mental health support. Overall, this research contributes to

the growing body of evidence supporting the use of TF-CBT as a cornerstone in trauma-informed care for children.

5.3. Recommendation

Based on the Results identified in the study regarding the effectiveness of TF-CBGT for children's with PTSD, the following recommendations are proposed to enhance the effectiveness in this area:

Expand TF-CBT Implementation:-It is recommended to increase the availability of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) programs across various community centers and schools within the MCDP network. Enhancing accessibility to TF-CBT will enable a greater number of children who have experienced trauma to benefit from this evidence-based intervention. Future research should focus on identifying effective strategies for scaling up TF-CBT delivery, assessing barriers to implementation, and evaluating outcomes to ensure sustained impact within diverse community settings.

Future Research Directions for TF-CBT in Ethiopian Childhood Trauma:-The findings of this study suggest that Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) holds significant potential in alleviating post-traumatic stress symptoms among Ethiopian children who have experienced trauma. Given the widespread prevalence of childhood trauma in Ethiopia and the critical need for culturally sensitive mental health services, it is recommended that future research prioritize replicating the effectiveness of TF-CBT within this context. Additionally, efforts should be made to culturally adapt the therapy to better align with local beliefs and practices, as well as to conduct comparative studies evaluating TF-CBT against other psychotherapeutic approaches. Such comprehensive research will provide policymakers and practitioners with robust, evidence-based guidance to develop culturally relevant and scalable interventions tailored to the Ethiopian setting.

Training and Certification Programs: Develop training sessions and certification programs for therapists and counselors in the MCDP to ensure they are well-equipped to deliver TF-CBT. Ensuring that practitioners are properly trained will enhance the quality of therapy provided and maintain fidelity to the TF-CBT model.

Many nongovernmental organizations (NGOs) provide vulnerable children with essential needs such as shelter, food, education, and medical services. However, the importance of

counseling and mental health services for these children is often overlooked. Given the evident need and the potential benefits of such support, it is crucial to promote the broader and more appropriate integration of counseling services within these institutions. Additionally, it is recommended to develop specialized training sessions and certification programs for therapists and counselors to ensure they are adequately prepared to deliver Trauma-Focused Cognitive Behavioral Group Therapy (TF-CBGT)

Conducting Longitudinal Studies to Assess Long-Term Outcomes:-Future research is recommended to prioritize longitudinal studies that assess the long-term effectiveness of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and group therapy interventions for children diagnosed with PTSD. By tracking participants over extended periods, such studies can provide critical insights into the durability and sustainability of treatment outcomes. Additionally, longitudinal data will help identify any ongoing or emerging support needs among this population. These findings will be instrumental in refining therapeutic approaches and guiding evidence-based policy decisions, thereby ensuring that mental health services remain adaptive and responsive to the evolving needs of children and their families following traumatic experiences.

Diverse Populations and Settings:-It is recommended that future research expand to include more diverse populations and settings. Specifically, studies should incorporate a broader range of demographic variables such as age, ethnicity, socio-economic status, and types of trauma experienced. Furthermore, implementing Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) across various community settings—such as schools, community centers, and clinics—will help assess its effectiveness in different contexts. This approach will enhance the generalizability and applicability of the findings to a wider population.

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Appendix 1: QUESTIONNAIRE

ADDIS ABABA UNIVERSITY
COLLEGE OF EDUCATION AND BEHAVIORAL STUDIES
SCHOOL OF PSYCHOLOGY

Dear Participant

I am a graduate student of Counseling Psychology at Addis Ababa University. Currently, I am undertaking research entitled "**Trauma-focused cognitive behavior group therapy for children with post-traumatic stress disorder: the case of Mission for community development program**". You are one of the respondents selected to participate in this study. Please assist me in giving correct and complete information to present a representative finding on the subject. Your participation is entirely voluntary, and your identity is completely anonymous. I confirm that the information that you share with me will be kept confidential and only used for academic purposes. Therefore, I kindly request you to answer the questions freely and openly to share your competence and knowledge with me. I thank you very much for your willingness to spare some minutes of your precious time to participate in this study.

General Instructions

No need for writing your name

Section 1: Demographic characteristics

1. Gender A. Male B. Female

2. Age _____

3. Please of birth_____

4. Educational level

A. Un able to read and write b. read and write c. Primary d. secondary d. first degree

5. Have you ever taken Trauma-focused Cognitive Behavior Group Therapy before?

A .Yes B. No

Instruction: Below is a list of problems that children sometimes have after experiencing an upsetting event. 0=Not at all 1= Once a week or less/a little 2=2 to 3 times a week/somewhat 3=4 to 5 times a week/ a lot 4=6 or more times a week/ almost always

These questions ask about how you feel about the upsetting thing you wrote down. Read each questions carefully. Then circle the number (0-4) that best describes how often that problem has bothered you in the last month. All the responses will be kept confidential. Thank you for your corporation!!!

No		0	1	2	3	4
1	Having upsetting thought or pictures about it that came in to your head when you didn't want them to					
2	Having bad dreams or nightmares					
3	Acting or feeling as if it was happening again(Seeing or seeing something and feeling as if you are there again)					
4	Feeling upset when you remember what happened (for example feeling scared, angry, sad, guilty, confused)					
5	Having feeling in your body when you remember what happened (for example sweeting, heart beating fast, stomach or head hurting)					
6	Trying not to think about it or have feeling about it					
7	Trying to stay away from anything that reminds you of what happened. (for example pleople places or conversation about it)					
8	Not being able to remember an important part of what happened.					

9	Having bad thought about you self, other people, or the world (for example “I can’t do anything right”, “All people are bad”, “The world is a scary place”.					
10	Thing that what happened is your fault. (for example “ I should have known better”, “I shouldn’t have done that”, “ I deserve it”.					
11	Having strong bad feelings (like fear, anger, guilt or shame)					
12	Having much less interest in doing things you used to do					
13	Not feeling close to your friends or family or not wanting to be around them					
14	Trouble having good feelings (like happiness or love) or trouble having any feeling at all					
15	Getting angry easily (for example yelling, hitting others, throwing things)					
16	Doing things that might hurt youself (for example taking drugs, drinking alcohol, running away, cutting yourself.)					
17	Being very careful or on the lookout for danger (for example checking to see who is around you and what is around you)					
18	Being jumpy or easily scared (for example when someone walks up behind you, when you heard a loud noise)					

19	Having trouble paying attention(for example losing track of a story on tv, forgetting what you read, unable to pay attention in class)					
20	Having trouble falling or staying a sleep					

Indicate below if the problems above have been getting in the way of these parts of your life in the past month?

1	Fun things you want to do		
2	Doing your chores		
3	Relationships with your friends		
4	Praying		
5	Schoolwork		
6	Relationship with your family		
7	Being happy with your life		

አባሪ 1፡ መጠይቅ።

አዲስ አበባ ዩኒቨርሲቲ።

የትምህርት እና የባህርይ ጥናቶች ኮሌጅ

የስነ-ልቦና ትምህርት ቤት

ውድ ተሳታፊ፡-

እኔ በአዲስ አበባ ዩኒቨርሲቲ የሳይኮሎጂ የድህረ ምረቃ ተማሪ ነኝ። በአሁኑ ጊዜ፣ "የድህረ-አሰቃቂ ጭንቀት ችግር ላለባቸው ልጆች ፤ የስሜት ቀውስ ሁኔታ ላይ ያተኮረ የአእምሮ ባህሪ የቡድን ህክምና፤በተልእኮ ለማህበረሰብ ልማት ፕሮግራም" ላይ ጥናት እያደረኩ እገኛለሁ። በዚህ ጥናት ላይ ለመሳተፍ ከተመረጡት ምላሽ ሰጪዎች አንዱ ነዎት። እባኮትን በጉዳዩ ላይ የሚውክል ግኝት ለማቅረብ ትክክለኛ እና የተሟላ መረጃ እንድሰጥ ይእርዱኝ። የእርስዎ ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት ነው፣ እንዲሁም ማንነትዎ ሙሉ በሙሉ የማይታወቅ ነው። ከእኔ ጋር የምታካፍለው መረጃ በሚስጥር እንደሚጠበቅ እና ለጥናት እና ትምህርታዊ ዓላማ ብቻ እንደሚውል አረጋግጣለሁ። ስለዚህ ብቃትህን እና እውቀትህን ከእኔ ጋር ለማካፈል ለጥያቄዎቹ በነፃነት እና በግልፅ እንድትመልስ በአክብሮት እጠይቃለሁ። በዚህ ጥናት ላይ ለመሳተፍ የተወሰኑ ደቂቃዎችን ከውድ ጊዜዎ ላይ ስለሰጡኝ እና ላሳዩት ፍቃደኝነት በጣም አመሰግናለሁ።

አጠቃላይ መመሪያዎች

ስምዎን መጻፍ አያስፈልግም

ክፍል 1፡ የአጠቃላይ መገለጫ።

1.ጾታ ሀ. ወንድ ለ. ሴት

2.ዕድሜ ፡- _____

3.የትውልድ ቦታ ፡- _____

4.የትምህርት ደረጃ ሀ.መደበኛ ትምህርት የለም ለ. የመጀመሪያ ደረጃ ሐ. ሁለተኛ ደረጃ

5. . ከድርጅቱ በአሰቃቂ ሁኔታ ላይ ያተኮረ የግንዛቤ ባህሪ ቡድን ህክምና ከዚህ በፊት ተጠቅመሽ ታውቂያለሽ? ሀ. አዎ ለ. አይደለም

መመሪያ፦ **ቀጥሎ የተዘረዘሩት ጥያቄዎች ልጆች የደረሰባቸውን አሰቃቂ ጥቃትን ተከትለው የሚከሰቱ የስሜትና የመንፈስ መረበሽ ችግሮች የሚለኩ ሲሆኑ እያንዳንዱን ጥያቄ በጥሞና በማንበብ ወይም**

በማዳመጥ የሚከተሉትን ከሚከተሉት አማራጮች (0-4) የአንቺን ስሜት በትክክል ይገልፃል በሚለው ምርጫ ሥር ካሉት ቁጥሮች ምልክት በማድረግ መልስሽን አክቢቢ 0= በጭራሽ አይደለም 1= በሳምንት አንድ ጊዜ ወይም ከዚያ ያነሰ/ትንሽ 2=2 እስከ 3 ጊዜ በሳምንት/በተወሰነ ጊዜ ከ 3=4 እስከ 5 ጊዜ/ብዙ 4=6 ወይም በሳምንት ብዙ ጊዜ/ሁልጊዜ ማለት ይቻላል።

እያንዳንዱን ጥያቄ በጥንቃቄ ያንብቡ። ከዚያም ባለፈው ወር ያጋጠመሽ ችግር ምን ያህል ጊዜ እንዳስቸገረ የሚገልጸውን ቁጥር (0-4) ክበቡ። የመረጥሽው ምላሽ ሁሉ በሚስጥር ይቀመጣል። ለትብብርሽ በጣም አመሰግናለሁ!!!

ተ.ቁ		0	1	2	3	4
1	ስለ ደረሰብኝ ጥቃት የሚያስፈሩና የሚያስጨንቁ ሀሳቦች ሳልፈልጋቸው በአዕምሮዬ እየተመላለሱ ያስቸግሩኛል።					
2	መጥፎ ህልሞች ወይም ቅዠቶች መኖር					
3	እርምጃ መውሰድ ወይም እንደገና እየተከሰተ እንዳለ ሆኖ መሰማት (አንድ ነገር ማየት ወይም ማየት እና እንደገና እዚያ እንዳለ ሆኖ ይሰማዎታል)።					
4	የሆነውን ነገር ስታስታውሱ ብስጭት ይሰማዎታል (ለምሳሌ ፍርሃት ፣ ቁጣ ፣ ሀዘን ፣ ጥፋተኛ ፣ ግራ መጋባት)።					
5	የሆነውን ነገር ስታስታውሱ በሰውነትዎ ውስጥ ይሰማዎታል (ለምሳሌ ጣፋጭ ፣ የልብ ምት በፍጥነት ፣ ሆድ ወይም ጭንቅላት ይጎዳል)።					
6	ስለ እሱ ላለማሰብ ወይም ስለ እሱ ስሜት እንዳይሰማዎት መሞከር።					
7	ምን እንደተከሰተ ከሚያስታውስዎት ከማንኛውም ነገር ለመራቅ መሞከር። (ለምሳሌ ስለ እሱ ብዙ ቦታዎች ወይም ውይይት)።					
8	የተከሰተውን አስፈላጊ ክፍል ማስታወስ አለመቻል.					
9	ስለእራስዎ፣ ስለሌሎች ሰዎች ወይም ስለ አለም መጥፎ ሀሳብ (ለምሳሌ “ምንም ነገር ማድረግ አልችልም”፣ “ሁሉም ሰዎች መጥፎ” ናቸው፣ “አለም አስፈሪ ቦታ” ነው።					

10	የሆነው ነገር የእርስዎ ጥፋት ክንደሆነ መሰማት ። (ለምሳሌ “ የተሻለ” ማወቅ ነበረብኝ፣ “ያንን” ማድረግ አልነበረብኝም፣ “ ይገባኛል”።					
11	ጠንካራ መጥፎ ስሜቶችን (እንደ ፍርሃት፣ ቁጣ፣ ጥፋተኝነት ወይም እፍረት) ማዳበር።					
12	ቀደም ሲል ያደረጓቸውን ነገሮች ለማድረግ በጣም ያነሰ ፍላጎት					
13	ከጓደኞችዎ ወይም ከቤተሰብዎ ጋር አለመቀራረብ ወይም በዙሪያቸው መሆን አለመፈለግ።					
14	ጥሩ ስሜት (እንደ ደስታ ወይም ፍቅር) ወይም ምንም አይነት ስሜት የመሰማት ችግር።					
15	በቀላሉ መበሳጨት (ለምሳሌ መጮህ፣ ሌሎችን መምታት፣ ነገሮችን መወርወር)።					
16	እራስህን ሊጎዱ የሚችሉ ነገሮችን ማድረግ (ለምሳሌ አደንዛዥ ዕፅ መውሰድ፣ አልኮል መጠጣት፣ መሸሸ፣ እራስህን መቁረጥ)።					
17	በጣም መጠንቀቅ ወይም አደጋን መጠበቅ (ለምሳሌ በዙሪያዎ ማን እንዳለ እና በዙሪያዎ ያለውን ለማየት ማረጋገጥ)።					
18	ዘላይ መሆን ወይም በቀላሉ መፍራት (ለምሳሌ አንድ ሰው ከኋላህ ሲወጣ፣ ከፍተኛ ድምጽ ሲሰማህ)።					
19	ትኩረት የመስጠት ችግር (ለምሳሌ በቲቪ ላይ ያለውን ታሪክ ማጣት፣ ያነበብከውን መርሳት፣ በክፍል ውስጥ ትኩረት መስጠት አለመቻል)።					
20	የመውደቅ ወይም የመተኛት ችግር					

ከላይ ያሉት ችግሮች ባለፈው ወር ውስጥ በእነዚህ የህይወትዎ ክፍሎች ላይ እንቅፋት እየፈጠሩ ነው?

		አዎ	አይደለም
1	ማድረግ የምትፈልጋቸው አስደሳች ነገሮች።		
2	የቤት ውስጥ ሥራዎችን መሥራት		
3	ከጉደኞችህ ጋር ያሉ ግንኙነቶች		
4	መጸለይ		
5	የትምህርት ቤት ስራ		
6	ከቤተሰብ ጋር ያለው ግንኙነት		
7	በህይወትሽ ደስተኛ መሆን		