An Najah National University
Faculty of Graduate Studies

THE EFFECTIVENESS OF CBT IN TREATING PTSD SYMPTOM AND IMPROVING PERCEIVED SELF-EFFICACY AMONG ABUSED CHILDREN: A RANDOMIZED EXPERIMENTAL STUDY

By
Sujoud Mahmod Sultan

Supervisors
Dr. Fayez Azez Mahamid
Dr. Denise Ziya Berte

This Thesis is Submitted in Partial Fulfillment of the Requirements for the Degree of Clinical Psychology, Faculty of Graduate Studies, An-Najah National University, Nablus, Palestine.
2022

THE EFFECTIVENESS OF CBT IN TREATING PTSD SYMPTOM AND IMPROVING PERCEIVED SELF-EFFICACY AMONG ABUSED CHILDREN: A RANDOMIZED EXPERIMENTAL STUDY

By

Sujoud Mahmod Sultan

This Thesis was Defended Successfully on 24/03/2022 and approved by:

This Thesis was Defended Successfully on 24/03/2022 and approved by:

Dr. Fayez Azez Mahamid	
Supervisor	
Dr. Denise Ziya Berte	
Co-Supervisor	
Dr. Mohamed Shaheen	
External Examiner	
Dr. Adnan Sarhan	
Internal Examiner	

Dedication

الى كل من وضع الثقة بخطواتي حتى قدمت وحققت انجازاتي حتى هذا اليوم وما زال المزيد ...

الى من وضعوا مكانة اهميتي أولوية في حياتهم ولاحقوا خطى السعادة لتملأ ارجاء الأرض قوة استمد منها الفخر والمحبة والشجاعة لإكمال خطواتي الأخيرة لإنهاء مرحلة تحت مسمى الخطوة الأولى لبدء مراحل جديدة بحلة متجددة ...

امي الغالية وابي الابي

الى العائلة الثمينة التي طالما اشكر ربي على تكويني بها، فهم الحضن الأكثر اتساعا الداعم الذي لا يميل ...

اخوتي محمد، عز الدين ونور الدين

الى شريك قلبي وحياتي ... رفيق دربي وجميل اختياري وخيرتي ... السند الابدي طوال العمر ...

محمد الحبيب

الى الحكيم في الدنيا، الى من شاركني شموخه، كرمه وحبه للعلم ... لطالما أعاد من معرفته لينير دربي بما سبق ...

جدي، رحمه الله واسكنه فسيح جناته

واسال الله ان يوفقني ويوفقكم ويعيننا على تقديم الخير.

Acknowledgments

بسم الله الرحمن الرحيم

﴿يَرْفَعِ اللهُ الذينَ آمنوا مِنْكُمْ والذينَ أُوتوا العِلْمَ دَرَجَاتٍ واللهُ بِمَا تَعْمَلونَ خَبِيرٌ﴾

بسم الله الرحمن الرحيم والصلاة والسلام على أشرف المرسلين سيدنا محمد وعلى آلة وصحبه أجمعين.

فإني أتقدم بالشكر الجزيل بداية لا يكون لغير الله سبحانه وتعالى ...

ثم الى جامعتي جامعة النجاح الوطنية التي منحتني فرصة البحث العلمي.

كما وأخص بالشكر الجزيل والامتنان العظيم إلى الدكتور المحترم د. فايز محاميد وال د. دينيس زيل مشرفين الدراسة الحالية، لما كان لهم الأثر القيّم في حياتي العلمية، جزاهم الله كل خير.

وجزيل الشكر والعرفان إلى أساتذتي الكرام لمساعدتهم بكل إخلاص وأمانة في حياتي العملية مع حفظ الألقاب والمسميات، ممن كانوا الشمعة لتضيء لي طريق العلم والمعرفة.

وكل الشكر إلى القلب الطيب والعيون الساهرة في سبيل تربيتي إلى أمي الغالية التي كانت ومازالت الداعمة لي في مسيرة حياتي وكل الفضل لها وابي الغالي الذي قدم الكثير من القلب بكل حب وامل ولعائلتي التي اتاحت لي الدرب للسير بأمان وثقة لأتقدم وأصل لتحقيق الاهداف.

ولا ينتهي الشكر لشريك قلبي ... ادامك الله السند الذي لا يميل ... يا من كنت وما زلت الخير في حياتي وخطواتي.

أنتم الفخر الكبير ... وسأبقى اسير على خطى حالمة وقوية طول الحياة لأقدم لكم المزيد كما وهبتموني وأكثر.

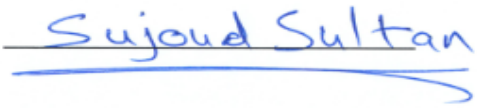
Declaration

I, the undersigned, declare that I submitted the thesis entitled:

THE EFFECTIVENESS OF CBT IN TREATING PTSD SYMPTOM AND IMPROVING PERCEIVED SELF-EFFICACY AMONG ABUSED CHILDREN: A RANDOMIZED EXPERIMENTAL STUDY

I declare that the work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

Student's Name: Sujoud Mahmod Sultan

Signature: 

Date: 24/03/2022

List of Contents

List of Tables

List of Appendices

THE EFFECTIVENESS OF CBT IN TREATING PTSD SYMPTOM AND IMPROVING PERCEIVED SELF-EFFICACY AMONG ABUSED CHILDREN: A RANDOMIZED EXPERIMENTAL STUDY

By
Sujoud Mahmod Sultan
Supervisors
Dr. Fayez Azez Mahamid
Co-Supervisor
Dr. Denise Ziya Berte

Abstract

The study aims were to evaluate the efficiency of Cognitive Behavioral Therapy (CBT) in alleviating symptoms of post-traumatic stress disorder (PTSD) and improving perceived self-efficacy among abused children. This study employed the experimental approach. The sample of study consisted of (30) children (aged 10-15), diagnosed with PTSD currently treated at a local mental health clinic. Study instruments included a PTSD scale (CPSS – SR – 5) that measures PSTD in children and a scale of perceived self-efficacy in children (Self-Efficacy Formative Questionnaire). The sample was randomly divided into two groups; an experimental group treated with Therapeutic Program based on CBT (n = 15), and a control group (n = 15). The results of the study revealed statistically significant positive effects of CBT in reducing PTSD related symptoms and improved perceived self-efficacy among abused children. The results of the study suggest that CBT is effective in treating children with PTSD and improving self-efficacy. The study recommended the necessity of paying attention to cognitive behavioral therapy and integrating it into various therapeutic areas, and developing more cognitive behavioral therapy programs to treat additional psychological disorders among children.

Keywords: CBT; PTSD; Abused Children; violence; self-efficacy.

Chapter One

Introduction and Theoretical Background

1.1 Introduction

During the course of their lives, individuals typically face various problems and negative experiences that may impact their mental health (Gabriel, 2013). Psychological research (Smith, 2017) has demonstrated that individuals who experience traumatic events such as wars and crises are often more likely to suffer from mental disorders. Evens related to trauma can be defined as one of the threatening instances of serious injury or death to oneself or others showing extreme fear, horror and helplessness. Such instances include road accidents, violence/prolonged abuse, natural disasters and serious illnesses. Strategies often used to survive trauma and manage the associated emotions may become non-productive, habitual methods of emotional regulation, which can have unintended, harmful consequences and manifest as PTSD symptoms, (Zaidan, 2017).

Traumatic events occur throughout the world and have negative consequences that affect all age groups, in various aspects of their lives, specifically in terms of health, psychological and social functioning. Traumatic events may be beyond the coping abilities of certain individuals and thus may result in mental disorders, the most common of which is PTSD, (Zaidan, 2017).

PTSD occurs when one experiences a traumatic event or psychological trauma that goes beyond his or her familiar experiences. Symptoms of PTSD are + characterized by re-experiencing the trauma, e.g., via flashbacks and nightmares, avoidance of trauma-related stimuli as places as well as people related with the traumatic event, increased arousal (hypervigilance) as well as difficulty sleeping or sleeping excessively, and difficulty concentrating, (Hughes & Jones, 2000).

PTSD is acute in case of the continuation of the symptoms for less than three months, chronic if symptoms persist for more than three months, and deferred if symptoms appear six months after the traumatic event, according to the classification of “Diagnostic and Statistical Manual of Mental Disorders”, Fifth Edition, published by the American Psychiatric Association, (American Psychiatric Association, 2013).

Post-traumatic reactions of individuals vary, ranging from those with high resilience (i.e. with little or no level of emotional distress), moderate resilience, to those with low resilience and the lack of coping tools which can lead to chronic and debilitating symptomology. In addition to those directly affected by the traumatic event, the trauma may have a secondary negative impact on those close to the affected individuals and/or on their caregivers, thus, the outcome of the trauma may be extensive, (Al-Dahery, 2018).

Family violence is considered one of the most harmful phenomena because of its negative impact on the child's development, and often leads to mental health disorders. Reports of domestic violence have been increasingly documented internationally, specifically in Arabic-speaking communities. Domestic violence, which is not restricted to a specific ethnic group or gender, includes all age groups, ethnic backgrounds, economic statuses, social levels and marital statuses. Victims of domestic violence are the most commonly women and children, (Laurel, 2010).

Domestic violence is the most prevalent, detrimental and widespread type of human violence today. There are increasing rates of domestic violence, indicating the need for more interventions, treatment solutions and preventative efforts such as social education throughout society, (Hughes & Jones, 2000). Abuse associated with domestic violence is often undetected or reported and remains within the confines of the home or homes in question. Victims often feel powerless and afraid to seek help, (Waugh & Bonner, 2010).

Many studies (O'Callaghan, et.al, 2013; Benjamin, et.al, 2013; Sukhodolsky, et.al, 2016), report the psychological and emotional consequences of domestic violence. Associated abusive relationships figured out to result in low self-esteem in victims and symptomatic disorders of anxiety and depression which are characterized by feelings of loneliness, helplessness and low self-efficacy, (Aguilar and Nightingale, 1994).

Trauma related events target the central nervous system by following mechanisms underlying cognitive, affective, sensory, integrative, regulatory, neuroendocrine, and motor functions are organized in the life threat response leading to neuronal network imprint in the memory.

In the case of young children, their brain is maturing using their interaction with their surrounding that their memory may become lifelong traits. Furthermore, their use a

dissociative adaptive defense in an acute response to trauma would later primarily demonstrate dissociative or somatic symptoms. On the other hand, children who primarily use hyperarousal adaptation to an acute stressor would be more likely to develop chronic hyperarousal symptoms, such as startle response, anxiety, motor hyperactivity, sleep disturbance, or tachycardia, (Soffer-Dudek and Sumer, 2018).

CBT is used to identifying and reassessing the way of thinking and the subconscious perspective of the trauma and its associated memories. It concentrates on how people see themselves, others, and the world after experiencing a trauma related event, **(**Al-Tamimi, 2016; Al-Wandi, 2012; Al-Zoghbi, 2014; Bilal, 2017). Inaccurate thinking after the trauma often keeps the person stuck in his memories, and thus prevents his recovery from the trauma. In this treatment method, the patient looks at the cause of the trauma and its impact on his thinking, which can be personally useful for people who blame themselves for the trauma, (Al-Anbari, 2016).

The most important methods of specialized CPT for PSTD include prolonged exposure to trauma. This is another form of CBT that depends more on behavioral therapy techniques to help people gradually approach and accept memories, situations, and emotions associated with trauma. This approach focuses on helping people with PTSD stop avoiding traumatic memories. Although avoiding these memories may help a person in the short term, it prevents recovery from trauma in the long term, (Gabriel & Muhammad, 2013; Kobany, 2003; Cohen et al. 2004; Hussein, 2004; Momani, 2008; Wanda, 1999).

Stress Management Training is an additional type of CBT treatment for PTSD that aims to alleviate anxiety by teaching the person skills to deal with the PSTD stress. This method can be used as a stand-alone treatment or in combination with other CBT methods for PTSD, (Riyadh, 2014).

1.2 Problem Statement

Exposure of a child to sudden danger (or to seeing a terrifying scene or hearing tragic news), may cause psychological trauma, and the trauma may have severe psychological outcomes. The consequences of the trauma are the negative effects that remain with the child, which may accompany him throughout his life. Traumatic events world over,

impact society, especially children, and etch in their memories unforgettable images which affect their mental health and wellbeing, and may turn become chronic psychological lesions, (Tohamy, 2017).

The psychological impact of calamities may be greater than the physical effects on the child, and can lead to feelings of fear and terror that become a chronic mental disorder that requires an extended period of treatment. This research addresses the treatment of children who experienced traumatic events. The study sample includes abused children (boys and girls) who developed PTSD which followed their exposure to very painful events that manifests in obstructions to daily living performance and life activities, (Hussein, 2020).

The child's environment is comprised of the family, social system, and the educational setting. The child is thus exposed to many situations, owing to the interactions that take place. The child affects and is affected by those environments. A diverse, and volatile social system of inherited values and habits can affect children negatively through violence or abuse, causing subsequent psychological disorders. The primary determinant is inside the home (the family) and the way the child is treated. The second determinant of PTSD in a child is the external environment. The child recognizes and learns behaviors from the environment in which he lives through interaction and communication. This is reflected in his psychological and social structure; physically, behaviorally and emotionally, (Zoghbi, 2014).

There is a large number of children at the psychiatric clinic that were diagnosed with PTSD following exposure to verbal or physical violence. The researcher diagnosed the existence of a problem that warranted scientific study, and the importance of an appropriate treatment intervention for the abused children. The research question is:

Does the CBT program effective in alleviating the symptoms of PSTD and improving their self-efficacy among abused children?

1.3 Research Importance

1.3.1 Applicant Importance

The relevance of the study is based on the significance of providing therapeutic services for children diagnosed with PTSD, to alleviate their symptoms and to promote recovery and self-efficacy. In addition, children who suffer from abuse and from a violent family atmosphere, may have difficulties with their social relationships and may have reduced self-efficacy. These children need assistance and care to increase their self-esteem and their self-efficacy. They need support to enhance their abilities, to speak for themselves, to solve problems appropriately, to perform daily activities with awareness, to develop skills and acquire education. This can be achieved through a program of Cognitive Behavioral Therapy.

The majority of studies that dealt with violence and abuse of children were limited to the types of violence, the degree of its prevalence and its negative effects. However, these studies did not develop a program to treat psychological effects, especially PTSD, resulting from violence and abuse directed against children. This study is novel in its endeavor to develop a program for the treatment of PTSD among abused children and to show its effectiveness in reducing the symptoms of the disorder and increasing the perceived self-efficacy of children. This study can serve as an introduction and starting point for other studies that seek to contribute to the development and application of therapeutic counseling programs to deal with psychological disorders in abused children.

In order to treat trauma and their sequential effects after the trauma and its causes have passed, the individual may begin to develop symptoms. They must be diagnosed and psychological therapy should be initiated early in order to alleviate suffering. CBT is one of the methods of psychotherapy that helps the individual to realize negative or incorrect thinking patterns, and enables him to adapt to the difficult situations he has been exposed to and deal with them more effectively. This therapeutic approach can be applied alone or together with other treatments for a number of psychological and mental disorders, such as anxiety and depressive disorders. These programs include methods and techniques applied during the sessions, which the therapist and psychologist share with the students, (Al-Qaisi, 2013).

CBT is a form of “VCBT therapy” and the psychotherapist implements it to reveal the roots of the disorder. There is then a short-term treatment that achieves effective results either alone or together with other treatments. Treatment varies from case to case, but in general, CBT programs aim to change the patient's thinking pattern and provide him with skills through which he can gradually return to his normal life and engage in activities that he has been avoiding as a result of his anxiety, (Al Dayni, 2019).

Self-efficacy requires personal characteristics and capabilities that allow the individual to achieve development, growth and goals to overcome crises and obstacles. The current study sheds light on the concept of self-efficacy in its relationship to both psychological flow and crisis management. Bandura (1977) emphasized that individuals with high self-efficacy take on difficult tasks as a kind of challenge, which leads to an increase in the internal tendency and integration in the performance of tasks and activities, as they set goals for themselves. Lack of self-efficacy promotes failure via insufficient effort or lack of knowledge and skills required to complete tasks. Individuals with low self-efficacy avoid performing difficult tasks that can be perceived as sources of personal threat, and they quickly stop facing those challenges and difficulties.

1.3.2 Theoretical Importance

1- Focus on the importance of treating PTSD and on enhancing self-efficacy in children to improve their mental health through the cognitive behavioral therapy program (CBT).

2- The current study is concerned with children, who represent of the future society, and directs studies to identify the variables and phenomena that confront them in a scientific and practical way. And by addressing the various causes of violence towards children and how it affects the psychological aspect, which leads to the presence of symptoms of post-traumatic stress disorder and its impact on reducing their self-efficacy.

3- The significance of this study is based on the scarcity of previous studies in the Arab countries that deal with the concept of PTSD among abused children and improving their self-efficacy using a program of CBT. (Through the Informed Consent Form (Appendix G) for the parents, before starting the treatment program with their children).

1.3.3 Practical Importance

1. Provision of a cognitive behavioral therapy program according to a scientific research protocol, to evaluate its efficacy in reducing the post-traumatic effects of child abuse.
2. Research findings will putatively benefit therapists and victims of child abuse.

1.4 Research Aims

1. Identify the impact of domestic violence resulting in child abuse, and its negative impact on their Self-efficacy, reducing PTSD and mental health side and the performance of their daily activities.
2. To treat the abused children using CBT.
3. Evaluation of the effectiveness of CBT in reducing PTSD symptoms among abused children.
4. Improving the perceived self-efficacy of abused children.
5. Reducing the symptoms of PTSD in abused children.

1.5 Research Boundaries

1. Spatial boundaries: primary school students in Palestine (Tira).
2. Duration of study: (02/2021-01/2022).
3. Human boundaries: abused children (10-15) years old, who have been subjected to domestic violence (Mental health patients).

1.6 Definition of Terms and Concepts

1.6.1 Cognitive Behavioral Therapy (CBT)

CBT is a psychological treatment demonstrated to be efficent for a range of disorders. Numerous research studies suggest that CBT leaing to great improvement in functioning and quality of life. In many studies, CBT has been demonstrated to be as influential as, or more influential than other forms of psychological therapy. CBT treatment usually involves efforts to change thinking patterns. These strategies might include: learning the recogniyion of one's thinking distortions creating difficulties as well as re-evaluating them in light of reality; having a better understanding of the behavior and motivation of others; employing problem-solving skills to overcome challenging situations and learning to develop self- awareenss in one's own abilities. Also, it includes fears facing instead of

avoiding them as well as employing role playing to prepare individuals for problematic interactions with others and learning to cool one's mind and relax one's body.

CBT therapists focus on people's current life events leading to their critical moment since information about one's history is needed. However, they maily progress in time to develop more effective ways of coping with life, (APA Div. 12, Society of Clinical Psychology, 2017).

CBT is an evidence-based, solutions-focused treatment approach that requires clients to take an active role in their recovery. Cognitive-behavioral therapy is used in most diagnoses but is particularly effective for depression and anxiety disorders. Cognitive behavioral therapy explores harmful thoughts and emotions a patient may be feeling that aggravate their symptoms, (Abdul Rahman, 2017). CBT encourages clients to challenge their assumptions, change their thinking patterns, and improve their behavior through changes and positive expectations. Clients who undergo CBT sessions with a trained therapist have the lowest rates of relapse among depression clients who do not use CBT in their treatment plan, (Al-Hajj, 2015).

1.6.2 Posttraumatic Stress Disorder (PTSD)

PTSD results from the exposure of the individual to psychological trauma, such as a severe and delayed reaction to stress, usually characterized by its continuity, the return of the traumatic event, the continuous avoidance of stimuli related to the trauma, and the lax response that affects the safety of the individual in the social, academic, professional and psychological aspects, (Khairy, 2018).

Procedural definition: PTSD is a set of reactions after experiencing or witnessing a life-threatening event, that can occur after someone has been through a traumatic event, recalling the traumatic event repeatedly, and the symptoms persisting for months.

1.6.3 Self-efficacy

Self-efficacy is a person's judgement about his ability to do a specific mission his flexibility in handling difficult situations and challenging them, and to what extent his perseverance to complete the missons given to him. (Bandura, 1995). Procedural definition: "The concept of self-efficacy refers to the individual's awareness and

evaluation of his abilities to perform a task. Academic, social and creative", (Nelson, 2017).

1.6.4 Abuse

The World Health Organization's definition of child maltreatment:

“Child maltreatment can be defined as neglecting children under the age of 18 including physical and/or emotional ill-treatment, sexual abuse, neglect, and commercial or other exploitation resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power”, (World Health Organization, 2020).

The concept of maltreatment may differ owing to cultural factors specific to a society, that is, the meaning of maltreatment may not mean the same meaning for different groups, and the factors affecting the definition of the concept can be identified as follows: (Zerman, 2016).

Cultural influence: That is, the social culture of a society determines socially acceptable, deviant or unacceptable behavior. The behavior that is acceptable in one culture may not be acceptable in another culture or society.

Time context: The time range affects the change of socially acceptable behaviors, for example, the previously used school disciplinary beating behaviors, are now educationally prohibited.

Custom and social consensus: Custom is the frame of reference for judging behaviors as being socially acceptable or socially unacceptable.

The group: The group - in which the transgression occurs - constitutes the cultural, social and customary framework for judging behavior.

Perception: The perpetrator or victim’s perception of the practiced behavior varies, so what the actor perceives as acceptable behavior, the victim may not see as such.

The effect of the action on the recipient (the child): It is considered one of the important criteria, meaning “Did this behavior result in negative consequences for the child

(disability, emotional or psychological problems), or a positive effect such as physical strengthening and strengthening the self-concept ... etc?".

The source of the criteria used in the judgment: This relates to the judgment of the group to which the perpetrator and the victim belong. Either this behavior is acceptable to the group or rejected. Therefore, these factors are essential to define the concept of abuse or violence.

Child: According to Article No. (1) of the Convention on the Rights of the Child, a child is "a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier". This definition has been adopted in most countries in the Middle East and North African countries, (UNICEF, 1989).

Chapter Two

Theoretical background and Literature review

2.1 Introduction

An individual should have good mental health to do his personal social and personal duties in an attempt to avoid hindrances affecting his achievements .Mental health allows for psychological and social harmony, the ability for productivity, happiness and giving. During childhood children enjoy play and education, and it is the stage that children are encouraged to have strength and confidence by showing them love and encouragement from family and society, (Nelson, 2017).

The significance of childhood lies in enjoying security, protection from exploitation and abuse, and protection from violence in all its forms. (Zlotnick, et al., 2008; Kubany, 2003; Momani, 2008); It is divided into several stages based on the developmental skills that the child learns at each stage, and these skills, whether mental, emotional or physical, follow a specific sequence (Al-Zoghbi, 2014; Bilal, 2017; Cloitre et. al., 2002); Since mastering one skill leads to the transition to the next skill, children act in different ways and show many behaviors for different reasons.

The child may exhibit disruptive behaviors resulting from anxiety, learning difficulties, or psychological trauma. If the tantrums and collapse that the child exhibits are caused by something that disturbed him, the first step to treating such behaviors is to understand the reason that led to the child's discomfort. It is advised to consult experts for advice to learn how to help children manage their feelings, and to understand the behavioral problems that children may have. Specialized attention is necessary for dealing with such cases. (Al-Ahri, 2018). Child abuse has been the subject of many cultural, social studies since it influences the development of developmental, cognitive, emotional and behavioral aspects prevailing to adulthood, (Gartlehner, 2016).

2.2 Children's Mental Health

It is well known that parents care about the physical health of their children, such as the integrity of their organs, and the normal functioning of the vital systems in the body. However, the child's mental health differs from physical health. The physical treatment of the child, the treatment of the body, is taken care of by the pediatrician. However, the

treatment of the child's psyche involves the family, school, relatives and friends, the concept of children's mental health, should not differ from physical health and may be more important than physical health because of its great impact on the formation of the psychological structure of the child and his personality. The most important conditions that must be met by the child in order for him to achieve the greatest psychological balance and mental health throughout the different stages of childhood from early childhood to late childhood will be discussed, (Ledesma, 2007).

In order for parents to learn about a child's psychological safety they must be acquainted with those in the child's environment. The definition of mental health varies greatly in different environments, cultures, and religious beliefs. Positive characteristics of the individual's behavior and attitudes towards himself and others, make him a happy, balanced and well-mannered individual, (Qassem, 2016).

Mental health is one of the most important things that must be cultivated within the child, so that he has a strong influence and role in society. Mental health enables and individual to achieve his goals., and the ability to be courageous in difficult situations, Mental health helps the child to grow up in a psychologically balanced family. The fact that the child has a measure of psychological peace, and enjoys good mental health, is evidence that he lives in a family that necessarily enjoys the same, and this makes him a normal member in society.

Mental health enables a child to overcome the negative feelings that society may have towards him, and restores his confidence in himself and those around him. It enables him discover the personalities around him, and his own personality, and opens up new horizons for him regarding what he wants to become in the future, and creates a balance between feelings and mental thoughts. And young child may be subjected to certain pressures, but they are generally commensurate with his age, and he may also face a number of problems. Certainly, his mental health helps him to overcome his problems, restore balance, and help prevent him from becoming excited easily, (Ali, 2011).

Most children who have good mental health have greater ability to deal with members of society, even if they are strangers to them, and they can open a dialogue with personalities they do not know, and form friendships. A mentally healthy child can assume the responsibilities assigned to him, which are commensurate with his abilities. Perceiving

experiences in a positive way enables children to try new things. Distancing one's self from any source of fear, tension, and anxiety, helps psychological safety.

Outward appearance is the first thing people notice. Attention to one's appearance can boost self-confidence. A person who enjoys mental health must have a goal that he strives for throughout his life. Various activities such as yoga, together with its psychological benefits can promote good health. One of the most important components of childcare is showing love to the child, embracing him financially and morally, enabling him to develop his interests, and dealing in a strong and firm manner with anything that can harm the child. The use of encouragement techniques, and rewards can motivate the child, (Al Alawi, 2018).

Setting a good example for the child, is of utmost importance. The child needs support and encouragement more than punishment. It is important to answer children's questions in a way that they can understand. There are many things that help to affect the child's psychological health. Every child is born with the natural instinct as the Prophet - may God's prayers and peace be upon him - said, and parents have the ability not to change this instinct or vice versa.

Eliminate the factors affecting both the family and the school with all the sub-influences of the workers. The first five years are the most important years in a child's life, which necessarily help in the formation of his personality, trends and behavioral patterns. The psyche of the child will grow with him in his advanced stages and help in forming his personality. The normal child is influenced from a young age by his relationship with his father, or with his brothers and relatives. Good mental health, and the normal personality of the child indicate psychological peace and a normal life that his parents created for him. On the contrary, we find that children who grow up in an unsuitable family atmosphere, exhibit bad behavior patterns such as selfishness, nervousness, and the inability to take responsibility as he grows older, (Qassim, 2016).

The family is where individuals learn about principles and values. The educational environment supports the family by instilling values, self-respect and the ability to form friendships in the school and the community. The main role is transferred from the family to the teachers, as the child spends most of his time in this period at school, not at home. Children need to be trained to take responsibility, (Tohamy, 2017).

2.3 Abused Children

Child physical abuse may cause physical injuries, broken bones, head trauma, abdominal injuries and skin injuries. Also, they may have behavioral, emotional, and psychological effects from exposure to abuse. Other studies found that there are differences in aggressive behavior between men and women, (Scarpa, et al., 2010).

It is obvious men and women react differently to trauma that men engage themselves in antisocial behaviors while women become more withdrawn, (Hill, 2003; Kilpatrick et al., 2003, Scarpa et al., 2010). Depression can be a difficult disorder so understanding the bridge between depression and childhood trauma is vital in this study.

It is essential to recognize that self-asserted abused tends to be less abusive than professionally assessed. Young people may believe they are provoked deserving the abusive behavior experiencing as they are responsible for their abuser's actions and genital and anal intercourse, (Al-Alawi, 2018; Al-Anbari, 2016; Al-Azzawi, 2017; Al-Dayni, 2019).

Thus, they are hesitant to disclose -completely or partially- the extent of their abuse. Also, many studies investigated child abuse incidents asking adults to describe experiences happening in their past. When it occurs in a child's formative years, it is possible that experiences could be forgotten or grossly underestimated, (Bilal, 2017 Cloitre et. al., 2002; Gartlehner, 2016). Many researchers tackled abused people's ability to forget memories until an incident accessing the hidden childhood memories. Also, people can often forget trauma related events for long periods of time or emerge later in adulthood, (Brewin and Holmes, 2003).

Research has shown that previous maltreatment is a clear indicator of later behavioral difficulties, including increased likelihood of aggression. The reason for the appearance of these behaviors such abusive behavior, alcohol and other substance misuse and offending behavior should always be investigated, (Bilal, 2017; Cloitre et. al., 2002; Gartlehner, 2016; Hughes and Jones, 2000; Riyadh, 2014; Johnson and Zlotnick, 2006; Al-Dayni, 2019).

2.4 Violence against Children

Violence is an expression of physical force that is intentionally exerted against oneself or against another and can result from the feeling of pain caused by harm one has been exposed to. Violence can refer to the destruction of property. Violence can be used as a tool to influence others. Legal and cultural systems work to suppress the phenomenon of violence, (Saleh, 2013).

Behavioral consequences of child maltreatment, and predominantly child abuse have been broadly studied. The Adverse Childhood Experiences (ACE) study was cosponsored by CDC and Kaiser Permanente. They examined the result of exposure to several types of ACE's such as abuse, neglect, and household dysfunction on future health and well-being 60% of the surveyed had suffered at least one ACE, and more than one in five respondents reported three or more such experiences, (Saleh, 2013).

Violence can be psychological violence, or emotional violence, and some researchers indicate that psychological violence includes threats, intimidation, or verbal violence, or a demand to perform unrealistic tasks or to hurt one's feelings, **(**Al-Kaabi, 2018; Al-Muntasir, 2015; Al-Qaisi, 2013; Al-Samarrai, 2015).

Psychological violence of children is "any intentional behavior or action, committed by one or both parents, others surrounding the child, or strangers to the child, towards one or all of the children in the family, and causing any kind of harm. The methods that cause psychological pain to the child, such as ridicule, neglect, ostracism, threats, intimidation, directing hurtful words to the child, treating him badly, separating him from his siblings, or depriving him of kindness, love and tenderness, (Al-Azzawi, 2017).

2.5 Types of Violence/Child Abuse

2.5.1 Physical Violence

Assault on a child that results in physical harm (hitting, shaking, kicking, biting, burning, suffocating, or poisoning). The aggressor may or may not intentionally harm the child, but the injury occurs because of the severity of the punishment or because of extreme negligence, (WHO, 2015).

In his book "The Case against Hitting, how to Raise Your Child Without Hitting", Hyman (1997) clarified the danger of using physical and psychological punishment as a method of school discipline. He indicated that hitting children destroys their personality and is considered a sterile behavior in education and discipline, which leads them to become violent people in the future.

2.5.2 Verbal and Emotional Violence

Verbal and emotional violence is a self-destructive behavior by the child abuser, and includes rejection, isolation, intimidation, ignoring, insulting, cursing, restricting his morals, giving him responsibilities beyond his abilities, and discriminating against him or any form of mistreatment based on hatred and rejection, which harms the child's physical, mental, emotional, moral and social development, (Abdullah, Al-Badania, 2015).

In a Greek study (Georgoulas, 2010) the ICAST questionnaire was administered to a sample of 504 students, and the results indicated that 33% of the students were subjected to verbal abuse such as screaming loudly and forcefully; 29% said that they had been subjected to hair pulling or pinching in parts of the body or ear bending 17% said that they were embarrassed by adults in front of others. In terms of physical abuse, 27% of the students reported that they had been hit either by hand with an object. More than 6% of the students reported that they had been locked outside of their houses on various occasions.

2.5.3 Sexual Violence

Sexual abuse is the exposure of a child to any sexual activities or behaviors, including sexual acts by mouth, by touching, embracing any part of the body. Verbal harassment of a sexual nature is also abuse, as is exploitation of the child for sexual purposes through modern means of communication such as the Internet, (WHO report, 2016).

Al-Shahri (2017), conducted a study on child abuse at school, which included a sample of 400 students. The results indicated that more than half of the students (58%) were subjected to insults, and more than a third of the students (39%) stated that they were abused with vulgar and offensive terms, 33% were intentionally insulted, and in terms of physical abuse, 28% said they were beaten at school and 10% were slapped, and 5% of

students said they had been sexually harassed by touching their sensitive parts of the body. It turns out that schoolmates are ranked first in committing such abuse.

2.5.4 Neglect

It is the inability to give the child basic physical, emotional, educational or material needs." (Al-Badania, 2015). A study conducted by the International Society for the Prevention of Child Abuse and Neglect used the IPSCAN Child Abuse Screening Tool Children's Version (ICAST-C) to examine violence against children. The study was conducted in four countries and the sample included 600 boys and girls. The results revealed that many children reported exposure to violence (51%), physical victimization (55%), psychological victimization (66%), sexual victimization (18%), and neglect in their homes (37%) in the last year. High rates of physical victimization (57%), psychological victimization (59%), and sexual victimization (22%) were also reported in schools in the last year. Internal consistency was moderate to high (alpha between .685 and .855) and missing data low (less than 1.5% for all but one item), (Zolotor et al., 2009).

In a study consisted of 100 children, Elias et al., (2016) revealed that the types and ratios of abuse among children were neglect (64%), physical abuse (25%) and sexual abuse (11%). In addition, among 51% of the children exposed to abuse, the offender was the father, next, the mother, followed by relatives.

2.5.5 Witnessing Abuse

A child may witness domestic violence by a family member, whether by listening or watching. (Child Welfare Information Gateway, 2013). Fantuzzo and Mohr (1999), investigated the future impact of a child's experience to domestic violence, and focused on the negative effects on young children who witness domestic violence and quarrels. Results showed that 70% of children witnessing domestic violence were also exposed to physical violence, and that children witnessing domestic violence had increased aggressive behavior, depression and other mental disorders. Summer (2009) measured the long- and short-term effects, as well as the direct and indirect effects of domestic violence on children. The study revealed that between 20-30% of children who witness domestic violence face behavioral problems in the future.

2.5.6 Violence

Violence is the intentional use of physical force either by threat or actual physical use, against one's self, another person, or a group or society, which leads to the occurrence or possibility of injury, death, psychological harm, developmental disorder or deprivation, (WHO, 2015).

Al-Hamidi (2018), evaluated aggressive behavior and its relationship to parental treatment methods. In a study population of 834 male and female students ages 13-15 years, he revealed a correlation between the increase in students' aggressive behavior and parental treatment methods., Hamidi revealed a statistically significant difference between strictness and marital status in favor of students whose parents were separated, and statistically significant differences between strictness and gender, in favor of males.

2.5.7 Domestic Violence

Domestic violence is any act committed by a family member with the aim of causing harm to another family member, whether the harm is material (beating, causing injury), or moral harm (authority, restriction of freedom, humiliation), and direct (verbal violence, physical violence), or indirect. (moral violence), (Fahmy, 2018).

Osofsky (2003), researched the children's wide exposure to domestic violence and child abuse: indications for prevention and intervention. He sought to determine the extent to which children experience violence as a result of domestic violence. The study found that younger children are the most vulnerable to abuse, violence and neglect, and between 45-70% of children who witness domestic violence are also exposed to physical violence.

2.5.8 School Violence

Every behavior that takes place within the school that leads to either physical or psychological harm to others, is school violence. Ridicule and mockery of the individual, imposing opinions by force, and the use of foul language are all different forms of the same phenomenon. (Al-Shehri, 2016). Al- Sweig (2003) investigated the nature of violence in secondary schools from the point of view of teachers and students. The results of the study showed that 31.6% of students were punished physically for abnormal behavior, and 20.1% were verbally reprimanded. Continuous punishment was 21.9%, and punishment "sometimes" was 34.3%.

Regarding students' exposure to moral and verbal abuse, 3.1% of the sample answered that teachers "always" use bad words with them, and 5.2% reported that teachers "often" used bad words, while 12.9% answered that the teachers sometimes use bad words, regarding teachers insulting students, the responses of the students were 3.1% always, 4.8%, often, and 9.8% replied sometimes. With regard to students being subjected to physical abuse, such as being slapped across the face by the teacher, 1% replied always, 1% replied often happens and 4% replied sometimes. With regard to students being hit on the head by the teacher, 1.6% reported that it is a common occurrence, 1.4% said often and 4% said sometimes. Finally, 14.95% of the students reported that they were subjected to beatings by colleagues in school, and that boys were more likely to be abused and beaten than girls, (Al-Sweig, 2003).

2.6 Reasons for Violence against Children

Al-Youssef et al. (2005) emphasized that the reasons for the various types of violence against children cannot always be traced to a specific cause (Al-Youssef et al., 2005). In general, it the causes of violence and ill-treatment against children are due to overlapping factors that are interrelated with the personality of the parents, the temperament of the child, the amount of pressures faced by parents and the nature of the family system and organization. Some studies have indicated that parents who engage in violence against their children are characterized by a number of the following characteristics:

Neurological and psychological disorders: Parents who lack self-control, or suffer from mental retardation and disordered thought, can be violent towards their children. Parents who suffer from anti-social personality disorder, tend towards violent interactions, and they may have only superficial understanding of their children's behavior which may lead to violent behavior towards their children.

Problems with cognitive processes: There are some parents who are not positively aware of the child's behavior, so their expectations are too high or too low for their children's behavior, which makes them feel the need for violent intervention to modify the behavior of their children.

Emotional problems: Some parents are characterized by rapid agitation and extreme jitters, with the emergence of excessive physiological responses when their children

misbehave. This may lead to severe beating of the child in in an effort to stop his misbehavior.

Previous experiences with violence: Some fathers tend to reproduce their patriarchal model in their family life. It has been suggested that parents who persecute their children were themselves victims or witnesses of such violence in their nuclear families.

Economic Burden: The economic burden and the need to support the family may lead some parents to feel inferior, so they focus on working to alleviate financial difficulties.

*Traditional educational ideas***:** Traditional education in some cultures is based on violence as an educational tool. However, current research focuses on modern education based on persuasion through addressing the intellect and awareness of the child, in order to urge him to adhere to certain behaviors without force or coercion. However, some parents continue to believe in the effectiveness of violence in the upbringing of their children.

Chpater Three

Theories Explaining Posttraumatic Stress Disorder in Abused Children

3.1 Introduction

Psychotherapy theories offer therapists and counselors with a framework for interpreting a client's behavior, ideas, and feelings and guiding them through the client's path from diagnosis to post-treatment. Theoretical methods are, of course, an important aspect of the therapeutic process, (IPL, 2022).

Many studies (Indekeu et al., 2013; Qiao, Li, & Stanton, 2013; Steuber & Solomon, 2011) suggest that Disclosure reactions, notably maternal emotions, are a key moderator of the link between disclosure and trauma responses. A recent meta-analysis characterized non-offending caregiver support following disclosure of violence and found that PTSD was not significantly related to nonoffending caregiver support though the authors caution that significant methodological flaws in the included studies prevent firm conclusions.(Bolen & Gergely, 2015). Beyond disclosure of violence, theories and models of disclosure have also been applied to understand disclosure of sensitive information in other contexts, in order to provide treatment for these children and to be able to support them in facing what they suffer from, and to provide them with the necessary skills, (Bolen, 2015).

Many theories tackled for PSTD such as emotional inhibition theory, learning theories, schema theories, cognitive theory, dual representation theory, and emotional processing theory (Cahill and Foa, 2014; Frazier, 2012; González-Prendes and Resko, 2012; Sloan & Marx, 2004). Most of these theories focused on mediate or moderate PSTD responses. For example, emotional inhibition theory was posed by Pennebaker (1997) sugested person’s mental health ehnhancements after writiing cause mastery over characteristics of traumatic events via expressing more coherent narration of their experience.

His work has been applied to understand closures whether they benefit the disclosed or not, (Lamb & Edgar-Smith, 1994). Emotional processing theory talks about verbal disclosure. It suggests that PTSD occurs from a great fear related to traumatic events since some people naturally got took away these fears by processing trauma material very day emotionally through repeated disclosures (Cahill & Foa, 2014). According to the emotional processing theory, PTSD is the result of individuals’ avoidance of emotional

processing of traumatic material. For example, a test prepared to assess children's processing of trauma narratives in therapy did not find this process to be the active component of treatment (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011), making it unclear if, when, and how disclosure is beneficial to children.

3.2 Psychological Processes and PTSD

3.2.1 Memory and PTSD

Memory functions changes have been identified in PTSD that there are bias toward improvements in the recollection of trauma-related material , difficulties and autobiographical memories of specific incidents (Skreet al, 1993). Among PSTD individuals, there is a Controversial pattern of recollections related to the traumatic material itself. In some studies, high levels of emotions are related to strong and long-lasting memories (Foy et. al., 1987; Krystal et. al., 1989; Riyadh, 2014; True et. al., 2000;). However, in other studies , they are related to vague memories lacking in detail, and are error prone (Eysenck, 2000; Roche et al., 1999; van der Kolk et. al., 1985). The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition,(DSM IV) (American Psychiatric Association, 1994) describes PTSD as characterized both by high distress, intrusive memories and by amnesia for the details of the event.

Clinical studies report that confusion and forgetting are as typical of trauma memories as is vivid, lasting recollection (Bilal, 2017; Cloitre et. al., 2002; Gartlehner, 2016; Hughes & Jones, 2000; Johnson & Zlotnick, 2006 Riyadh, 2014;), More systematic studies of memories of patients personally experienced traumatic events assure that recollection tends to enhanced over the first few weeks (Hughes and Jones, 2000; Riyadh, 2014), that their content may change (Foy et. al., 1987; Riyadh, 2014; True et. al., 2000), and that they tend to be chaotic including gaps, (Eysenck, 2000; van der Kolk et. al., 1985).

Another special aspect of memory in PTSD is the release of experiences or ‘‘flashbacks’’ to the trauma. Comparing it to normal autobiographical memory, flashbacks are dominated by sensory detail such as complex visual images.

In any case, these images and sensations are ordinarily disconnected and fragmentary. "Remembering" of these recollections is reflected in a twisting in the feeling of time with the end goal that the awful mishaps appear to be going on in the present as opposed to (as

on account of common recollections) having a place with the past. Remembering episodes additionally doesn't appear to happen because of an intentional inquiry of memory, however are set off automatically by unambiguous updates that relate somehow or another to the conditions of the injury, like a police alarm or the smell of smoke, or specific contemplations or images connecting with the occasion. In spite of the fact that flashbacks are regularly portrayed by clinicians and scientists working with damaged casualties (e.g., Al-Alawi, 2018; Al-Zoghbi, 2014; Bilal, 2017; Cloitre et. al., 2002; Cohen et al. 2006; Gover and Mackenzie, 2003; Slope, 2003; Kilpatrick et al., 2003; Kubany, et al., 2003; Momani, 2008; Scarpa, et al., 2010;), there has been somewhat little exploration to back up the numerous casual perceptions about their tendency.

Reynolds and Blending((1998) talked with mutual visits to patients experiencing either PTSD or melancholy, as well as nonclinical controls, and requested that they portray the image or thought connected with an upsetting occasion that most often ring a bell. Flashbacks, either all alone or in mix with different images and contemplations, were accounted for as the most successive meddling peculiarities by 43% of the PTSD patients, 9% of the discouraged patients, and none of the nonpatients. This upholds the case that flashbacks are a particular element of PTSD. Later exploration started to examine other memory processes that are applicable to PTSD. For instance, individual contrasts in working memory limit (i.e., the capacity to hold and control material in central consideration) have all the earmarks of being connected with the capacity to keep undesirable material from meddling and adversely influencing task execution. Sound people with more noteworthy working memory limit are better at stifling undesirable contemplations when educated to do as such under exploratory circumstances, whether these considerations are impartial (Genuine et. al., 2000) or obsessional (Riyadh, 2014) in nature.

These discoveries might assist with making sense of why low insight, which is unequivocally connected with working memory limit, is a gamble factor for PTSD (Gover and Mackenzie, 2003; Slope, 2003; Kilpatrick et al., 2003). Given the requests of mental treatment, low degrees of working memory limit may likewise foresee a less fruitful result in treatment.

3.2.2 Attention and PTSD

Studies of consideration in PTSD have as of late been reviewed by Saleh (2018), who divided the literature into studies of automatic and strategic processing. Two studies have suggested that there is an attentional bias very early in processing, as shown by slowed color naming following subliminal presentation of trauma words on a Stroop test and speeded reaction time to trauma words in a dot probe paradigm. However, similar outcomes were not gotten utilizing a hear-able acknowledgment task with Vietnam veterans, (Hughes and Jones, 2000).

Accordingly, Solid conclusions can't be drawn since additional proof is required concerning automatic processing . Conversely, Buckley et al. (2000) contended that the proof for attentional predisposition is clearer in examinations focusing on post-recognition processes, for instance utilizing Stroop errands with supraliminal presentation times (Al-Alawi, 2018; Al-Anbari, 2016; Al-Azzawi, 2017; Al-Dayni, 2019; Bilal, 2017; Cloitre et. al., 2002; Gartlehner, 2016; Hughes &Jones, 2000; Riyadh, 2014; Johnson and Zlotnick, 2006).

However, attentional predisposition is obviously significant in PTSD, research doesn't give proof that the impacts are novel to PTSD. As opposed to utilizing the above standards, assignments which take a gander at supported consideration and rehashed openness to danger upgrades might be more pertinent to mental and openness medicines which expect patients to join in and cycle their injury recollections for a lengthy timeframe. They may likewise be all the more biologically legitimate as far as patients' everyday experience of cautiousness in conditions wealthy in danger signs. In any case, the accessible proof in regards to whether PTSD is related with deficiencies in supported consideration is conflicting, (Saleh, 2018; Genuine et. al., 2000).

3.2.3 Dissociation and PTSD

“Dissociation’’ has been characterized as a transitory breakdown in the generally nonstop, interrelated forms of seeing the world around us, recollecting the past, or having a single character that joins our past with our future (Genuine et. al., 2000). Gentle dissociative responses are common beneath push, for case, they have been detailed by 96% of troopers experiencing survival training, (Momani et. al., 2008). Dissociative side effects most commonly experienced in injury incorporate enthusiastic desensitizing,

derealization, depersonalization, and 'out-of-body' encounters. Separation is related to the seriousness of the injury, fear of passing, and sentiments of powerlessness, (Al-Zoghbi, 2014; Bilal, 2017; Cloitre et. al., 2002; Momani, 2008).

It has been proposed that such responses reflect a cautious reaction related to immobilization (''freezing'') in creatures (Koopman et. al., 2000). In contrast to fight–flight responses, in which heart rate regularly increments, separation has been linked to a decrease in heart rate, (Roche et. al., 1999 & van der Kolk et. al., 1985).

When these symptoms happen within the course of a traumatic involvement, they are alluded to as 'peri-traumatic dissociation'. At slightest seven prospective studies have surveyed peri-traumatic separation without further ado after an injury and found it to be a great indicator of afterward PTSD (Cohen et al. 2004; Gover & Mackenzie, 2003; Slope, 2003; Kilpatrick et al., 2003; Kubany et al., 2003; Momani, 2008; Scarpa et al., 2010).

Laboratory studies with healthy participants affirmed that separation amid introduction to an injury trauma is related to an increment in ensuing intrusive recollections of the film (Hughes & Jones, 2000) However, the nearness of dissociative indications happening after instead of amid the injury is not as reliably related to the chance for afterward PTSD (Al-Anbari, 2016; Bilal, 2017; Kilpatrick et al., 2003, Scarpa, et al., 2010;).

3.2.4 Cognitive-Affective Reactions and PTSD

According to DSM-5 (American Psychiatric Association) a diagnosis of PTSD requires encountering seriously fear, defenselessness, or frightfulness at the time of the injury. There is a solid relationship between each of these particular responses in the casualties of horrific crimes and the chances of PSTD is 6 months afterward, (Hughes & Jones, 2000).

Of those casualties who did not go on to create PTSD, 44% detailed at slightest one of these responses at high levels, compared to 89% of those who did go on to create PTSD. Be that as it may, reliable with other considers, a little number of casualties who would have met past symptomatic criteria for PTSD did not report encountering any of these responses' escalation. Instep, they detailed tall levels of outrage or shame.

Other examiners have recognized an assortment of feelings counting shame and outrage as now and then being present amid the foremost seriously minutes of the traumatic occasion, (Cloitre et. al., 2002; Gartlehner, 2013; Hughes and Jones, 2000; Johnson and Zlotnick, 2006; Riyadh, 2014)

'Mental defeat,' can be characterized as ''the seen loss of all autonomy, a state of giving up in one's claim mind all efforts to hold one's character as a human being with a will of one's own'' (Saleh, 2018). It may be a significant state that, like powerlessness, opposes categorization as either a feeling or a conviction, and has a few characteristics of both.

Injury casualties whose involvement mental defeat may depict themselves as feeling like a question or as feeling annihilated, or ceasing to care whether they live or pass on. Mental overcome, at that point, goes past simple defenselessness in assaulting the person's exceptionally character. A consideration of previous political detainees in East Germany found that indeed permitting for the degree of torment experienced, those who still had PTSD a long time after their detainment was characterized by having responded amid the injury with mental defeat. Though a few feelings are the coordinated result of results, others depend on a component of cognitive evaluation, (Ehlers et al., 2000).

Traumatic occasions shift impressively within the time it takes for the causality to evaluate what is happening and to produce comparing feelings. Post injury, in any case, cognitive examination, and future suggestions of the injury will give various openings to create negative feelings (see more beliefs and underlying PSTD) There's copious prove that sentiments of blame, shame, pity, disloyalty, mortification, and outrage regularly go with PTSD (Al-Alawi, 2018; Al-Anbari, 2016; Al-Azzawi, 2017; Al-Dayni, 2019). Longitude studies showed that high levels of outrage (Foy et. al., 1987), and more particularly outrage with others, (Cohen et al. 2004; (Kubany et al., 2003;), anticipate a slower recuperation from PTSD.

In victims of violent crime, shame may be a capable indicator of how PTSD indications create over time (Momani, 2008). This study provided the primary evidence of an instrument that connected a pre-trauma helplessness associated with childhood abuse and a disappointment to recuperate from grown-up injuries. Both the victims who had been abused as children and the victims who felt more shame after being abused tend to cope

gradually. In addition, being abused as a child made victims are more likely to report encountering shame.

The impact of childhood abuse on recuperation was almost entirely interceded by the involvement of shame. Later advancements within the treatment of PTSD have too centered on adjusting shame and blaming it to fear, (True et. al., 2000).

Some researchers propose that the conditioning orientation is correct in that it predicts that the high level of anxiety caused by a traumatic event-related stimulus actually leads to avoidance behavior of such stimulus in patients with PTSD, but it does not provide us with details of what is happening, nor does it tell us why some people develop PTSD after experiencing a traumatic event, while others who have experienced the same event do not.

3.2.5 PTSD Diagnosis / DSM5 and ICD11

Symptoms of PTSD are as old as human existence. At the end of the nineteenth century, German psychologist Emil Kraepelin coined the term "fear neurosis" to describe the symptoms that appeared in victims of accidents and serious injuries, especially victims of fires, or hit by trains. Early symptoms of PTSD were described by one of Sigmund Freud's students, Abram Kardiner (Kubany et al., 2003). The diagnosis of PTSD was introduced in 1980, in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, (APA, 1980) The syndrome is listed as a form of fear disorder under section 309.81. PTSD also appears in the (ICD-11) (WHO, 1995) under the code F43.1.

3.2.6 Diagnostic Criteria for Posttraumatic Stress Disorder (PTSD)

ICD-11 diagnostic criteria for PTSD, require that the individual has experienced an exceptionally serious or catastrophic event over a short or prolonged period (Al-Tamimi, 2016, Al-Wandi, 2012, Bilal 2017). An individual suffering from PTSD is traumatized repeatedly by intrusive thoughts regarding the first traumatic event (echo memories, ruminations, dreams, or nightmares), or a sense of distress upon facing related situations (Gartlehner, 2016). The person avoids situations that resemble painful conditions, with at least one of the following criteria: Partial or complete inability to remember some important aspects of the stressful experience; or the presence of persistent symptoms of agitation and increased psychological sensitivity, in which at least two of the following

features must be present: Difficulty falling asleep or insomnia; increased sense of surprise; motivation and excessive alertness; difficulty concentrating; agitation and tantrums, (Huizinga, 2015).

PTSD symptoms must appear within six months after the stressful event (or after a period of stress, e.g., after a period of imprisonment), often with withdrawal, social isolation, emotional numbness, indifference towards others as well as irritability. The symptoms of PTSD are chronic and a permanent personality change can be diagnosed after exceptional stress. (F62.0): PTSD can be diagnosed when three of the following seven criteria are met: deliberate avoidance of traumatic thoughts, feelings, or conversations. deliberate avoidance of activities, places, or people that trigger memories; the inability to remember an important part of the trauma; marked decrease in interest or participation in important activities; feelings of lack of communication and alienation from others; limited emotional vulnerability; feeling limited; persistent symptoms of increased arousal. When two of the following five criteria are met: difficulty sleeping or insomnia; agitation or tantrums; difficulty concentrating; motivation (high alertness) startle; upset lasting more than one month; disturbance due to severe clinical pathological pain, impairment of social or occupational status, and the like (DSM-5).

3.2.7 PTSD in Children

PTSD in children is comprised of a group of symptoms that result from a child's exposure to terrifying and dangerous incidents that lead to the child's emotional suffering and increase the rate of behavioral avoidance, which may cause the re-experiencing of the traumatic event. There is also a decline of social and academic skills. Childhood is one of the most crucial stages of development in the formation of the human personality, A healthy personality, with its different dimensions and components, establishes what the individual acquires at this stage of habits and trends, (Al-Azzawi, 2017; Al-Kaabi, 2018; Al-Wandi, 2012; Riyadh, 2014).

Children may suffer from exposure to shocks of different intensity and pain, whether at the sensory level such as exposure to severe beatings or sexual abuse, or psychological trauma such as losing a loved one or witnessing excessive violence, or by being bullied and intimidated. The degree of children's reaction to these crises varies according to the circumstances and the child's nature. Between 1-15% percent of children experience

various psychological symptoms known as PTSD, after experiencing these traumas, (Saleh, 2018).

The mere presence of psychological symptoms resulting from a traumatic experience is not a disease in itself, unless the duration of symptoms exceeds a certain period and persists for several months, because psychological pain is a natural reaction to the event. Psychological symptoms resulting from exposure to various crises can last for up to 4 weeks or more. But the persistence of panic, stress and anxiety for several months becomes a pathological symptom that requires treatment, (Koopman et al., 1995).

PSTD often accompanies depression in adolescents. Parents should consider that the post-crisis period is a critical period in which the child's behavior varies and may become more aggressive, or on the contrary become completely deprived of volition, may suffer from sadness and difficulty sleeping and may seek more attention than usual. The child may find it difficult to be alone, which makes him unwilling to go to school and socialize with others. Adolescents with PTSD may also fear performing some of the tasks that they performed easily in the past, such as crossing the street alone after witnessing a serious traffic accident. PTSD symptoms often take several forms, including re-experiencing traumatic events, which may cause nightmares that capture the event in all its details, (Ehlers al., 2004).

For younger children, nightmares can revolve around frightening things in general rather than the specific event (Riyadh, 2014). Children with PTSD may experience 'Avoidance', i.e., avoiding any person, thing, place, or even conversations that might remind the child of the traumatic event. This results from a negative association, in the sense that the child avoids people who did not harm him, but simply because they were with him during a trauma. Following exposure to trauma there may be a significant bi-directional change in the way a child thinks and feels, that is, some children become very emotional, constantly sad, easily or constantly feel guilty, while others become indifferent to the situation, (Samurai, 2015).

3.3 Self-Efficacy

3.3.1 The Concept of Self-Efficacy

According to clinician Albert Bandura who initially proposed the concept, it may be a subjective judgment of how well an individual can handle a given circumstance based on the aptitudes they have and the circumstances they experience. Self-efficiency influences each region of human endeavors.

By characterizing one's convictions with respect to his or her capacity to impact circumstances her capacity to impact circumstances, Self-efficiency emphatically impacts both the challenges an individual must really successfully confront and the choices an individual is likely to form. A solid sense of self-efficiency upgrades human accomplishment and individuals' well-being.

Its efficacy bargain circumstances with the conviction that they can control them. These characteristics have been connected to lower levels of push and lower presentation to the impacts of trauma, (Mahmoud, 2017).

Self-efficacy is an important characteristic that represents an aspect of psychological strength and positive progression. However, when self-efficacy greatly exceeds reawhen self-efficacy is much less than real capacity, it debilitates development and ability improvement. Investigate appears that the ideal level of self-efficacy is marginally above capacity; In this case, individuals are significantly energized to manage troublesome assignments and pick up encounters, (Salum, 2015).

The concept of self-efficacy is of great importance for teachers, who strive to encourage their students see themselves in a positive and highly efficient way, thus contributing to the enhancement of their abilities and aptitudes in all areas. It has become clear that perceived high self-efficacy leads to more efficiency and effectiveness in dealing with many tasks of life. Self-efficacy contributes to behavior modification and refers to subjective expectations about an individual's ability to overcome difficulties (Cohen et al., 2004; Kubany et al., 2003; Momani, 2008). The individual encounters difficulties and also determines the energy that is expended to overcome those difficulties and thus determines not only the pattern of behavior, but also the most efficient patterns of

behavior. In achieving performance of a certain task, one's conviction in his ability to address the inherent obstacles is evident, (Bandora, 2015).

Performance achievements are a source of information related to efficiency because they come from real and good experiences and practices of the individual. The concept of self-efficacy varies according to the nature and difficulty, (Momani et. al., 2008).

Tasks can be arranged according to the level of difficulty of the task and the abilities of the individual. Once accomplished, there can be transition of self-efficacy from one condition to similar situations (Al-Kaabi, 2018; Riyadh, 2014). The degree of generalization varies up to unlimited, which expresses the highest degree of generality, (Al-Zoghbi, 2014; Bilal, 2017; Cloitre et. al., 2002; Cohen et al. 2004; Kubany et al., 2003; Momani, 2008) and unilateral restrictions that are limited to a specific field, activity or specific tasks. The degree of generality varies according to the degree of similarity of activities, means of expression of a person or situation, focus of behavior, abilities, qualitative characteristics of situations, including behavioral, cognitive and emotional characteristics. In working and exerting his maximum energies in the face of subsequent trials and difficult situations to come, a sense of strong self-efficacy enables the individual to choose the activities that he will successfully accomplish, (Salum 2015).

3.3.2 The Effect of PTSD on the Concept of Child Self-Efficacy

When an individual endures negative experiences, accumulated negativity may cause the an internal psychological impact (Gabriel & Muhammad, 2013) especially if negative experiences are serious and frequent. Treatment of PTSD is very important, as it can provide appropriate support in alleviating the severity of the disorder. Thus, when anticipating events that may cause trauma the individual can prepare himself and seek assistance in order to mitigate the expected disturbance, (Salum, 2015).

Self-efficacy is one of the important psychological variables that direct an individual's behavior and contribute to achieving his personal goals. Self-efficacy is considered self-based knowledge that contains subjective expectations regarding an individual's ability to successfully overcome situations and tasks, (Mahmoud, 2017).

The self depends on the individual's assumptions regarding the prospects for achieving certain behavioral choices, and therefore poor self-efficacy is an undesirable expectation

in any given situation. When an individual tries to attribute to himself the ability solve a problem it should be based on actual knowledge or abilities, (Cohen, 2004).

As the concept of self-efficacy develops through important experiences and activities prevailing in the life of the individual, it is also affected by the individual's painful experiences. Thus, situations or problems are only fully realized through the development of self-efficacy and the effective practice of behaviors that lead the individual to self-efficacy and good health.

The level of self-efficacy after trauma can be in one of three possible situations, (Saleh, 2018):

The first situation: The level of self-efficacy following trauma returns to its pre-trauma state. This may result from the individual's strength and energy reserves and flexibility. that enable the individual to overcome the trauma and return to his previous life.

The second situation: The level of self-efficacy increases in the posttraumatic stage, according to the well-known saying "shocks that do not break the back strengthen it". In this case, the shock improves the individual's coping style despite the temporary loss of strength. The traumatized individual develops an increased adherence to life and to the value of individuals and the things around him, and his relationships with each of them significantly improves.

The third situation: The individual loses the level of self-efficacy that he enjoyed before the trauma. Prioritization of his basic needs is disturbed, as he may regress to a less adaptive style. He may return to fulfilling his needs, but his perspective may become negative and pessimistic, and thus will face daily activities and encounters in a less adaptive way.

3.4 Cognitive Behavioral Therapy (CBT)

3.4.1 Cognitive Behavioral Therapy (CBT)

Cognitive-behavioral therapy is a treatment method that attempts to modify behavior and control psychological disorders by modifying the patient's thought processes and awareness of himself and his environment. Therefore, the researcher envisioned a CBT program for abused children with increased anxiety and PTSD symptoms, and a decline in the sense of self-efficacy, (Saleh, 2018).

Also, an important step in creating a treatment program is based on a clinical theoretical framework (Beck, 1997), theories and on some treatment, programs that focus on how the individual perceives different stimuli, his interpretations of them, and the meanings of his experiences (Gartlehner, 2013; Hughes and Jones, 2000; Johnson and Zlotnick, 2006; Riyadh, 2014). This therapeutic style is based on the information-cognitive process, which purports that during periods of psychological stress an individual's thinking becomes more stressed and confused, his judgments become absolute, and they are dominated by excessive generalization. In addition, this treatment is effective, structured and timed. Foreign and Arab studies indicate that CBT is an effective method for treating many psychological or behavioral disorders, (Zaidan, 2017).

Given the positive results of previous studies, the researcher hypothesizes that CBT can be effective in treating severe anxiety, reducing PTSD symptoms, and improving self-efficacy, (Momani, et. al., 2008).

3.4.2 Cognitive Behavioral Therapy Program in PTSD

CBT is one of the most common treatments for depression. Studies show that CBT helps patients overcome depressive symptoms such as hopelessness and anger, and reduces the risk of future relapses. There is a common belief that CBT works well to reduce the impact of trauma because it produces changes in perception or distorted thoughts that fuel vicious cycles (Al-Zoghbi, 2014; Bilal, 2017; Cloitre et. al. Momani, 2008). CBT has shown promising results in the treatment of postpartum depression, and as an add-on to pharmacotherapy for patients with bipolar disorder. CBT works well as an anxiety treatment because it includes a variety of techniques that include psychological learning about the nature of fear and anxiety, self-monitoring of symptoms and physical exercise,

cognitive restructuring, elimination of ineffective safety signals, and relapse prevention (Kubany, 2003).

CBT improves self control, perceptions of individual adequacy, levelheaded problem-solving aptitudes, social aptitudes, and interest in exercises that bring a sense of joy or authority (Kalabi, 2006). CBT can offer assistance to children between 7 and 15 years to encounter decreased uneasiness, expanded adapting aptitudes, and moved forward towards passionate mindfulness (Suveg, et al., 2009). CBT can prepare children with the abilities to get it and bargain with their feelings: Children and teenagers who can oversee their feelings viably are 60% less likely to create mental disorders afterward in life, (Cambridge College, 2011).

CBT essentially improves symptoms of PSTD and decreases sadness related to abuse, disgrace and hurtful sexual behavior in children under the age of 7. (Cohen, et al., 2004). They (2004) also found that consideration of a parent or gatekeeper in injury-centered CBT resulted in essentially more noteworthy progress traumatized children with regard to individual certainty and seen validity. Rather, CBT has appeared to improve expression of social aptitude whereas diminishing social uneasiness and self-reported forlornness in 11-18-year-olds (PenCRU: Childhood Inability Inquire about, 2017).

CBT may be tailored to permit youngsters who're not able or unwilling to specific their emotions to achieve this in different methods. An exam of school-primarily based totally CBT applications located upgrades in resilience, wonderful thinking, improved feel of control, decreased bad self-communicate and unproductive coping techniques (Fantuzzo & Mohr., 1999). CBT may also enhance slight to intense anger, irritability, and bodily aggression in youngsters and kids (Sukhodolsky et al., 2016). During CBT, youngsters can learn how to modify frustration, enhance social problem-fixing abilities, and function-play and assertive behaviors that may be used at some stage in conflicts in preference to aggression. CBT is bendy and interventions may be tailored to deal with a patient's developmental degree that allows you to deal with unique issues the usage of age-suitable strategies (Bremner et al., 1999; Muhammad, 2019; Qassem, 2016; Rabie, 2014; Radwan, 2011). Cognitive-behavioral play remedy (CBPT) may be used to deal with selective silence, tension issues, separation tension, sexual abuse, sleep troubles,

representational behavior, and the consequences of parental divorce on younger youngsters, (Knell, 1998).

During CBT, age-suitable gear is used to symbolize eventualities that depict wholesome methods of managing bad emotions, consequently supporting youngsters' study new methods of managing trauma. Among youngsters with PTSD, use of CBT in mixture with medicinal drugs ended in lowering PTSD signs higher than use of pharmaceutical remedy alone, (Powers and Fyvie, 2013).

3.4.3 Using CBT with Children

In this study the CBT It shares some features with protocols used in previous studies involving children (e.g., Cloitre, et al., 2002), but differs in several important respects. The intervention was based on the cognitive model of PTSD in Kubany (2003), which has produced effective treatments for adults (Cohen et al., 2004). There is now accumulating evidence that the model, when appropriately adapted, is applicable to children and young adults (Hussein 2004; Momani 2008; Wanda 1999). According to the model, persistent PTSD is perpetuated by poorly detailed and incoherent traumatic memories, individual misperceptions of trauma and trauma-related symptoms, and dysfunctional coping strategies (behavioral and cognitive). Modifications of the model for children take into account the important role those parental responses and coping strategies play in maintaining PTSD in children, (Gabriel & Muhammad, 2013).

A large body of work supports the effectiveness of cognitive behavioral therapy (CBT) for children with PTSD and other symptoms following sexual abuse (Deblinger et al., 2006; O'Callaghan, et al., 2013)., Cohen et al., 2004. Trauma-focused cognitive-behavioral therapy (which includes Anxiety management components such as coping training and working with parents) with children ages 3 to 16 is effective in reducing PTSD symptoms and relieving related symptoms, (Smith et al. 2007).

However, not all participants in these studies met the criteria for a PTSD diagnosis, and many had additional difficulties (including behavioral problems and other anxiety disorders). CBT rose to prominence in the mid to late 1970s, leading to the multifaceted and widespread CBT as we know it today (Benjamin et al., 2012). It was originally developed for use in adults. And adolescents, (Al-Alawi, 2018; Al-Anbari, 2016; Kilpatrick et al., 2003, Scarpa, et al., 2010).

Leading theories of cognitive development posit that by the time most children reach puberty, they are cognitively equipped to deal with abstract concepts, understand that they can be manipulated, and compare information from different sources to make decisions, (Piaget, 1952).

An analysis of 64 studies involving 413-year-olds found that while CBT was effective in all age groups, the effect size in children in the formal surgery stage (age 1113) was twice that in the youngest children, (Durlak, et al., 1991).

The results of this analysis suggest that for CBT to be effective, the material needs to be adapted and presented at an appropriate level of sophistication. In this way, abstract concepts could be translated into simple, age-appropriate media such as art or play (Vostanis et al., 1996). CBT for adults is a predominantly verbal process, for use with children the approach can be modified to include simpler language, metaphors and visual aids. Metaphors offer alternative methods that the new and complex concepts can be presented to children in concrete, understandable ways, (Cloitre et. al., 2002; Cohen et al. 2004).

Barrett al. (2000) described unhelpful thoughts as "thought intruders" that children are encouraged to destroy, while Williams et al. (2002) used the analogy of an annoying song constantly playing in the head to explain intrusive thoughts. Today's children and young people are the first generation to truly grow up in a technology-driven world. Computers, smartphones, laptops and computer games are becoming part of everyday life: researchers investigated whether the use of familiar technology could be beneficial in the psychological treatment of young people", (retrieved 19 January 2022 from https://positivepsychology.com/cbt-for-children/).

3.4.4 CBT Techniques

CBT techniques are evidence-based methods for changing thoughts, feelings, and behaviors and improving overall life satisfaction, functional and social performance. Psychologists have proven that CBT techniques are among the most effective interventions for mood disorders and psychological issues.

Cognitive restructuring is a cognitive behavior therapy technique that aims to help people identify the thought patterns responsible for negative moods and ineffective behavior

(Cloitre et. al., 2002; Gartlehner, 2013; Johnson & Zlotnick, 2006; Riyadh, 2014). There are many techniques used during cognitive restructuring, the most common method is to trace confused or disordered thoughts into a model of thought records, and to elicit more fluid psychological thought patterns, (Wenzel, 2017).

Graduated or systematic exposure or detection is a CBT technique that helps people think systematically about what they fear. Fear generally causes people to avoid situations, which reinforces feelings of fear and anxiety. Through systemic exposure, subjects gradually encounter the situations they fear, and then process the increased exposure tasks. Exposure is one of the most successful psychological treatments, with an efficacy rate sometimes as high as 90% in some anxiety disorders and PTSD, (Al-Anbari, 2016).

Activity scheduling: Activity scheduling in cognitive behavioral therapy is designed to help people increase positive behaviors that should be intensified. By identifying and scheduling beneficial behaviors, such as meditating, walking, or working on a particular project, the likelihood of these activities being completed increases. Activity scheduling technology is especially useful for people who do not participate in many important activities because they suffer from depression, or who find it difficult completing tasks due to procrastination, (Al-Kaabi, 2018).

Back-to-back approximation: Cognitive behavioral therapy successfully works with people who find it difficult to complete tasks, either because they are unfamiliar with the task, or because the task appears difficult and stressful. The cascading approximation technique works by helping people master an easier task that is similar to the original, more difficult task. This is similar to practicing addition and subtraction before learning long division. Once you've practiced addition and subtraction, long division is not difficult. Likewise, practicing one simple behavior makes the most difficult behavior more manageable and dispels our fears or preconceived notions of difficult challenges, (Al-Tamimi, 2016).

Satisfied Mindfulness Exercises: Satisfied mindfulness or instant awareness is a cognitive behavioral therapy technique that was derived from Buddhism. The goal of satisfied mindfulness exercises is to help people let go of their obsession with negative thoughts and redirect their attention to what is actually happening in the present moment. Satisfied mindfulness is an important topic of much new research in psychotherapy, (Bilal, 2017).

Skills Training: Many problems result from a lack of appropriate skills to achieve owners' goals. Skills training is a CBTmethod used to correct such defects. Common areas of competence training are the training of social and communicative skills as well as assertiveness. .Skills training is usually done through direct instruction, examples or role play, (AlTamimi, 2016).

3.4.5 CBT steps

Standard mode CBT involves the following steps (Al-Tamimi, 2016):

1. Identify disruptive situations or circumstances in your life. These issues can include illness, divorce, grief, or anger. In addition to addressing the symptoms of a mental disorder, you and your therapist can spend some time identifying issues and goals you want to achieve. focus on.
2. Be Aware of Your Thoughts, Feelings, and Beliefs About These Issues: Once you have identified the issues you want to work on, the therapist will encourage you to share your thoughts about them. This may include observing what you tell yourself about your experience of "inner dialogue," how you interpret the meaning of the situation, and what you believe about yourself, other people, and events. Your therapist may suggest that you keep a journal of your thoughts.
3. Identify negative or inaccurate thoughts. To help you identify patterns of thinking and behavior that might be causing your problem, your therapist may ask you to pay attention to your physical, emotional, and behavioral responses in a variety of ways. This step may seem difficult, and you may have long-term mindsets about your life and yourself. With practice, helpful thought and behavior patterns will become normal things that don't require much effort.
4. Reframe Negative or Inaccurate Thinking: The therapist will likely encourage you to ask yourself whether your view of the situation is based on fact or an inaccurate perception of what is happening. This step may seem difficult, and you may have a long-term mindset. about your life and about yourself. With practice, helpful thought and behavior patterns become normal things that don't require much effort.

3.4.6 Duration of CBT

CBT is a short-term treatment, with about 5 to 20 sessions. You and your therapist can discuss how many sessions are right for you. However, a number of factors must also be taken into account, such as (Kubany, 2003):

- The type of disorder or situation.
- The strength of your symptoms.
- The length of time you have had symptoms.
- How quickly you are progressing with treatment.
- The amount of stress you were experiencing.
- The amount of support you receive from family members and people close to you.

3.4.7 Using CBT to Treat PTSD

Therapists use a variety of techniques to help patients reduce symptoms and improve function. Therapists using CBT can encourage clients to re-evaluate their thought patterns and assumptions to identify unhelpful patterns (often referred to as "distortions") in thought, such as: B. Overgeneralizing negative thoughts. Results, negative thinking reducing positive thinking and expectation of results. (Zaidian, 2017). Stress management and crisis planning can also be an important part A study by Gabriel and Muhammad (2013) aimed to determine the effect of a treatment program to reduce symptoms of stress (PTSD) in abused women in Jordan. The study concluded that the treatment program is effective in reducing post-traumatic stress symptoms. Over the long term, CBT improves overall symptom severity in patients with PTSD compared to those without, but does not necessarily change the overall prognostic status. Patients receiving CBT report less severe PTSD symptoms than patients receiving supportive counseling.

There is evidence that CBT may also have preventative benefits. However, study results are mixed and more research is needed in this area. Hughes and Jones (2000) wanted to find out how violence is related to post-traumatic stress. and the effect of the self-affirmation strategy in reducing post-traumatic stress symptoms in abused women (AlAlawi, 2018; AlAnbari, 2016; AlAzzawi, 2017; Scarpa, et al., 2010). The stress strategy helped reduce violent behavior, which in turn led to a decrease in PTSD symptoms.

CBT is an evidence-based, solutions-focused treatment approach that requires clients to take an active role in their recovery. It uses most of their assumptions, especially with depression and anxiety disorders. Cognitive behavioral therapy explores harmful thoughts and emotions a patient may be feeling that aggravate their symptoms. Cognitive behavioral therapy encourages clients to challenge their assumptions, change their thinking patterns, and improve their behavior through changes and positive expectations, (Johnson & Zlotnick, 2006).

Those who underwent CBT sessions with a trained therapist have the lowest rates of relapse among depression clients who do not use CBT in their treatment plan. CBT includes treatment strategies that contain anxiety management methods, such as relaxation, assertiveness training and correcting trauma-related misconceptions. It is based on an integrative theory of behavior change, by changing the patient's irrational beliefs (self-blaming the accident) and also works to reduce PTSD symptoms by separating stressful events from anxiety. Responding is done using relaxation and logical reasoning, training in alternative responses to replace avoidance and overstimulation responses.

Cognitive behavioral therapy views stress and related behaviors as a result of self-defeating awareness and interpretation. These negative perceptions or thoughts can be changed and replaced with more positive concepts and interpretations. By helping clients develop their ability to assess traumatic events in a more realistic way, by believing in the need to rebuild the cognitive system and by supporting it with positive and self-supporting thought patterns, (Al-Azzawi, 2017; Al-Kaabi, 2018; Al.-Wandi, 2012, Riyadh, 2014). Stress immunization strategies have been used as a preventive intervention that seeks to enhance an individual's abilities to respond to stressful situations. These strategies deal with the effects of stress. and stressful situations while maintaining a state of less disturbed emotions and a higher level of adaptation. This is accomplished by raising awareness of the nature of stress and stress reactions, and by training counselors in various physical and cognitive coping skills and helping them to apply those skills to help clients reduce symptoms and achieve a degree of comfort, (Al-Kaabi, 2018; Al-Muntasir, 2015; Al-Qaisi, 2013; Al-Samarrai, 2015).

These goals and ideas began to turn into specific interventions and programs that led to progress in identifying symptoms and providing appropriate treatment to individuals. CBT is a type of psychotherapy that experts have always considered the most effective treatment for PTSD in the short and long term. Cognitive behavioral therapy for PTSD focuses on the trauma, (Gartlehner, 2013; Hughes and Jones, 2000; Johnson and Zlotnick, 2006; Riyadh, 2014). The goals are identifying, understanding, and changing thought patterns and patient behavior. It is an effective and participatory therapy. CBT requires the patient to attend and participate in weekly and external appointments and learn the skills that he must apply in his life based on his symptoms. Those skills acquired during therapy sessions are then practiced repeatedly and help improve symptoms until they are completely resolved.

3.4.8 The Main Interventions for CBT

While different psychosocial treatments have different criteria and conditions for exposure and psychological and cognitive interventions, they are key components of the larger class of behavioral therapies that have been repeatedly discovered and tried by clinicians and psychologists, and which have demonstrated their ability to reduce PTSD symptoms successfully, (Mohammed, 2019).

3.4.9 Basic CBT Interventions

Trauma exposure therapy: This form of intervention enables human beings face and manage their fears through exposing them to the reminiscence in their trauma withinside the context of a secure surroundings. This technique can use intellectual images, writing, or visits to locations or human beings that remind the affected person of the mental trauma that he skilled. Virtual reality (growing digital surroundings akin to the annoying event) also can be used to reveal the man or woman to the surroundings that consists of the scary situation. Regardless of the technique of publicity to the trauma, someone is frequently uncovered to the trauma steadily to assist them turn out to be much less touchy to it over time (Bilal, 2017). Cognitive restructuring: This form of intervention enables human beings apprehend horrific recollections associated with the trauma they've skilled withinside the past. Often human beings take into account their trauma otherwise than what clearly came about, and they'll take into account it in a disjointed way or in fragments wherein creativeness may also overlap, growing the volume in their fear. It is

not unusualplace for human beings to sense responsible approximately factors in their trauma that have been now no longer clearly their fault. Cognitive restructuring enables human beings examine what came about in actual existence and consider it to get a sensible angle of the trauma, (Bilal, 2017).

3.4.10 CBT Program Goals for PTSD

CBT goals for PTSD among children include the following (Qassem, 2016):

- Demonstrating the effectiveness of cognitive-behavioral therapy with the help of relaxation exercises in reducing anxiety and aggressive behavior, and raising the level of social responsibility among abused children in the treatment program.
- Training abused children to see the relationship between thoughts and feelings.
- Training the abused children to self-monitor negative thoughts and fantasies.
- Training abused children how to replace false beliefs and negative perceptions with positive ones.
- Modifying negative trends using cognitive reconstruction, which is to replace negative thoughts with positive thoughts.
- Training abused children in the technique of relaxation.
- Training abused children to do all of the above; As (extra) homework to replace positive behaviors instead of negative ones.

The importance of the current program is evident from the methods and techniques on which it is based, as they are effective in treating mental disorders. The importance of the program lies in the clarity of the cognitive theory. It includes the cognitive aspect and the behavioral aspect. Its importance is evident in the short period of time compared to other treatment methods.

The foundations of the cognitive-behavioral program can be summarized as follows:

1. General foundations: These foundations include taking into account the flexibility of human behavior, the patient's right to acceptance without restriction or condition, as well as his right to psychological treatment. It is based on the susceptibility of behavior to modification, change, training, and the need to continue in psychotherapy sessions.

2. Teaching abused children, the skills of facing anxiety and resisting aggressive behavior and raising the level of self-efficacy. The children are trained with the skills necessary to control these variables.
3. Setting some household behavioral tasks, where expectations are set at an early stage. The researcher conducts training and guidance, and that the children are responsible for applying that information, in addition to practicing self-help skills.
4. Focusing on the here and now without relying too much on the long history of abused children.

Program beneficiaries:

The researcher prepared a cognitive-behavioral program to reduce some of the symptoms of abused children such as anxiety symptoms of traumatic disorder, and reduced self-efficacy. The study group included abused children between the ages of 10-15 years who were treated in a mental health clinic.

Services provided by the program:

1. *Therapeutic services:* to reduce anxiety and some symptoms of post-traumatic stress disorder and improve the self-efficacy of abused children by modifying wrong thoughts and replacing them with correct and more positive thoughts and applying activities in accordance with the cases.
2. *Preventive services:* by providing abused children with cognitive, emotional and behavioral methods that enable them to face these variables and problems and overcome them in the future, such as relaxation practice, imagination training, and other methods.

Stages of applying the treatment program:

The treatment program includes four phases (Al Kaabi, 2018):

1. Acquaintance, preparation and exchange of personal information between the researcher and the abused children, and the presentation of the general framework and objectives of the program.
2. The cognitive stage, which aims to present a plan to overcome severe anxiety, aggressive behavior and a low sense of social responsibility, by presenting theoretical concepts and cognitive skills to control the three variables.

3. The behavioral stage. The goal is to present and practice these procedures after presenting the theoretical concept of them through the sessions.
4. This stage aims to summarize the objectives of the program and prepare the abused children to finish the treatment program.

3.4.11 Techniques Used in the Program

Cognitive-behavioral therapy is characterized by its multiplicity of cognitive and behavioral techniques, and the most important of these techniques used by the researcher in this study are the following:

1. *The technique of identifying automatic thoughts* and working to correct them: Automatic thoughts are thoughts that immediately precede any unpleasant emotion, and they are unreasonable thoughts that have a negative character for a specific event or situation. This technique aims to identify those thoughts and then replace them with positive thoughts.
2. *Self-monitoring technique*: The individual observes and records what he is doing in a notebook or forms prepared in advance by the therapist. This is done in order to be able to identify the problem, which often leads to a decrease in the frequency of unwanted behaviors. Evidence is provided that limits his tendency to remember his failures rather than his successes.
3. *The technique of exposure* includes exposing the individual to the situation or situations that cause his difficulties, and results in the dispersion of the individual's response to the problem. The aim of this technique is to influence the negative symptoms of the problem by extinguishing them, by confronting the stimuli on the one hand and confronting the avoidance behavior that reinforces the problem on the other.
4. *The art of imagination*: In which the therapist asks the examinee to close his eyes and tell him about the fantasies that come in his imagination or to imagine a picture of a certain unpleasant situation. The therapist sees that it is related to his problem and notices his responses. He imagines a pleasant situation and describes his feelings, so that he can realize by that changing the content of his thoughts affected his feelings, and thus he can change his feelings if he changes his thoughts.
5. *Technical homework* contributes to determining the degree of cooperation and familiarity that exists between the therapist and the examinee. It is presented as an

appropriate experience for the examinee to discover some cognitive factors related to his difficulties. Additional tasks are used to practice new and logical skills and perspectives to help the examinee recognize his dysfunctional thoughts and irrational tendencies and attempt to modify them. This is considered complementary treatment.

6. *Artistic modeling*: is one of the most important methods used in learning many social skills. Modeling is achieved by recognizing and imitating normal models in the environment. The therapist presents the clients with the desired models of their behavior, and they imitate them after observing them. One of the purposes of modeling is to increase positive behavior and reduce undesirable behaviors, (Bilal, 2017).
7. *Technical problem-solving training*: There are several steps that must be followed while solving the problem at hand: The stage of realizing the existence of the problem - reducing the excitement - developing a formulation of the problem - thinking in an alternative way - thinking about the consequences - the skill of scientific thinking - evaluating the results.
8. *The technique of self-talk*: Dialogue with oneself at any particular activity would alert the individual to the impact of his negative thoughts about his behavior. One's talk with himself and the impressions and expectations he perceives about the situations he faces is the reason for his turbulent interaction. The cognitive-behavioral therapist attempts to determine the content of such talking and works to modify it as an essential step in helping the individual overcome his disorders.
9. *Artistic role-playing* is considered one of the strategies which might be used with the emotional thing in cognitive-behavioral therapy. This approach gives the possibility for emotional venting and unloading of fees and obvious pent-up desires.This is done by representing a specific behavior or social situation as if it is actually happening, provided that the therapist plays the role of the other party in the interaction, dialogue and discussion. Role playing is repeated until the desired behavior is learned (Mahmoud, 2017).
10. *Technical Test Guide:* is one of the effective techniques for confronting misconceptions, in which the idea is supported or not supported by the available event, even if there are some other interpretations that are more appropriate. The process not only includes testing the evidence, but also considers the source of that information and the validity of using the client's opinions, as well as considering

whether the client has overlooked some of the available information. Many clients start with a final judgment such as "I'm not a good person", and then choose events that support their point of view.

11. *Recognize the methods of wrong and ineffective thinking*: When thinking about solving or understanding a particular problem, errors in understanding and interpretation occur which distort the picture of reality and thus provoke behavioral disturbances. Among the cognitive distortions that occur are exaggeration, over-generalization, selective abstraction, and errors of judgment and conclusion.
12. *Artistic distraction:* The distraction technique is used in cognitive-behavioral therapy for specific and short-term goals, by asking the client who suffers from anxiety, for example, to perform a behavior that distracts his attention from the symptoms he feels because focusing on these symptoms makes them get worse. Some of the techniques used for distraction are focusing on a specific object - sensory awareness - mental exercises - pleasant memories and fantasies.
13. Technical rest training: The simple concept of the artwork of rest is that the frame in a kingdom of hysteria and acute feelings is subjected to 2 processes: muscle anxiety and mental anxiety. All of the muscular tissues of the frame are taught to some extent parallel to the mental anxiety of someone in a kingdom of hysteria. If the kingdom of anxiety and muscle anxiety of the human frame is stopped or transformed right into a kingdom of rest, then mental anxiety will become a kingdom of rest, which reduces the diploma of hysteria in humans. Thus, someone isn't always bodily worrying and psychologically comfortable on the equal time. (Al Samurai, 2015).

Comment on Studies:

1. Studies have agreed that domestic violence and witnessing violence affect the psyche of children and their behavior in the future, so they become more aggressive.
2. Studies have agreed that physical abuse in the form of beatings at home or at school is an ineffective method of education that negatively affects children and increases their aggressive behavior in the future.
3. Most of the results of Arab and foreign studies indicated that the most common type of abuse, both at home and at school, is verbal abuse.
4. The results of the studies agreed that physical violence is more common, especially in the home.

5. The most common types of abuse in foreign schools were verbal abuse, and the most prominent types of abuse in Arab schools were a mixture of neglect and physical abuse, followed by verbal, and last was sexual abuse.
6. Some studies have stated that men are more susceptible to physical abuse than women, and that women are more vulnerable to moral abuse.
7. Studies differed regarding the perpetrator of the abuse, in some studies it is the father and in other studies it is the mother or the brother.
8. The most prominent causes of aggressive behaviors of children inside the school, whether towards their colleagues or teachers, is family disintegration or poor relations within the family and psychological pressures on student. This was confirmed in several studies.

3.5 Uniqueness of This Study

By reviewing the results of previous studies, whether Arab or international, it becomes clear that the phenomenon of child abuse remains widespread for various social and economic reasons. However, earlier studies did not address all types of abuse that occur in the home, its surroundings and in educational institutions. The current study was devoted to discussing the most sensitive issues in society, namely violence or abuse against children. In addition, the current study addressed the widespread abuse at home and school alike in one study. In addition, the current study highlighted the importance of treating these children with CBT is for the treatment of mental disorders, in particular post-annoying strain disease and a lower in self-efficacy The intention is to assist lessen the phenomenon of baby abuse with the aid of using highlighting it and treating kids with the aid of using lowering the signs of post-annoying strain disease, enabling them to face problems and to deal with them by raising the level of their perceived self-efficacy, and providing them with additional skills.

Chapter Four

Methodology

4.1 Study Design and Variables

The study followed the experimental approach, with CBT Program, pre- and post-measurements for two control and experimental groups, and a follow-up measure for the experimental group only. The design of this study can be clarified as follows:

G1: O1.1.2 **X** O2.1.2 O3.1.2

G2: O1.1.2-O2.1.2

(G1): The experimental group; (G2): The control group; (O1): Pre measurement;

(O2): Post measurement; (O3): Follow-up measurement; (X): Experimental processing;

(-): No treatment; (O1.1.2): Pre-test (PTSD scale) and Pre-test (self-efficacy); (O2.1.2): Post-test (PTSD scale) and Post-test (self-efficacy).

4.2 Variables of study

The independent variable: Therapeutic Program based on CBT.

Dependent variable: The scores of the study sample members in the Post and follow-up measurements on two scales: reducing posttraumatic stress disorders (PTSD) symptoms and improving perceived self-efficacy among abused children.

4.3 Study Population

The population of the current study consisted of children who were selected from the Mental Health Clinic in "Tira". They represent abused children diagnosed with PTSD. The results of this study were determined by the scales used and the psychometric properties of these measures and the program The therapeutic treatment was prepared to meet the study's objectives during the first semester of the academic year (2021/2022).

4.3.1 Study Sample and Sampling

The study sample consisted of 30 abused children that diagnosed with post-traumatic stress disorder, who were selected from the Mental Health Clinicin in Tira. The available sample method was also used, which met the conditions for participation in the study, namely: individuals suffering from post-traumatic stress disorder at a high level, and

those who showed awareness of the nature of their situation and expressed their desire for help. All participants expressed agreement to participate in the therapeutic program. The experimental group included 15 children, and the control group included 15 children, were determined in a random manner, the sample was selected from 30 abused children diagnosed with the same severe PTSD disorder. Then the first 15 children were placed in the experimental group and the last 15 children in the control group. Willingness to participate in the therapeutic program was verified in the formation stage, which was the first stage of forming the counseling group. The two independent groups were assigned to the experimental and control groups, as shown in Table (1).

Table 1

Arithmetic averages, standard deviations, and results of t-test results for the experimental groups (n = 15) and the control group (n = 15) on the study scale in the pre-measurement

Scale	Group	Arithmetic mean	Standard deviation	"T" value	Statistical significance
PTSD	Experimental	64.00	5.695	0.304	0.763
	Control	63.40	5.096		
Self-Efficacy Among Abused Children	Experimental	39.53	4.086	0.643	0.525
	Control	38.67	3.244		

The results mentioned in table indicate that there are no statistically significant differences between the two groups in the t-test, which confirms their equivalence the experimental group and control group.

4.4 Study Tools

To achieve the objectives of the study, the following tools were used: the scale of (CPSS – SR – 5) PTSD symptoms, the scale of (Self-Efficacy Formative Questionnaire) and therapeutic program based on cognitive behavioral therapy (CBT).

4.4.1 Posttraumatic Stress Disorders (PTSD) Scale - (CPSS - SR - 5)

PTSD Scale was designed for individuals with posttraumatic stress disorders based on previous studies to assess the level of posttraumatic stress disorders in the study sample. (CPSS-SR-5 Form, Foa et al., 2018, translated by: Ministry of Health and Dr. Raeeda Daeem).

4.4.1.1 Scale Validity

The apparent validity of the study scale was verified by presenting it in its initial form Appendix (C) to a number of specialized arbitrators, who hold a PhD in Clinical Psychology. There were seven arbitrators who are professors of Palestinian universities in the occupied territories. The scale consisted of 20 paragraphs, and the arbitrators were asked to express their opinion and suggestions regarding the scale in terms of their suitability and formulation. In light of the arbitrators' suggestions, some paragraphs were modified. The percentage of approval of the correctness of the paragraphs among the arbitrators reached 80%, and therefore adjustments were made in language and modification of some of the items on the PTSD scale (Appendix B), to reach its final form for the purposes of the current study.

4.4.1.2 Construct Validity

The construct validity was verified by calculating the correlation each item and the total score of the scale, with an exploratory sample consisting of 14 individuals from outside the study sample, and Table (2) shows the value of the correlation coefficients.

Table 2

The values of the correlation coefficients for each item of the reducing posttraumatic stress disorders (PTSD) symptoms scale with the total score of the scale

Paragraph number	Correlation coefficient	Paragraph number	Correlation coefficient	Paragraph number	Correlation coefficient	Paragraph number	Correlation coefficient
1	.683**	6	.913**	11	.712**	16	.664**
2	.502**	7	.664**	12	.793**	17	.512**
3	.633**	8	.913**	13	.768**	18	.664**
4	.705**	9	.635**	14	.642**	19	.574**
5	.694**	10	.816**	15	.600**	20	.805**

** statistically significant at the level of significance ($\alpha = 0.01$).

The above table shows that the values of the correlation coefficients between the items of the scale and the total score ranged between (0.512-0.913), which indicates that it is a good indicator of the construct validity of the scale, as all are greater than (0.30), the minimum and acceptable limit for validity.

4.4.1.3 Scale Reliability

Reliability coefficients of the posttraumatic stress disorders (PTSD) symptoms scale:

- Internal consistency (Cronbach's alpha coefficient used to calculate the reliability the posttraumatic stress disorders (PTSD) symptoms scale. The internal consistency of the scale's paragraphs was calculated, and it reached (Cronbach's alpha) ($\alpha = 0.868$), confirming that the study tool is valid, reliable, and applicable for the purposes of the study.
- The re-testing (Test-Reset) method: The final form of the posttraumatic stress disorders (PTSD) symptoms scale was administered to the sample of the exploratory study which consisted of 14 individuals from the original study population (outside the members of the control and experimental groups), and the scale was re-administered to the sample mentioned again, two weeks after the initial administration of the scale., The test-retest reliability coefficient was calculated between the scores of the study sample members at both time points, and the value of the reliability coefficient for the total score of the scale using Pearson’s equation was ($t = 0.858$). This value of the scale's reliability is acceptable for the purpose of achieving the objectives of the study.

4.4.2 Self-Efficacy Formative Questionnaire Scale

The scale for Self-Efficacy Formative Questionnaire was designed for individuals with posttraumatic stress disorders based on previous studies, to assess the level of perceived self-efficacy in the study sample. (Gaumer Erickson A.S. & Noonan, P.M. (2018) translated by: Ministry of Health).

4.4.2.1 Construct Validity

The construct validity was verified by calculating the correlation of the paragraph with the total score of the scale, with an exploratory sample consisting of 14 individuals from outside the study sample and Table 3 shows the value of the correlation coefficients.

Table 3

The values of the correlation coefficients for each item of the improving perceived self-efficacy with the total score of the scale

Paragraph number	Correlation coefficient	Paragraph number	Correlation coefficient	Paragraph number	Correlation coefficient
1	.879**	6	.633**	11	.651**
2	.907**	7	.784**	12	.874**
3	.888**	8	.693**	13	.687**
4	.635**	9	.717**	14	.549**
5	.914**	10	.506**		

**statistically significant at the level of significance (α = 0.01).

It is noted from the above table that the values of the correlation coefficients between the items of the scale and the total score ranged from 0.506-0.914, which indicates that it is a good indicator of the construct validity of the scale. All correlation coefficients are greater than (0.30) and this is the minimum and acceptable limit for validity.

4.4.2.2 Scale Reliability

The reliability coefficients of the improving perceived self-efficacy scale in two ways:

- Internal consistency: Cronbach's alpha coefficient was used to calculate the reliability of the improving perceived self-efficacy scale. The internal consistency of the scale's paragraphs was calculated, and it reached α = 0.917. This means that the study tool is valid, reliable, and applicable for the purposes of the study.
- The re-testing (Test-Reset) method: The improving perceived self-efficacy scale was administered in its final form to the sample group of the exploratory study consisting of 14individuals from the original study population (outside the members of the control and experimental groups). The scale was re-administered to the sample, two later, and the retest reliability coefficient was calculated between the two scores of the study sample members. The value of the reliability coefficient for the total score of the scale using Pearson’s equation was t = 0.874. This value of the scale's reliability is acceptable for the purposes of achieving the objectives of the study.

4.4.3 Application and Correction Method

The final version of the reducing posttraumatic stress disorders (PTSD) symptoms scale includes 20 items, which measure the extent of (PTSD symptoms. They were asked to respond to the scale statements on a five-point Likert scale as follows: permanently (4),

frequently (3), somewhat (2), little (1), and not once (0). The total score for all items of the scale ranges from 0-80.

The scale of improving perceived self-efficacy in the current study consists in its final form of 13 items that measure the extent of perceived self-efficacy. The study sample were asked to respond to the scale statements on a five-point Likert scale as follows: very like me (5 marks), like me (4), somewhat (3), not like me (2), and not very like me (1) where the total score ranges over all paragraphs of the scale (14-70) degrees.

4.4.4 Intervention - Therapeutic Program Based on CBT

The therapeutic program based on cognitive behavioral therapy was applied over a period of two months, with two to three sessions per week, with a total of 18 treatment sessions, each with a duration of 1-3 hours. The program sought to train the study sample members to perform some meditation exercises: muscle relaxation, anger and pain management, and others to increase the sense of control. The program began by focusing on the body, mind and emotion, to increase the ability to sense security by helping to develop capabilities and potentials. The aim was to enable participants to take effective steps towards self-protection, to identify traumatic experiences and symptoms that result from trauma and help reduce feelings of guilt. In addition, to help realize the impact of trauma on current life, provide support through necessary confrontation experiences, pain and grief. Furthermore, the program sought to change the image of being self-affected by the trauma through understanding the symptoms and cognitive re-evaluation of the trauma. The participants realized the importance and function of these exercises in decreasing the symptoms of post-traumatic stress in the abused children and improving the level of their perceived competence. The program consisted of 18 sessions, in addition to a final session devoted to administering the Post scale to the members of the experimental group (n = 15), and to the control group (n = 15), and a follow-up session two weeks after the end of the program to administer the follow-up measurement to the members of the experimental group only (n = 15).

4.4.4.1 Program Validity

The validity of the program used in the study was verified by arbitrators who are professors of the Palestinian university, and who are specialists in the field of clinical

psychology. They determined suitability of the program for the objectives of the proposed study prior to initiation of the program.

4.4.4.2 Location

An appropriate room was arranged and equipped in the mental health clinic in Al-Tira, in the occupied Palestinian territories for the sessions of the program. The room has the necessary supplies such as papers, flipchart and pens. The guides participated in setting the rules of the group and hanging them on the fixed board, emphasizing the instructions for attendance, confidentiality and commitment. The feedback was also used as a reminder at the end of each session. The sessions of the program proceeded according to the following arrangement and repeatedly in each session:

1. Welcoming the members of the guidance group, checking their conditions, and thanking them for attending.
2. Linking the topic of the current session to the previous session.
3. Providing the necessary reinforcement and feedback.
4. Presenting the topic of the current session and employing the respective techniques.
5. Summarizing the course of the session.
6. Confirmation of the date and place of the next session.
7. The importance of their participation to achieve the goal.
8. The importance of confidentiality and respect of the other participants.

4.5 Study procedures

The researcher took the following steps in conducting his study:

1. The researcher chose the subject of the study, determined its title, and obtained the necessary approval from the college and department concerned.
2. The researcher prepared the tools (the study scales and the treatment program), and presented them to a group of arbitrators for arbitration.
3. Obtained university approval to administer the program.
4. The study sample (n = 30) was distributed into two experimental and control groups, (15) individuals in the experimental group, and (15) individuals in the control group, and the equivalence of the control and experimental groups was verified through their response to the study tools.

5. Obtained an assignment facilitation letter from An-Najah University addressed to health care units in Tira, in order to implement the study tool.
6. Conducted and administered the program to the members of the experimental group (n = 15) for a period of 8 weeks, and then administered the Post measures after the end of the program to the members of the study sample (n = 30), and readministered the scale for the third time to the experimental group only (n=15) two weeks after conducting the post-measurement for tracer scores.
7. Gathered tools, studied, and entered data to the computer then analyzed the data using the SPSS program.
8. Presented a summary of the results and proposed recommendations consistent with the study findings.

4.6 Statistical Plan

This study is based on the experimental method, which is based on random distribution to the experimental and control groups with pre- and post-measurements. In order to evaluate the description of the sample members and the results of the study and to verify its questions, the frequencies, percentages, arithmetic averages and standard deviations were extracted. T-test was used for two independent samples, in order to compare the averages of the experimental and control groups in the Pre measurements, Analysis of Covariance (ANCOVA) was employed for each scale for the Post comparisons between the experimental and control groups in the Post measurement, according to the study size. In addition, the Eta square value (η^2) was employed to calculate the effect size recorded by the treatment program used on the dependent variables. Paired-sample t-test was also performed.

4.7 The inclusion criteria

30 abused children are selected, from the Arab sector in Palestine, were diagnosed with the same degree of disorder by a psychiatrist, their ages ranged (10 – 15 years old) male and female.

4.8 The exclusion criteria

If the level of the disorder is different, not from the Arab community, it has not been diagnosed by a psychiatrist, if the child does not live with his family, and if the child is receiving medication for treatment, then it is a special case that isn't integrated.

Chapter Five

Results and Discussion

5.1 Results

- Hypothesis: The CBT program will reduce the symptoms of post-traumatic stress disorder in abused children.

To test this hypothesis, the researcher extracted the arithmetic averages and standard deviations of the scale of PTSD for the members of the experimental and control groups, and the total score in the pre and post scales. As shown in Table 4.

Table 4

Arithmetic averages and standard deviations of PTSD scale for the members of the experimental and control groups

Scale	Group	NO#	Pre-Scales		Post Scales	
			Mean	Standard Deviation	Mean	Standard Deviation
PTSD	Experimental	15	64.00	8.053	48.80	5.695
	Control	15	63.40	8.804	61.87	9.234

It is evident from the above table, that there are apparent differences in the arithmetic averages of the members of the experimental group on the PTSD scale, while there are no apparent differences in the arithmetic averages of the members of the control group on the same scale. The modified arithmetic averages and the modified standard errors of the PTSD scale were also calculated in the post-scale for both the control group and the experimental group, after taking into account the scores of the Pre scale for both groups, with a common variable for the existence of a variation in the post-scale of PTSD scale, as shown in Table 5.

Table 5

Adjusted Mean and Adjusted Standard Errors

Scale	Group	No	Adjusted Mean	Adjusted Standard Errors
PTSD	Experimental	15	48.645	2.218
	Control	15	62.021	2.218

As shown in the above table there are apparent differences between the adjusted mean of the control and experimental groups in the post measurement of the measure of PTSD scale of the experimental group, where the adjusted arithmetic mean of the experimental

group was (48.645), while the adjusted mean of the control group was (62.021), This indicates the effect of the treatment program in reducing the symptoms of post-traumatic stress disorder.

Also, analysis of covariance (ANCOVA) was used to detect an effect of the treatment program on the overall scores of the PTSD scale, as shown Table 6. To show the significance of the statistical differences between the arithmetic averages, a one-way analysis of variance was used, and the following table shows that.

Table 6

ANCOVA Test Results for PTSD

Scale	Source	Sum of Squares	DF	Mean Square	F	sig	ETA^2	R^2
PTSD	Pre. Scale	217.607	1	217.607	2.955	.097	0.402	0.387
	Group	1337.505	1	1337.505	18.160	.000		
	Error	1988.527	27	73.649				
	Corrected total	3486.667	29					

The results of the analysis of covariance shown in the above table indicate that there is a statistically significant effect at the level of significance ($\alpha = 0.05$) for the variable of the treatment program between the total scores of the study sample members in both the experimental and control groups on PTSD scale, where the "F" value of the scale reached 18.160 This value is indicative at the significance level ($\alpha = 0.05$), and the differences were in favor of the experimental group that received the treatment program, which means that the treatment program contributed to reducing PTSD symptoms, and the effect size was found using the Eta square, as it reached the scale (40.2%).

To determine the scientific significance of the differences between the pre and post measurements, the interpretation coefficient (R^2) was extracted, where its value was (38.7%), which indicates that the program contributed to reducing posttraumatic stress disorders symptoms. This means accepting the null hypothesis, which states that There are statistically significant differences at the level of significance ($\alpha = 0.05$) between the two arithmetic averages of the experimental group and the control group on PTSD after the experimental group received treatment.

- Hypothesis: Following the treatment program there the experimental group will have higher scores on the self-efficacy scale.

To test this hypothesis, the researcher extracted the mean and standard deviations of self-efficacy scale for the members of the experimental and control groups, and the total score in the pre and post scales, as shown in Table 7.

Table 7

Mean and standard deviations of self-efficacy scale for the members of the experimental and control groups

Scale	Group	NO#	Pre Scales		Post Scales	
			Mean	Standard Deviation	Mean	Standard Deviation
Self-Efficacy	**Experimental**	15	39.533	4.086	56.40	6.033
	Control	15	38.667	3.244	38.67	3.457

It is evident from the above table, that there are apparent differences in the mean scores of the members of the experimental group on self-efficacy scale, while there are no apparent differences in the mean scores of the members of the control group on the same scale. Adjusted mean and adjusted standard errors of the self-efficacy scale were also calculated in the post-scale for both the control group and the experimental group, after taking into account the scores of the Pre scale for both groups. There was a common variable for the existence of a variation in the post-scale of self-efficacy scale, as shown in Table 8.

Table 8

Adjusted Mean and Adjusted Standard Errors

Scale	Group	NO#	Adjusted Mean	Adjusted Standard Errors
Self-Efficacy	Experimental	15	56.158	1.178
	Control	15	38.909	1.178

It is clear from the above table that there are apparent differences between the adjusted mean of the control and experimental groups in the post measurement of the measure of self-efficacy scale of the experimental group, where the adjusted arithmetic mean of the experimental group was (56.158), while the adjusted mean of the control group was (38.909), This indicates an effect of the treatment program in improving perceived self-efficacy.

Also, analysis of covariance (ANCOVA) was used to detect an effect of the treatment program on the overall scores of the self-efficacy scale, as shown in Table 9.. To show the significance of the statistical differences between the arithmetic averages, a one-way analysis of variance was used, as shown in Table 9.

Table 9

ANCOVA Test Results for Self-Efficacy

Scale	Source	Sum of Squares	DF	Mean Square	F	sig	ETA^2	R^2
Self-Efficacy	Pre. Scale	119.207	1	119.207	5.771	0.023	0.798	0.803
	Group	2198.851	1	2198.851	106.448	0.00		
	Error	557.726	27	20.657				
	Corrected total	3035.467	29					

The results of the analysis of covariance shown in the above table indicate that there is a statistically significant effect at the level of significance ($\alpha = 0.05$) for the variable of the treatment program between the total scores of the study sample members in both the experimental and control groups on self-efficacy scale, where the “F” value of the scale reached (106.448) This value is indicative at the significance level ($\alpha = 0.05$), and the differences were in favor of the experimental group that received the treatment program, which means that the treatment program contributed to improving perceived self-efficacy. The effect size was found using the Eta square, as it reached the scale (79.8%).

To determine the scientific significance of the differences between the pre and post measurements, the interpretation coefficient (R^2) was extracted, where its value was (80.3%), which indicates that the program contributed to improving perceived self-efficacy. This means accepting the null hypothesis, which states that " There are statistically significant differences at the level of significance ($\alpha = 0.05$) between the two arithmetic averages of the members of the experimental and control group on the self-efficacy scale after the experimental group was exposed to treatment".

- Hypothesis: There will be differences between the scores of the experimental group members on the two study scales in the follow-up measurement with a two-week interval.

To validate this hypothesis, a paired-sample t-test was used. Table 10 shows the arithmetic mean, standard deviation, and the results of the t-test for the differences

between the two points of post-measurement and follow-up on the two study scales for the members of the experimental group, which included seven individuals.

Table 10

Paired- sample t-test Results for PTSD and Self-Efficacy scores

Scale	Group	Mean	Standard Deviation	T value	Significance level
PTSD	Post Measurement	49.6667	8.27791	0.912	0.377
	Follow-Up Measurement	48.8000	8.50378		
Self-efficacy	Post Measurement	56.0667	6.09996	0.791	0.442
	Follow-Up Measurement	56.4000	6.03324		

The results in the above table show that there were no statistically significant differences between the post-measurement scores and the follow-up scores in the two study scales for the members of the experimental group, P-value >0.05 and this indicates the continuity of the effectiveness of the treatment program sessions in PTSD symptoms and improving perceived self-efficacy among abused children.

- Hypothesis: There will be no gender differences in the reduction of symptoms following treatment.

The results contained in the above table showed that there were no statistically significant differences between the two arithmetic averages of the members of the control group between boys and girls in the reduction of symptoms of the disorder after treatment, P-value > (0.05), as shown in appendix I.

5.2 Discussion

The results of the analysis of covariance indicated that there is a statistically significant effect of the therapeutic program based on cognitive behavioral therapy (CBT) in reducing PTSD symptoms among abused children, this result is attributed to the role of cognitive behavioral therapy in helping children realize negative thinking patterns, which enables them to adapt to the difficult situations they were exposed to and to deal with them more effectively. This is accomplished by identifying disturbing situations in their lives and urging them to share their thoughts and beliefs and helping them define their thinking patterns and monitoring their behavioral and emotional reactions. The next step

is to work to modify negative thoughts and direct them towards looking positively at the problems they are exposed to.

This result is also attributed to the role of the cognitive behavioral program in enabling the abused child to directly confront the traumatic event by urging him to remember and identify the feelings and thoughts of the child and work to change them from a negative to a positive situation, and thus reduce disturbing behavior which contributes to alleviating sensitivity and symptoms. This result is also attributed to the importance of cognitive-behavioral therapy in helping the child to confront his irrational thoughts and beliefs, and increasing their sense of their ability to control their lives and their sense of safety, and to enable them to take effective steps towards self-protection. This result is also attributed to the dependence of cognitive behavioral therapy on the active interaction between the specialist and the child, which contributes to exchanging knowledge and experiences and helps the child overcome trauma.

These results support the findings of the study (Gabriel and Muhammad, 2013) which indicated that there were statistically significant differences between the experimental and control groups in the level of post-traumatic stress symptoms, as the level of posttraumatic stress symptoms decreased among the participants. The study concluded that the treatment program is effective in reducing post-traumatic stress symptoms. The study conducted by (Momani et. al., 2008) indicated that the self-assertion strategy helped reduce violent behavior, which in turn led to a reduction in the symptoms of post-traumatic stress disorder. And the study conducted by Kubany, (2003) indicated that there is a positive effect of the cognitive behavioral program in the treatment of post-traumatic stress in abused children.

In addition, the results of the analysis of covariance indicated that there is a statistically significant effect of the therapeutic program based on cognitive behavioral therapy (CBT) in improving perceived self-efficacy among abused children. This result is attributed to the effectiveness of the cognitive behavioral therapy program in reducing the level of psychological stress and psychological conditions that accompany the child and lead to a low self-esteem. CBT helps increase the child's self-confidence by reducing his sensitivity to some problems, thinking logically and rationally, and balancing different alternatives to solve problems.

In addition, the cognitive behavioral therapy program contributes significantly to creating new positive habits for abused children and providing them with adaptive skills that make them more able to deal with different situations and the pressures they face. This is in addition to increasing awareness of self-worth by changing their negative values, which reduces the feelings of depression, pain and anxiety. The cognitive behavioral therapy program also contributes to redrawing their self-image, and promoting acceptance and appreciation by establishing positive thoughts that make them happy and satisfied with their lives and enabling them to express themselves freely and spontaneously. Awareness of their feelings and enabling them to solve problems by increasing their experiences and their interactions during the sessions.

Moreover, the results showed that there were no statistically significant differences between the post-measurement scores and the follow-up scores in the PTSD symptoms scale and self-efficacy scale of the experimental group, this result is due to the continued effectiveness of the therapeutic sessions. The cognitive behavioral therapy program focuses on having a long-term effect to contribute to improving the mental health of abused children by addressing negative thoughts and solving the problem from their roots and directing them towards thinking positive.

This result is also due to the fact that the abused children transferred what they learned during the sessions to the reality of their daily lives, and applied what they learned from techniques and strategies in the situations they faced. This result is also attributed to the participants expressing their feelings of comfort and confidence because they possess new strategies and skills that enrich their life experiences and direct them towards how to face the obstacles they have gone through, understand themselves better, realize and interpret situations in a positive way, and change their ways of thinking to obtain positive results.

This result is in agreement with a previous study by Cloitre et al., (2002) which showed that the improvement continued over a period of (3-9) months of follow-up.

On the other hand, the results showed that there were no statistically significant differences between the two arithmetic averages of the members of the control group between boys and girls in the reduction of symptoms of the disorder after treatment, This result is due to the fact that the cognitive behavioral therapy program takes into account the needs of both sexes and is based on the principle of addressing negative thoughts and

replacing them with other positive thoughts through sessions that focus on liberating the subconscious mind from them and helping participants to relax and do away with feelings of anger, tension and anxiety. This result may be due to the fact that both boys and girls have the same feelings and reactions, not to mention that they possess the same abilities and skills that qualify them to overcome the difficult situations they have endured.

Chapter Six

Conclusions and Recommendations

6.1 Conclusions

The current study revealed the effectiveness of the cognitive-behavioral treatment program in reducing post-traumatic stress symptoms and improving the perceived effectiveness of abused children. CBT is one of the methods of psychotherapy that helps the patient to realize negative or incorrect thinking patterns, which enables him to adapt to and deal with the difficult situations he has been exposed to. More effectively, this therapeutic approach alone or in combination with a group of other therapies is used to control an unlimited number of psychological and mental disorders, especially excessive anxiety, depressive episodes, and more.

Thus, a behavioral therapy program focuses on ideas, concepts, mental images, beliefs, and attitudes; i.e., the so-called cognitive process, and its relationship to the behaviors with which a person deals with his psychological problems. The short duration of this type of psychotherapy is among its advantages, as it lasts for three to six months to solve most psychological problems, as the patient usually attends one to two sessions per week, lasting 50 to 60 minutes, during which he cooperates with the therapist to understand his problems and find new methods of dealing with them. In this therapeutic method, the therapist presents a set of principles to the patient to use when needed, which helps him to solve the problems he faces in his life. The therapist also assigns the patient certain tasks to perform between sessions, such as making a table of the things that aroused his feelings of anxiety or depression during that period. This enables the therapist to set additional goals for treatment. As for the progress of treatment, the therapist may assign the patient exercises to complete, or to practice the methods he learned to deal with the problems he faces, Although CBT is usually done as an individual treatment, it can be performed on a group of patients as a type of group therapy, especially at the beginning stage.

6.2 Recommendations

Based on the findings of the current study, the researcher recommends a set of recommendations that will reduce post-traumatic stress disorder symptoms and improve the level of self-efficacy among abused children:

- Interest in cognitive behavioral therapy and its application in all therapeutic fields due to its connection with the vulnerability of segments of society and its overlap with psychotherapy.
- Providing experienced guiding cadres to educate parents about the importance of taking into account the social and behavioral needs of children and the extent to which their behavior affects their lives and mental health.
- Develop more cognitive behavioral therapy programs to suit all age groups and psychological disorders in children.
- Training of psychotherapists through training and participation in programs, workshops, seminars and training and rehabilitation conferences inside and outside the Palestinian territories.
- Preparing programs directed to the family regarding tthe most appropriate educational methods to raise the child properly without resorting to violence and abuse.
- Awareness of parents about the law to protect children from abuse and the severe penalties for the perpetrator.
- Awareness of parents about the dangers of neglecting children and adopting or assigning the task of caring for children to others without follow-up and supervision.
- Preparing targeted programs for students that are included in the curriculum at various educational levels aimed at training in self-protection, introducing them to their rights and duties, self-defense mechanisms, anger control, and mechanisms for reporting cases of violence and abuse.
- Empowering institutions to perform their role in the best way, through laws and procedures.
- Increasing the speed of response of institutions by providing services, and training specialists and human cadres to deal with cases of violence and abuse against children.

References

1. Abdul Rahman, (2017). Societal violence against children inflicted with violence from the point of view of mothers and teachers. *The Arab Journal of Educational and Psychological Sciences*, The Arab Foundation for Education, Science and Arts.

2. Abdullah, Al-Badania, (2015). Child abuse types, causes and characteristics of those exposed to it, First edition. Riyadh. Arab University for Security Sciences.

3. Aguilar, R.J., Nightingale, N.N. (1994) The impact of specific battering experiences on the self-esteem of abused women. *Journal of Family Violence* 9**,** 35–45. https://doi.org/10.1007/BF01531967.

4. Al Hamidi, (2018). The culture of violence among secondary school students: crisis and confrontation. The National Center for Educational and Development Research, Cairo, Egypt, The Egyptian Book House.

5. Al-Ahri, S. M. (2018). *Childhood and Psychology*, Dar Al-Naba for Publishing and Distribution.

6. Al-Alawi, R. H. (2018). *Methods of Child Socialization*, 1st Edition, Dar Al-Salaam Library for Distribution.

7. Al-Anbari, B. M. (2016). *Psychotherapy according to the behavioral and cognitive perspective*, Dar Al-Asmari Publishing.

8. Al-Azzawi, A. Y. (2017). *The Psychological Effects of Sexual Violence*, Al-Yaziri Publishing House.

9. Al-Badania, 2015). Child abuse the forgotten victim. Volume eleven - first issue. The United Arab Emirates Police Research Center. Sharjah.

10. Al-Dahery, Najdawi, (2018). Aggressive behavior in children from their point of view. Studies, humanities and social sciences, Research Center. The Supreme Council for Culture.

11. Aldaini, Alkandary, (2019). Obstacles that prevent children from detecting sexual abuse. *Journal of Gulf and Arabian Peninsula Studies*, Kuwait University.

12. Al-Dayni, M. A. (2019). *Indications for post-traumatic stress symptoms*, 2nd edition, Dar Ibn Al-Nafis Publishing.

13. Al-Hajj, (2015). Domestic violence towards children within the family. *Journal of Social Sciences.*

14. Ali, Q. R. (2011). *The Child and the Family*, Dar Al-Hikma for Publishing.

15. Al-Kaabi, J. (2018). *Preventive Methods of Behavioral and Cognitive Therapy*, Dar Al-Arqam.

16. Al-Muntasir, A. F. (2015). *Compatibility and Mental Health*, Library of Modern Thought.

17. Al-Qaisi, A. N. (2013). *Contemporary psychological pressures*, Al-Mujtaba Book House.

18. Al-Samarrai, J. M. (2015). *The individual and post-traumatic symptoms*, Dar Al Mahboub Publishing.

19. Al-Shahri, (2017). The concept of child abuses among parents in society and the factors affecting it. first edition. *Research and Studies Series*. The National Center for Studies and Social Development. Ministry of Social Affairs.

20. Al-Shehri, (2016). Factors affecting the phenomenon of violence against children. *Research and Studies Series.* The National Center for Studies and Social Development. Ministry of Social Affairs.

21. Al-Sweig, (2003). *Violence among school students - social report -, Volume 1*. Cairo. National Center for Social and Criminological Research.

22. Al-Tamimi, B. A. (2016). *Cognitive Behavioral Therapy between Endoscopy and Application*, Dar Al-Ezz for Publishing and Distribution.

23. Al-Wandi, H. J. (2012). *The Individual and Psychological Disorder*, 1st Edition, International House for Publishing.

24. Al-Youssef et al., (2005). *The family and the problems of violence in children*. A field study of a sample of young people in the Arab League. Studies and Research Center.

25. Al-Zoghbi, K. M. (2014). *Educational Skills for Children*, 1st Edition, Ikleel House for Publishing and Distribution.

26. American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.).

27. American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.).

28. American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

29. APA Div. 12, Society of Clinical Psychology, (2017). https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral.Retrieved 17 January 2022/.

30. Bandura A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological review*, *84*(2), 191–215. https://doi.org/10.1037//0033-295x.84.2.191.

31. Bandura. A. (1995). Self-efficacy. In V. S. Ramachaudran (Ed.). *Encyclopedia of Human Behavior* (vol. 4. 71-81). Academic Press.

32. Beck A. T. (1997). The past and future of cognitive therapy. *The Journal of psychotherapy practice and research*, *6*(4), 276–284.

33. Benjamin, C. L., Harrison, J. P., Settipani, C. A., Brodman, D. M., & Kendall, P. C. (2013). Anxiety and related outcomes in young adults 7 to 19 years after receiving treatment for child anxiety. *Journal of Consulting and Clinical Psychology*, *81*(5), 865. https://doi.org/10.1037/a0033048.

34. Bilal, A. (2017). *The Behavioral Cognitive Perspective: Its Principles and Applications*, Dar Al-Hayat Publishing.

35. Bolen, R. M., & Gergely, K. B. (2015). A meta-analytic review of the relationship between nonoffending caregiver support and postdisclosure functioning in sexually abused children. *Trauma, Violence & Abuse*, 16(3), 258–279. https://doi.org/10.1177/1524838014526307.

36. Bremner, J. D., Narayan, M., Staib, L. H., Southwick, S. M., McGlashan, T., & Charney, D. S. (1999). Neural correlates of memories of childhood sexual abuse in women with and without posttraumatic stress disorder. *The American journal of psychiatry*, *156*(11), 1787–1795. https://doi.org/10.1176/ajp.156.11.1787.

37. Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical psychology review*, 23(3), 339–376. https://doi.10.1016/s0272-7358(03)00033-3.

38. Buckley, T. C., Blanchard, E. B., & Neill, W. T. (2000). Information processing and PTSD: a review of the empirical literature. *Clinical psychology review*, *20*(8), 1041–1065. https://doi.org/10.1016/s0272-7358(99)00030-6.

39. Cahill, S. P., & Foa, E. B. (2014). Psychological theories of PTSD. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.). Handbook of PTSD: Science and practice. (Second edition), The Guilford Press.

40. Child welfare information gateway, (2013). Aggressive behavior and its relationship to parenting styles, Educational Research Center.

41. Cloitre, M., Koenen, K. C., Cohen, L. R., & Han, H. (2002). Skills training in affective and interpersonal regulation followed by exposure: a phase-based treatment for PTSD related to childhood abuse. *Journal of consulting and clinical psychology*, 70(5), 1067–1074. https://doi.org/10.1037//0022-006x.70.5.1067.

42. Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse–related PTSD symptoms.

Journal of American Academy of Child and Adolescent Psychiatry, 43(4), 393-402. https://doi.org/10.1097/00004583-200404000-00005.

43. Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: Impact of the trauma narrative and treatment length. *Depression and Anxiety*, 28(1), 67–75. https://doi.org/10.1002/da.20744.

44. Deblinger, E., Mannarino, A. P., Cohen, J. A., & Steer, R. A. (2006). A follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, *45*(12), 1474–1484, https://fc-lc.com/1Paa570.

45. Durlak, J. A., Fuhrman, T., & Lampman, C. (1991). Effectiveness of cognitive-behavior therapy for maladapting children: a meta-analysis. *Psychological bulletin*, *110*(2), 204–214. https://doi.org/10.1037/0033-2909.110.2.204.

46. Ehlers, A., Hackmann, A., & Michael, T. (2004). Intrusive re-experiencing in post-traumatic stress disorder: phenomenology, theory, and therapy. *Memory (Hove, England)*, *12*(4), 403–415. https://doi.org/10.1080/09658210444000025.

47. Ehlers, A., Maercker, A., & Boos, A. (2000). Posttraumatic stress disorder following political imprisonment: The role of mental defeat, alienation, and perceived permanent change. *Journal of abnormal psychology*, *109*(1), 45.

48. Elias, Tayseer et al. (2016). The risk factors leading to abuse among the category of abused children in the Hashemite Kingdom of Jordan, a paper presented to a conference towards a violence-free environment for Arab children held in Amman.

49. Eysenck. M. W. (2000) *Psychology: A Student's Handbook.* Psychology Press.

50. Fahmy, E., & Williamson, E. (2018). Poverty and domestic violence and abuse (DVA) in the UK. *Journal of gender-based violence*, *2*(3), 481-501.

51. Fantuzzo, J. W., & Mohr, W. K. (1999). Prevalence and effects of child exposure to domestic violence. *The Future of Children*, *9*(3), 21–32.

52. Foy, D. W., Carroll, E. M., & Donahoe, C. P., Jr (1987). Etiological factors in the development of PTSD in clinical samples of Vietnam combat veterans. *Journal of clinical psychology, 43*(1), 17–27. https://doi.org/10.1002/1097-4679(198701)43:1<17::aid-jclp2270430104>3.0.co;2-q.

53. Frazier, P. A. (2012). Trauma psychology. In E. M. Altmaier, J. I. C. Hansen, & Oxford University Press (Eds.). *The Oxford handbook of counseling psychology*. . Oxford University Press.

54. Gabriel and Muhammad, (2013). *Domestic violence,* Modern University Office. Egypt: House of National Books and Documents.

55. Gartlehner, G., Forneris, C. A., Brownley, K. A., Gaynes, B. N., Sonis, J., Coker-Schwimmer, E., Jonas, D. E., Greenblatt, A., Wilkins, T. M., Woodell, C. L., & Lohr, K. N. (2013). *Interventions for the Prevention of Posttraumatic Stress Disorder (PTSD) in Adults After Exposure to Psychological Trauma*. Agency for Healthcare Research and Quality (US).

56. Georgoulas, S. (2010). Epidemiology of Child Abuse in two paired samples of high school students and their parents in the Greek Regions of Northern and Southern Aegean. In: K. Petroulaki, M.Stavrianaki, G. Nikolaidis, in J. Grey (ed.), *World Perspectives on child abuse, 9 th edition,* International Society for the prevention of child abuse and neglect.

57. Gonzalez-Prendes, A. A., & Resko, S. M. (2012). Cognitive behavioral theory. In S. Ringel, & J. Brandell (Eds.*). Trauma Contemporary Disorders in theory, practice, and research*, SAGE.

58. Gover, A. R. & MacKenzie, D. L. (2003). Child Maltreatment and Adjustment to Juvenile Correctional Institutions. *Criminal Justice and Behavior*.30(3), 374-396**.**

59. Hill, A. (2003). Issues facing brothers of sexually abused children: Implications for professional practice. *Child & Family Social Work, 8*(4), 281-290.

60. Hughes, N, J. and Jones, L. (2000). Women, Domestic violence, and posttraumatic stress disorder (PTSD**).** *Family Therapy*, 27(3), 128-138.

61. Huizinga, E., Hoencamp, R., van Dongen, T., & Leenen, L. (2015). Cross-sectional analysis of Dutch repatriated service members from southern Afghanistan (2003-2014). *Military medicine*, *180*(3), 310–314. https://doi.org/10.7205/MILMED-D-14-00474.

62. Hussein, (2004). The phenomenon of abuse in Bahrain, Conference on Child Protection from Abuse and Neglect through Family Protection. Association for Child Development in cooperation. University House for Publishing.

63. Hussein, A. F. (2020). *The Psychological Life of Children*, University House for Publishing.

64. Hyman, I. A. (1997). *The Case Against Spanking: How to Discipline Your Child Without Hitting*. Jossy-bass Publishers

65. IPL (2022). Psychodynamic Therapy: A Case Study. https://fc-lc.com/Z3QUOj (Accessed January 25, 2022).

66. Indekeu, A., Dierickx, K., Schotsmans, P., Daniels, K. R., Rober, P., & D'Hooghe, T. (2013). Factors contributing to parental decision-making in disclosing donor conception: A systematic review. *Human Reproduction Update,* 19(6), 714–733. https://doi.org/10.1093/humupd/dmt018.

67. Johnson, D. M., & Zlotnick, C. (2006). A cognitive-behavioral treatment for battered women with PTSD in shelters: findings from a pilot study. *Journal of traumatic stress*, 19(4), 559–564. https://doi.org/10.1002/jts.20148.

68. Kalabi, (2006). Verbal abuse against children by parents and its relationship to some demographic variables related to parents.

69. Khairy, (2018). Man's violence against women and its reflection on the behavior of the child, Center for Arab Unity Studies. The third and fourth issue.

70. Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: results from the National Survey of

Adolescents. *Journal of consulting and clinical psychology*, *71*(4), 692. https://doi.org/10.1037/0022-006x.71.4.692.

71. Knell S. M. (1998). Cognitive-behavioral play therapy. *Journal of clinical child psychology*, *27*(1), 28–33.

72. Kobane, B. A., and Tayseer, O. C., et al (2003). The Risk factors leading to abuse among the category of abused children, research presented to a conference towards an environment free of violence for Arab children. held in Amman. April.

73. Koopman, C. (2000). New DSM-5 diagnosis of acute stress disorder. *The American Journal of Psychiatry*, *157*(11), 1888. https://doi.org/10.1176/appi.ajp.157.11.1888.

74. Koopman, C., Classen, C., Cardeña, E., & Spiegel, D. (1995). When disaster strikes, acute stress disorder may follow. *Journal of traumatic stress*, *8*(1), 29–46. https://doi.org/10.1007/BF02105405.

75. Krystal et. al., (1989). The traumatic impact of child sexual abuse: A conceptualization. The American Journal of Orthopsychiatry.

76. Kubany, E. S., Hill, E. E., & Owens, J. A. (2003). Cognitive trauma therapy for battered women with PTSD: preliminary findings. *Journal of traumatic stress*, *16*(1), 81–91. https://doi.org/10.1023/A:1022019629803.

77. Lamb, S., & Edgar-Smith, S. (1994). Aspects of disclosure: Mediators of outcome of childhood sexual abuse. *Journal of Interpersonal Violence*, 9(3), 307–326. https://doi. org/10.1177/088626094009003002.

78. Laurel, (2010). A systematic review of the state of the literature on sexually exploited boys internationally. Child Abuse & Neglect.

79. Ledesma, A., (2007). Risk Factors Associated with Child Abuse and Mitigating Services: A Conceptual Framework. Applied Research Projects, Master's Thesis, Texas State University.

80. Mahmoud, D. (2017) *Psychological and Self-Activity,* Al Sharq Publishing Library, 1st Edition.

81. Momani, F. A. Al-Zogoul, R. A. (2008) *The impact of coping strategies and social support on post-traumatic stress disorder among victims and families of the Amman hotel bombings*, PhD thesis, College of Graduate Studies, Yarmouk University.

82. Muhammad, A. A. (2019) *Behavioral Therapy*, Al-Yaqout Book House.

83. Nelson, (2017). Violence against children and its reflection on self-concept, First edition.

84. Nolen, (2011). The psychology of family and school violence, Alexandria: New University House.

85. O'Callaghan, P., McMullen, J., Shannon, C., Rafferty, H., & Black, A. (2013). A randomized controlled trial of trauma-focused cognitive behavioral therapy for sexually exploited, war-affected Congolese girls. *Journal of the American Academy of Child and Adolescent Psychiatry*, *52*(4), 359–369. https://doi.org/10.1016/j.jaac.2013.01.013.

86. Osofsky J. D. (2003). Prevalence of children's exposure to domestic violence and child maltreatment: implications for prevention and intervention. *Clinical child and family psychology review*, *6*(3), 161–170. https://doi.org/10.1023/a:1024958332093.

87. Pennebaker, J. W. (1997). Writing about emotional experiences as a therapeutic process. *Psychological Science*, 8(3), 162–166. https://doi.org/10.1111/j.1467-9280.1997.tb00403.x.

88. Piaget, J., & Cook, M. T. (1952). The origins of intelligence in children. International Universities Press.

89. Power, M. J., & Fyvie, C. (2013). The role of emotion in PTSD: two preliminary studies. *Behavioral and cognitive psychotherapy*, *41*(2), 162–172. https://doi.org/10.1017/S1352465812000148.

90. Qassem, M. M. (2016) *Psychological problems of the middle childhood stage*, Al-Karkhi for publication and distribution.

91. Qiao, S., Li, X., & Stanton, B. (2013). Theoretical models of parental HIV disclosure: A critical review. *AIDS Care*, 25(3), 326–336. https://doi.org/10.1080/09540121.2012.712658.

92. Rabie, M. S. (2014). *Culture of Social Violence*, Dar Al-Mutasir for Printing and Distribution.

93. Radwan, M. (2011). *Behavior manifestations in childhood and adolescence*, Al-Wadih Library for Publishing and Distribution.

94. Reynolds, M., & Brewin, C. R. (1998). Intrusive cognitions, coping strategies and emotional responses in depression, post-traumatic stress disorder and a non-clinical population. *Behaviour research and therapy*, *36*(2), 135–147. https://doi.org/10.1016/s0005-7967(98)00013-8.

95. Riyadh, H. M. (2014). *Behavioral Therapy for Post Traumatic Behavior Manifestations*, Dijla University House.

96. Roche, D. N., Runtz, M. G., & Hunter, M. A. (1999). Adult Attachment: A Mediator Between Child Sexual Abuse and Later Psychological Adjustment. *Journal of Interpersonal Violence*, *14*(2), 184-207. https://fc-lc.com/3oz2Hj.

97. Saleh, T. (2018) *Contemporary Psychological Disorders*, Dar Al Yamamah Publishing.

98. Saleh, T. R. (2013) *Violence and the Child*, Al-Mutanabbi Book House.

99. Salum, (2015). *Forms of violence among families of secondary school students*, Yarmouk University.

100. Samurai, Al-Roud, and Abdul Salam, (2015). *Violence, its motives and treatment from an Islamic educational perspective*, Department of Islamic Studies, World of Books: Yarmouk University.

101. Scarpa, A., Haden, S. C., & Abercromby, J. M. (2010). Pathways linking child physical abuse, depression, and aggressiveness across genders. *Journal of Aggression, Maltreatment & Trauma*, *19*(7), 757-776.

102. Skreet, (1993). *The psychology of aggression and violence*, Cairo: Book Center.

103. Sloan, D. M., & Marx, B. P. (2004). Taking pen to hand: Evaluating theories underlying the written disclosure paradigm. *Clinical Psychology Science and Practice*, 11(2), 121–137. https://doi.org/10.1093/clipsy.bph062.

104. Smith, P., Yule, W., Perrin, S., Tranah, T., Dalgleish, T. I. M., & Clark, D. M. (2007). Cognitive-behavioral therapy for PTSD in children and adolescents: a preliminary randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*(8), 1051-1061. https://doi.org/10.1097/CHI.0b013e318067e288

105. Soffer-Dudek, N., and Somer, E. (2018). Trapped in a daydream: daily elevations in maladaptive daydreaming are associated with daily psychopathological symptoms. *Fronters in. Psychiatry* 9, 194. https://doi.org/10.3389/fpsyt.2018.00194

106. Steuber, K. R., & Solomon, D. H. (2011). Factors that predict married partners' disclosures about infertility to social network members. *Journal of Applied Communication Research,* 39(3), 250–270. https://fc-lc.com/uaYL8h.

107. Sukhodolsky, D. G., Smith, S. D., McCauley, S. A., Ibrahim, K., & Piasecka, J. B. (2016). Behavioral Interventions for Anger, Irritability, and Aggression in Children and Adolescents. *Journal of child and adolescent psychopharmacology*, *26*(1), 58–64. https://doi.org/10.1089/cap.2015.0120.

108. Summer, A. (2006). *Children's Exposure to Domestic Violence: A Guide to Research and Resource*. U.S. Department of Justice, Office of Justice Programs. Retrieved 18 January 2022 from https://www.ojp.gov/ncjrs/virtual-library/abstracts/childrens-exposure-domestic-violence-guide-research-and-resources.

109. Suveg, C., Sood, E., Comer, J. S., & Kendall, P. C. (2009). Changes in emotion regulation following cognitive-behavioral therapy for anxious youth. *Journal of clinical child and adolescent psychology : the official journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53*, *38*(3), 390–401.

110. Tamem et. al., (2000). Violence and childhood, Amman: Dar Al-Safa Publishing and Distribution.

111. Tohamy, M. M. (2017). *Child Mental Health*, 1st Edition, Dar Al-Ibtikar for Scientific Books.

112. UNICEF. (1989). Convention on the rights of the child. Retrieved 17 January 2022 from https://www.unicef.org/child-rights-convention/convention-text#.

113. Van der Kolk B. A. (1985). Adolescent vulnerability to posttraumatic stress disorder. *Psychiatry*, *48*(4), 365–370. https://fc-lc.com/lrBvPsu.

114. Vostanis, P., Feehan, C., Grattan, E., & Bickerton, W. L. (1996). A randomised controlled out-patient trial of cognitive-behavioural treatment for children and adolescents with depression: 9-month follow-up. *Journal of affective disorders*, *40*(1-2), 105–116. https://doi.org/10.1016/0165-0327(96)00054-7.

115. Wanda (1999). Child abuse importance and treatment, Dar Al-Fikr.

116. Waugh, F., Bonner, M. (2002). Domestic violence and child protection: Issues in safety planning. Child Abuse Review, 11(5), 282-295

117. Wenzel A. (2017). Basic Strategies of Cognitive Behavioral Therapy. *The Psychiatric clinics of North America*, *40*(4), 597–609. https://doi.org/10.1016/j.psc.2017.07.001

118. World Health Organization (WHO). (1993). *The ICD-11 classification of mental and behavioural disorders*. World Health Organization.

119. World Health Organization, (2020). Child Maltreatment. https://www.who.int/news-room/fact-sheets/detail/child-maltreatmentRetrieved 17 January 2022.

120. World Health Organization. (2015). Global Estimates of Health Consequences due to Violence against Children. Background paper for the United Nations Study on Violence against Children. Geneva.

121. World Health Organization. (2016). World Report on Violence and Health. Geneva, Switzerland.

122. Zaidan, A. (2017). *Psychological and Social Development*, 1st Edition, Science Library.

123. Zerman, Miller-Perrin, Cindy L. & Perrin, D., (2016). Child Maltreatment: An Introduction, London, Saga Publication, 1st Publication.

124. Zlotnick, C., Johnson, J., Kohn, R., Vicente, B., Rioseco, P., & Saldivia, S. (2008). Childhood trauma, trauma in adulthood, and psychiatric diagnoses: results from a community sample. *Comprehensive psychiatry*, *49*(2), 163–169. https://doi.org/10.1016/j.comppsych.2007.08.007

125. Zoghbi, (2014). Psychological, social and organic characteristics of abused children and the importance of treatment, Arab University for Security Sciences.

126. Zolotor, A. J., Runyan, D. K., Dunne, M. P., Jain, D., Péturs, H. R., Ramirez, C., Volkova, E., Deb, S., Lidchi, V., Muhammad, T., & Isaeva, O. (2009). ISPCAN Child Abuse Screening Tool Children's Version (ICAST-C): Instrument development and multi-national pilot testing. *Child abuse & neglect*, *33*(11), 833–841. https://doi.org/10.1016/j.chiabu.2009.09.004.

Appendices

Appendix A

PTSD Scale (Arabic Version)

CPSS – SR – 5استمارة

تحصل احيانا امور مخيفة ومقلقة للأولاد. على سبيل المثال حادث طرق، التعرض للضرب، سطو، هزة ارضية، لمس لا يروق لك، تعرض الأهل لإصابة أو موت الأهل، او أ ي حدث آخر مقلق جدا.

اكتب/ي من فضلك ما هو الشيء المخيف او المقلق الذي يقلقك/ي عندما تفكر/ي بذلك**:**

_____

متى حصل هذا؟

_____

البنود الاتية تسأل عن شعورك بالنسبة للأمر الذي اقلقك وكتبت عنه أعلاه. اقرأ بتمعن كل سؤال ومن ثم أحط بدائرة الرقم من (4-0) الذي يصف عدد المرات التي فيها شعرت انزعاجا من الأمر المقلق **خلال الشهر الأخير.**

4	3	2	1	0
6 مرات او اكثر	5-4 مرات بالأسبوع	3-2 مرات في الاسبوع	مره بالأسبوع او اقل	ولا مره على الاطلاق
بشكل دائم تقريبا	كثيرا	الى حد ما	قليلا	ولا مره

1	أفكار او صور مقلقة حول الشيء المقلق تخطر في بالك بالرغم من انك لا تريد التفكير فيها.	0	1	2	3	4
2	أحلام مزعجه او كوابيس ليلية.	0	1	2	3	4
3	التصرف او الشعور كان هذا الشيء يحصل مجددا (ان تسمع/ي او ترى/ي شيئا وتشعر/ي كأنك هنالك مجددا).	0	1	2	3	4
4	تشعر/ي بالقلق عندما تتذكر/ي ما حصل (مثل: خوف، غضب، حزن، شعور بالذنب، ارتباك).	0	1	2	3	4
5	ردود فعل جسدية عندما تتذكر/ي ما حدث(مثل: التعرق، نبض سريع، وجع راس او وجع بطن).	0	1	2	3	4
6	أحاول الا تكون لدي أفكار او مشاعر بخصوص ما حدث.	0	1	2	3	4
7	أحاول الابتعاد عن كل شيء يذكر بما حدث (مثل: اشخاص، أماكن، محادثات عما حصل).	0	1	2	3	4
8	لا تستطيع/ي ان تتذكر/ي جزءا مهماً مما حدث.	0	1	2	3	4
9	أفكار سيئة عن نفسي، عن اشخاص اخرين، عن العالم (مثل: "انا لا استطيع ان افعل شيء كما يجب"، "كل الناس سيئين"، "العالم هو مكان مخيف").	0	1	2	3	4
10	أفكار بان ما حصل هو بسببك (مثلا: "كان يجب ان اعرف اكثر"، "لم يكن علي القيام بذلك"، "انا استحق ذلك").	0	1	2	3	4
11	مشاعر قوية (مثل: خوف، غضب، شعور بالذنب، خجل).	0	1	2	3	4
12	اهتمام اقل بكثير بأداء الأشياء التي اعتدت القيام بها.	0	1	2	3	4
13	عدم الشعور بالقرب من اصدقائك وعائلتك او عدم التواجد بقربهم.	0	1	2	3	4
14	صعوبة بالإحساس بمشاعر جيده (مثل: السعادة، الحب) او الصعوبة بالإحساس مطلقا.	0	1	2	3	4
15	الغضب بسهولة (مثل: الصراخ، ضرب الاخرين، رمي الأشياء).	0	1	2	3	4
16	القيام بامور قد تؤذيك (مثل: تعاطي المخدرات، شرب الكحول، الهروب من البيت، إيذاء النفس باداه/تشطيب).	0	1	2	3	4
17	ان تكون حذرا جدا او تتحفظ من الخطر (مثل: ان تفحص من وماذا يوجد بقربك).	0	1	2	3	4
18	ان تكون اندفاعيا او الذعر بسهولة (مثل: عندما يمشي شخص من خلفك، عند سماع ضجة قوية).	0	1	2	3	4
19	صعوبة في التركيز (مثل: صعوبة في التعقب وراء قصة في التلفاز، نسيان ما قراته، صعوبة الاصغاء في الصف).	0	1	2	3	4
20	صعوبة في النوم او النوم باستمرار.	0	1	2	3	4

هل هذه المشاكل اثرت على حياتك خلال الشهر الأخير في المجالات الاتية:

الرجاء الإحاطة بدائرة حول "نعم" او "لا"

أمور ممتعة تريد/ي ان تفعلها/ تفعليها	نعم	لا
القيام بواجباتك	نعم	لا
علاقاتك مع اصدقائك	نعم	لا
ان تصلي	نعم	لا
واجبات بيتية	نعم	لا
علاقات مع عائلتك	نعم	لا
ان تكون/ي سعيدا/ سعيدة بحياتك	نعم	لا

****استمارة CPSS –SR- 5، Foa et al., 2018، ترجمة: وزارة الصحة و د. رائدة دعيم.**

Appendix B

PTSD Scale (Eng. Version)

CPSS – SR - 5

Sometimes scary and disturbing things happen to children. For example, a road accident, a beating, a burglary, an earthquake, touching you don't like, an injury or death to a parent, or any other very worrying event.

Please write what is scary or troubling that worries you when you think about it: _____

when did this happen?

_____

The following items ask how you feel about the matter that worried you and wrote about it above. Carefully read each question and then circle the number (4-0) that describes the number of times in **the last month** you have been disturbed by the concern.

0	**1**	**2**	**3**	**4**
Not once at all	**Once a week or less**	**3-2times a week**	**4-5 times a week**	**66 or more times**
Not once	**a little**	**To some extent**	**Much**	**Almost always**

1	Disturbing thoughts or images about the worrying thing come to your mind even though you don't want to think about it.	**0**	**1**	**2**	**3**	**4**
2	Bad dreams or nightmares.	**0**	**1**	**2**	**3**	**4**
3	Acting or feeling like this was happening again (to hear or see something and feel like you're there again).	**0**	**1**	**2**	**3**	**4**
4	You feel anxious when you remember what happened (such as: fear, anger, sadness, guilt, confusion).	**0**	**1**	**2**	**3**	**4**
5	Physical reactions when you remember what happened (such as: sweating, rapid heartbeat, headache or stomach ache).	**0**	**1**	**2**	**3**	**4**
6	I try not to have thoughts or feelings about what happened.	**0**	**1**	**2**	**3**	**4**
7	I try to stay away from everything that reminds of what happened (people, places, conversations about what happened).	**0**	**1**	**2**	**3**	**4**
8	You cannot remember an important part of what happened.	**0**	**1**	**2**	**3**	**4**
9	Bad thoughts about myself, other people, about the world (“I can’t do something right,” “All people are bad,” “The world is a scary place”).	**0**	**1**	**2**	**3**	**4**
10	Thoughts that what happened is because of you (“I should have known more”, “I shouldn’t have done this”, “I deserved it”).	**0**	**1**	**2**	**3**	**4**

11	Strong feelings (such as: fear, anger, guilt, shame).	**0**	**1**	**2**	**3**	**4**
12	Much less interest in doing the things you used to do.	**0**	**1**	**2**	**3**	**4**
13	Not feeling close to your friends and family or not being near them.	**0**	**1**	**2**	**3**	**4**
14	Difficulty feeling good feelings (happiness, love) or difficulty feeling at all.	**0**	**1**	**2**	**3**	**4**
15	Get angry easily (yelling, hitting others, throwing things).	**0**	**1**	**2**	**3**	**4**
16	Doing things that could harm you (taking drugs, drinking alcohol, running away from home, self-injury).	**0**	**1**	**2**	**3**	**4**
17	To be very careful or guarded against danger (for example: to check who and what is near you).	**0**	**1**	**2**	**3**	**4**
18	Being impulsive or panicking easily (when someone walks behind you, when you hear a loud noise).	**0**	**1**	**2**	**3**	**4**
19	Difficulty concentrating (difficulty tracing a story on TV, forgetting what you have read, difficulty listening in class).	**0**	**1**	**2**	**3**	**4**
20	Difficulty falling asleep or staying asleep.	**0**	**1**	**2**	**3**	**4**

Have these problems affected your life during the last month in the following areas:

Please circle "yes" or "no".

Fun things you want to do	**Yes**	**No**
do your homework	**Yes**	**No**
Your relationships with your friends	**Yes**	**No**
to pray	**Yes**	**No**
Homework	**Yes**	**No**
Relationships with your family	**Yes**	**No**

**** CPSS-SR-5 Form, Foa et al., 2018, translated by: Ministry of Health and Dr. Raeeda Daeem.**

Appendix C

Self-efficacy Scale (Arabic Version)

استبيان حول الكفاءة الذاتية المدركة

يرجى تحديد استجابة واحدة فقط تصفك على أفضل وجه. كن صريحًا، حيث سيتم استخدام المعلومات بسريه دون الكشف عن هويتك في البحث. ومن الممكن أيضا ان تكون نتيجة اجابتك في خدمتك ولمساعدتك في المدرسة وأيضًا مساعدتك على أن تكون أكثر استعدادًا للكلية والوظائف. لا توجد اجابات صحيحة أو خاطئة!

يشبهني جدا ←				**لا يشبهني ابدا**
5	**4**	**3**	**2**	**1**

1	يمكنني تعلم ما يتم تدريسه في الفصل هذا العام.	**1**	**2**	**3**	**4**	**5**
2	يمكنني اكتشاف أي شيء إذا حاولت بجدية كافية.	**1**	**2**	**3**	**4**	**5**
3	يمكنني تطوير أي مهارة تقريبًا، اذا قمت بالممارسة يوميا.	**1**	**2**	**3**	**4**	**5**
4	بمجرد أنني قررت إنجاز شيء مهم بالنسبة لي، استمر بالمحاولة لتحقيقه حتى لو كان اصعب مما كنت اعتقد.	**1**	**2**	**3**	**4**	**5**
5	أنا واثق من أنني سأحقق الأهداف التي حددتها لنفسي.	**1**	**2**	**3**	**4**	**5**
6	عندما أجد صعوبة في إنجاز شيء صعب ، أركز على تقدمي بدلاً من الشعور بالإحباط.	**1**	**2**	**3**	**4**	**5**
7	سوف أنجح في أي مسار وظيفي أختاره.	**1**	**2**	**3**	**4**	**5**
8	سوف أنجح في أي تخصص جامعي أختاره.	**1**	**2**	**3**	**4**	**5**
9	انا اؤمن بأن العمل الجاد يؤتي ثماره.	**1**	**2**	**3**	**4**	**5**
10	تنمو قدرتي مع الجهد.	**1**	**2**	**3**	**4**	**5**
11	انا اؤمن بأنه يمكن تطوير الدماغ مثل العضلات.	**1**	**2**	**3**	**4**	**5**
12	انا اؤمن أنه بغض النظر عن هويتك، يمكنك تغيير مستوى موهبتك بشكل كبير.	**1**	**2**	**3**	**4**	**5**
13	يمكنني تغيير الى حد كبير من مستواي الأساسي من القدرة.	**1**	**2**	**3**	**4**	**5**

Appendix D

Self-efficacy Scale (Eng. Version)

Self-Efficacy Formative Questionnaire

Please CHECK ONE response that best describes you. Be honest, since the information will be used to help you in school and also help you become more prepared for college and careers. There are no right or wrong answers!

Not very like me very like me →				
1	**2**	**3**	**4**	**5**

1	I can learn what is being taught in class this year.	**1**	**2**	**3**	**4**	**5**
2	I can figure out anything if I try hard enough.	**1**	**2**	**3**	**4**	**5**
3	If I practiced every day, I could develop just about any skill.	**1**	**2**	**3**	**4**	**5**
4	Once I've decided to accomplish something that's important to me, I keep trying to accomplish it, even if it is harder than I thought.	**1**	**2**	**3**	**4**	**5**
5	I am confident that I will achieve the goals that I set for myself.	**1**	**2**	**3**	**4**	**5**
6	When I'm struggling to accomplish something difficult, I focus on my progress instead of feeling discouraged.	**1**	**2**	**3**	**4**	**5**
7	I will succeed in whatever career path I choose.	**1**	**2**	**3**	**4**	**5**
8	I will succeed in whatever college major I choose.	**1**	**2**	**3**	**4**	**5**
9	I believe hard work pays off.	**1**	**2**	**3**	**4**	**5**
10	My ability grows with effort.	**1**	**2**	**3**	**4**	**5**
11	I believe that the brain can be developed like a muscle.	**1**	**2**	**3**	**4**	**5**
12	I think that no matter who you are, you can significantly change your level of talent.	**1**	**2**	**3**	**4**	**5**
13	I can change my basic level of ability considerably.	**1**	**2**	**3**	**4**	**5**

** Gaumer Erickson A.S. & Noonan, P.M. (2018). Self-efficacy formative questionnaire. In The skills that matter: Teaching interpersonal and intrapersonal competencies in any classroom (pp. 175-176). Thousand Oaks, CA: Corwin, translated by: Ministry of Health.

Appendix E

CBT – Program (Arabic Version)

الجلسات العلاجية

الجلسة الأولى

1. **المدة الزمنية للجلسة: ساعتين**

2. **عدد الأطفال المشاركين: 15 طفل**

3. **الهدف الرئيسي للجلسة**: التعريف ببرنامج اضطراب الضغط ما بعد الصدمة والتعريف بأهدافه

4. **الهدف الفرعي للجلسة:**

- التعرف على أفراد المجموعة، وإتاحة الفرصة لأفراد المجموعة التعرف علـى بعضهم البعض
- خلق جو من الثقة ما بين الباحثة وأفراد المجموعة وتخفيف حدة القلق.
- اعطاء أفراد المجموعة فكرة كاملة عن البرنامج وأهمية البحث.
- وضع القواعد الأساسية التي سوف يتم إتباعها أثناء عملية التفريغ.
- التعرف على توقعات أفراد المجموعة من البرنامج المقترح

5. **الإجراء:** استخدمت الباحثة أسلوب التفاعل مع الاطفال المعتدى عليهم وطريقة العصف الذهني من خلال أنشطة خاصة بالاطفال المعتدى عليهم ومحاولة التودد إليهم وكسر الجليد بينها وبين الاطفال المعتدى عليهم.

6. **الأنشطة المستخدمة:** تم اعطاء التعليمات للاطفال المعتدى عليهم بطبيعة الجلسة وما هي فوائدها من خلال بطاقات تم توزيعها عليهم حيث حصل كل طفل على بطاقة خاصة به مكتوب عليها اسمه للتعرف عليه، وتم استخدام طريقة المناقشة الجماعية لدى الاطفال المعتدى عليهم، واستخدام اسلوب اللعب عن طريقة اللعب بالقنينة الدوارة وعند وقوف القنينة عند الطفل يتحدث عن تجربته امام الجميع حيث تم استخدام نشاط اللعب للاطفال لكسر حاجز الخجل لدى الاطفال المعتدى عليهم.

7. **الأدوات:** قنينة فارغة، بطاقات عليها اسماء الاطفال في الجلسة.

8. **طريقة التطبيق:**

- بدأت الباحثة الجلسة بتعريف المجموعة عن نفسها وطبيعة عملها وهدفها من القيـام بهذا النشاط
- بعد ذلك تقوم بإعطاء وصف وعرض للبرنامج الذي سوف يتبع، وما هي الخطوط الرئيسية للبرنامج وما هي التوقعات المفترضـة منـه، وإعطـاء وصف عن عدد الجلسات (وهي 18 جلسة)، والمـدة الزمنيـة التـي سـوف تستغرقها كل جلسة (من ساعة الى 3 ساعات) والمكان الذي سوف تعقد فيه

- تؤكد الباحثة على سرية وخصوصية المعلومات من الجميع، بحيث لا يسمح لأحد من أفراد المجموعة الحديث عما دار أثناء جلسات التفريغ خارج قاعة التفريغ.
- تؤكد الباحثة أن حرية المشاركة مكفولة للجميع، ولكن لا يسمح لأحد بالمشاركة إلا بعد اخذ الإذن بذلك من الباحثه، وغير مسموح المشاركة أثناء قيام الآخرين بالحديث.
- تبين الباحثة أن المشارك قد يشعر بالألم من جراء الحديث عن تجارب موجعة، ولكن هذا الشعور بالألم طبيعي ومتوقع في مثل هذه الظروف.
- تذكر الباحثة أن كل شخص مطلوب منه الحديث عن تجربته الخاصة وليس مطلوب منه الحديث عن الآخرين أو عن تجاربهم.
- تذكر الباحثة أن الخروج من الجلسة مسموح فقط في الطوارئ أو لقضاء حاجة شخصية، عدا ذلك يجب على الجميع الالتزام بمواعيد انعقاد وإنهاء الجلسة.
- غير مسموح لأي شخص باستثناء الباحثة القائم على عملية التفريغ والأطفال أفراد المجموعة بالتواجد في غرفة التفريغ أثناء الجلسة، سواء كانوا من الإدارة أو إعلاميين أو أي شخص آخر بغض النظر عن مركزه.
- تترك الباحثة المجال للأطفال بالحديث عن توقعاتهم من هذا البرنامج أو إذا كانت لديهم أي فكرة عن برامج التفريغ النفسي أو أي برامج تدخل في الأزمات، أو إذا كان أي منهم قد تلقي خدمات سابقة في هذا المجال.
- التنويه لأفراد المجموعة بان الباحثة سوف تبقي مدة نصف ساعة بعد انتهاء وقت كل جلسة، فمن يرغب منهم بالحديث بشكل فردي مع الباحثة فيمكنه ذلك من خلال هذا الوقت.
- نفذت الباحثة نشاطاً آخر بصحبة الاطفال المعتدى عليهم بهدف إذابة الجليد وكسر الجمود فيما بين الاطفال المعتدى عليهم أنفسهم من جهة والباحثة من جهة أخرى، ومن أجل خلق أجواء مليئة بالثقة والألفة والفرح والسرور، وتمثل هذا النشاط بلعبة (دارت القنينة) حيث طلبت الباحثة من الاطفال المعتدى عليهم الجلوس على شكل دائرة وقام بوضع قنينة " زجاجة " بلاستيكية فارغة في وسط الدائرة وقام بلفها، ومن تشير إليه فوهة الزجاجة يقوم بالإجابة على سؤال أو القيام بشيء يطلبه منه الذي تقع عليه مؤخرة القنينة، بعد ذلك يقوم الطالب الذي وقعت فوهة الزجاجة اتجاهه بلفها لمعاودة الكرة. وهنا تحاول الباحثة تشجيع الاطفال المعتدى عليهم على سؤال بعض الأسئلة المتعلقة بمشكلات ومشاعر وحياة الاطفال المعتدى عليهم اليومية.

9. **التكنيك المستخدم:** استخدمت الباحثة تقنية المراقبة الذاتية للاطفال وهو تكنيك للتعامل مع الاطفال المعتدى عليهم، وتم استخدام تقنية التعرف الآلي على الأفكار والعمل على تصحيحها للاطفال المعتدى عليهم.

10. **المهام البيتية:** تمارين الاسترخاء.

11. **الإنهاء:** أتاحت الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم حول البرنـامج عامة وما دار في الجلسة خاصةً، ومن ثم قدمت الباحثة الشكر والتقدير للاطفال المعتدى عليهم المشاركين.

الجلسة الثانية

1. **المدة الزمنية للجلسة: ساعتين ونصف**

2. **عدد الأطفال المشاركين: 15 طفل**

3. **الهدف الرئيسي للجلسة:** تعريف اضطرابات ما بعد الصدمة والمواضيع التي يتناولها البرنامج وفهم أعراض اضطراب ضغط مابعد الصدمة والتكيف الذاتي

4. **الهدف الفرعي للجلسة:**

- تعريف الاطفال المعتدى عليهم بطبيعة العلاج المعرفي للصدمة الذي يركز على ان الاحداث التي وقعت لا تتغيير ولكن نستطيع تغيير تفسير ماحدث.

- التعريف بمحتويات البرنامج العلاجي الخاص بالاطفال المعتدى عليهم واسلوب التكيف الذاتي لدى الاطفال

5. **الإجراء:** تقوم الباحثة في البداية بمراجعة ما جرى في الجلسة السابقة ومشاركة الاطفال بمجموعة من الاسئلة تطرحها عليهم ومن ثم تدخل في الجلسة من خلال التوزيع على الاطفال اوراق واقلام ملونة لكي يقوم الطفل المعتدى عليهم بالرسم على تلك الاوراق والتلوين وذلك بهدف التخفيف النفسي عن الطفل المعتدى عليه وتفريغ طاقاته الايجابية وتغيير النمط الفكري لدى الطفل المعتدى عليه.

6. **الأنشطة المستخدمة:** تم استخدام نشاط الرسم للاطفال، واستخدام نشاط التلوين على الاوراق التي تم توزيعها في الجلسة واستخدام نشاط الحوار مع الاطفال، وتم عمل نشاط من خلال تقسيم الاطفال الى مجموعات عمل مع الطلاب وتقسيمهم الى مجموعات، عصف الأفكار من خلال أنشطة يقوم بها الأطفال المعتدى عليهم باشراف الباحثة.

7. **الأدوات:** أوراق بيضاء، بطاقات، أقلام تلوين، ورق ملون صغير.

8. **طريقة التطبيق:**

- يتم طرح أسئلة محددة على المجموعة ثم تتاح الفرصة لكل طفل للحديث عن تجربته الخاصة وكيف يري الحدث.

- الأسئلة التي سيتم طرحها من قبل الباحثة: ما الذي حدث؟ أين كنت ساعة وقوع الحدث؟ من كان معك لحظة وقوع الحدث؟ ما هو أول رد فعل لك بعد وقوع الحدث؟ ماذا رأيت، سمعت، شممت لحظة وقوع الحدث؟
- ويمكن للباحثة أن يتدخل ببعض الأسئلة أثناء سرد التجارب بهدف تشجيع الشخص على مواصلة الحديث عن النقطة نفسها أو الحديث بشكل أكبر عن نفس النقطة إذا شعر الباحثة أنها مهمة، أو التوجيه الشخصي نحو نقطة معينة، ومن الضروري أيضا إظهار المعالج تفهمه لما حدث مع الأطفال وتعاطفه معهم عن طريق التغذية الراجعة، أو عن طريق التواصل الغير لفظي
- تمكينهم من ابتكار أدوار جديدة واكتساب الكفاءة الذاتية اللازمة للتغلب على آثار العنف

9. **التكنيك المستخدم:** تم استخدام تقنية النمذجة الفنية، وتقنية التدريب على حل المشكلات الفنية، واستخدام تقنية الحديث الذاتي: حيثث تم تقديم الدعم اللازم لأحد الأفراد إذا شعر بضرورة ذلك. وتقوم الباحثة بالتركيز فقط على الحقائق المتعلقة بالحدث الصادم ويتجنب الدخول في أي تفرعات قد تستهلك الكثير من الوقت

10. **المهام البيتية:** تطلب الباحثة من كل طفل القيام بتوضيح الأحداث الصادمة التي مر بها وما تزال تتردد على ذاكرته. ثم بعد ذلك يقوم بتوضيح الاستجابات التي قام بها بعد وقوع الحدث مباشرة، ثم الاستجابات التي يقوم بها عند تذكره للحدث في الوقت الراهن.

11. **الإنهاء:** أتاحت الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم من خلال الانفعالات التي يرغبون في التصريح عنها حول البرنامج عامة وما دار في الجلسة خاصةً، ومن ثم قدم الباحثة الشكر والتقدير للاطفال المعتدى عليهم المشاركين.

الجلسة الثالثة

1. **المدة الزمنية للجلسة: ساعة واحدة**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** تحديد الأفكار والمشاعر المتعلقة باضطراب ضغط مابعد الصدمة وتعليمهم اسلوب التكيف الذاتي.
4. **الهدف الفرعي للجلسة:**

- تعرف أعراض اضطراب ضغط مابعد الصدمة، حيث وضعت الاعراض ضمن أربعة أصناف: اعراض اعادة التعرض للحدث الصادم، اعراض التجنب، أعراض فقدان الإهتمام، أعراض الاستثارة.
- استيعاب ان الأعراض هي ردود فعل طبيعية تجاه الضغط النفسي الشديد.
- تصحيح الأفكار السلبية المتعلقة بالحدث.
- تفعيل دعم المجموعة
- رفع الكفاءة الذاتية لدى الطفل المعتدى عليه.

5. **الإجراء:** تقوم الباحثة في البداية باحصاء الاطفال المعتدى عليهم في الجلسة والتاكد من اكتمال عددهم، ثم تقوم الباحثة بتهيئة الاطفال بشكل نفسي للجلسة من خلال التمهيد بموضوع الجلسة واعطائهم نبذة صغيرة عن موضوع الجلسة، ومن ثم تقوم ببدأ الجلسة من خلال العاب تقوم بها مع الاطفال المعتدى عليهم ومجموعة من النشاطات.
6. **الأنشطة المستخدمة:** استخدام نشاط التعزيز الايجابي للاطفال، تم استخدام نشاط التغذية الراجعة من الاطفال المعتدى عليهم توزيع بطاقات صغيرة للاطفال، واستخدام نشاط تمثيل الادوار للاطفال المعتدى عليهم.
7. **الأدوات:** أوراق، أقلام تلوين، بطاقات.
8. **طريقة التطبيق:**

- تقوم الباحثة بطرح أسئلة محددة، واضحة المجال للنقاش المفتوح، ومن بين هذه الأسئلة
  ما هي الأفكار التي وردت إلى ذهنك وقت وقوع الحدث ؟
  ما هي الأفكار المتعلقة بالحدث وما تزال موجودة في ذهنك حتى الآن ؟
  ما هي الأفكار التي وردت إلى ذهنك بعد الجلسة الأولى وحتى الآن؟
  ما هي المشاعر التي شعرت بها وقت وقوع الحدث ؟
  ما هي المشاعر التي تشعر بها عندما تأتيك هذه الأفكار؟
  كيف تتعامل مع هذه المشاعر؟
- ثم تقوم الباحثة بالتدخل من خلال: -

- إظهار التفاهم والتعاطف بشكل لفظي أو غير لفظي للمشاعر والأفكار التي تظهر خلال الجلسة.
- توجيه بعض الأسئلة المحددة عندما يشعر أن الطفل وصل إلى مرحلة لا يستطيع فيها الاستمرار البحث عن العناصر التي تعكس العمل المعرفي باتجاه التكيف، وتقوم الباحثة أيضاً بالتركيز على القرارات والأنشطة تتولى الباحثة أهمية للمشاعر التي يحاول أفراد المجموعة إخفاؤها وخاصة ما يتعلق بمشاعر الذنب

تقوم الباحثة أيضاً باستخدام المجموعة في تعديل الأفكار السلبية عن طريق تركيز الضوء عليها والطلب من أفراد المجموعة التعليق عليها، أيضا تقوم الباحثة بتحويل كل الذكريات المتعلقة بالانطباعات الحسية إلى كلمات وأن يركز على شعور التجنب الذي يقوم به الشخص للهروب من هذه الانطباعات الحسية.

المحافظة على درجة من الصمت تسمح للشخص الحديث بعمق عن مشاعره، وتعزيز مصادر الكفاءة الذاتية في كيفية إدراك الاطفال المعتدى عليهم لحالتهم الانفعالية والجسمية وتفسيرهم لها.

جعل الطفل شرح المهارات الاجتماعية التي يقوم بها وتوضيح للطفل بان تلك المهارات الاجتماعية لها أثر كبير في رفع الكفاءة الذاتية للطفل المعتدى عليه.

9. **التكنيك المستخدم:** قامت الباحثة باستخدام تقنية المراقبة الذاتية للاطفال المعتدى عليهم، واستخدام تقنية التعرض، وتقنية فن التخيل، واستخدام تقنية الواجب المنزلي الفني: لتشجيع المشارك على الحديث، ولإشعاره بأن ما يشعر به هو استجابة طبيعية لحدث غير طبيعي تعرض له، ويمكن استخدام جمل مثل: أنت ليس وحدك مع هذه الأفكار، من الطبيعي أن تشعر بذلك بعد كل ما تعرضت له، هناك آخرين أفصحوا أنهم

10. **المهام البيتية:** يطلب الباحثة من كل طفل القيام بتسجيل ما يفكرون به عندما تنتابهم مشاعر مؤلمة، وما هي الانطباعات الحسية (ذاكرة الحواس) التي ما تزال تهاجمهم دائما، بعد ذلك يطلب الباحثة من أفراد المجموعة القيام بالتمرين التالي: أن يقوموا باستحضار الصور المتعلقة باضطرابات ضغط مابعد الصدمة، ويتخيلوا أن هذه الصور تعرض أمامهم على شاشة كبيرة، وهم يمسكون بجهاز التحكم عن بعد، وعندما يصل عرض هذه الصور إلى حد مزعج أن يقوموا بإيقاف العرض عن طريق جهاز التحكم عن بعد الموجود لديهم. وأن يعيدوا هذا التمرين يومياً أكثر من مرة.
11. **الإنهاء:** أتاح الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم حول البرنـامج عامة وما دار في الجلسة خاصةً، ومن ثم قدمت الباحثة الشكر والتقدير للاطفال المعتدى عليهم المشاركين.

الجلسة الرابعة

1. **المدة الزمنية للجلسة: ساعة وربع**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** التعرف على آلية التفريغ الإنفعالي للطفل المعتدى عليه والتعرف على طريقة التعامل مع التفريغ الإنفعالي
4. **الهدف الفرعي للجلسة:** استخراج المشاعر المؤلمة المتعلقة بالحدث الصادم للطفل المعتدى عليه ومعالجته
5. **الإجراء:** توجيه الطفل المعتدى عليه للقيام بامور ايجابية تساعده على المضي قدماً ورفع روحه المعنوية وكفاءته الذاتية من خلال تعليمه اساليب التكيف الذاتي مع الحدث وتعزيز الروح الايجابية لدى الطفل المعتدى عليه وترسيخ فكرة ان الذي حدث عبارة عن تجربة قد مضت وجعل الطفل المعتدى عليه القيام بتدوين افكاره في بطاقات قامت الباحثة بتوزيعها على الاطفال المعتدى عليهم.
6. **الأنشطة المستخدمة:** الحوار مع الاطفال المعتدى عليهم، استخدام بطاقات صغيرة، استخدام اسلوب لعب الادوار بين الاطفال المعتدى عليهم في الجلسة الحالية
7. **الأدوات:** أوراق، أقلام، بطاقات.
8. **طريقة التطبيق:**

- يتم تدريب الاطفال على طريقة التعامل مع الماضي، أو مع المشكلات المتوقعة كما لو كان الصراع يحدث الآن فالمشاعر الشديدة القوية يتم اخراجها على نحو نموذجي وقد صممت هذه العملية بحيث تكون خبرة انفعالية سليمة، بعد حدوث مستوى كبير من الاستبصار يحدث التفريغ الانفعالي، إذ مع تحرير تلك المشاعر مثل اليأس والحزن والاثم فإن كل المشاركين في السيكودراما بما في ذلك الاطفال في الجلسة العلاجية يحققون مستوى جديد آمن لفهم الموقف المشكل الصراعي، فهناك إذن عملية تفريج متكاملة في علاج السيكودراما، لأنه يتم تشجيع الفرد من خلالها على أن يتوحد مع مواقف ومشكلات الآخرين وبهذه الطريقة يجد الأشخاص الذين كانوا يعدون أنفسهم في مواقف سابقة غير قادرين على الفرار من العزلة الانفعالية، تعريف الطفل المعتدى عليه بأهمية الإنجازات التي يحققها الطفل في رفع كفاءته الذاتية فإذا شعر الطفل المعتدى عليه بأنه ينجز بصورة ناجحة، ستزيد توقعاته لمدى كفاءته الذاتية

9. **التكنيك المستخدم:** استخدام اللعب في التفريغ الانفعالي للطفل، حيث يمثل اللعب تفريغ اسقاطي لمشاعر الطفل في مرحلة محنة اضطراب الضغط ما بعد الصدمة وهو تكنيك فعال في حالة الاطفال المعتدى عليهم
10. **المهام البيتية:** قيام الطفل بالتدريب على التفريغ الانفعالي من خلال واجب بيتي تقوم الباحثة باعطاءه للاطفال المعتدى عليهم
11. **الإنهاء:** أتاحت الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم من خلال ردودهم على الاحداث التي حدثت معهم، وما دار في الجلسة خاصةً، ومن ثم قدمت الباحثة الشكر والتقدير للاطفال المعتدى عليهم المشاركين.

الجلسة الخامسة

1. **المدة الزمنية للجلسة: ساعة ونصف**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** تشجيع الطفل المعتدى عليه بالتفاعل مع الاحداث التي حدثت معه ومحاولة التغلب عليها من خلال البرنامج العلاجي
4. **الهدف الفرعي للجلسة:**
   - توضيح العلاقة بين سؤال لماذا والشعور بالذنب
   - توضيح العلاقة بين سؤال لماذا والشعور بالعجز
   - ملاحظة الافكار اللاعقلانية التي تتعلق بالاجابة على اسئلة لماذا.
   - تعديل الصورة المشوهة التي قد تكون موجودة عن اضطرابات ضغط مابعد الصدمة
   - توضيح المعاني الإيجابية لاضطرابات ضغط مابعد الصدمة
   - تحويل الحدث الصادم من حدث استثنائي إلى خبرة يمكن إدراجها ضمن خبرات الحياة.
5. **الإجراء:** قيام الباحثة في البداية باحصاء الموجودين بالجلسة العلاجية، ثم تقوم بالطلب من المجموعة تقييم الحدث ومدى خطورته وتهديده لهم عن طريق طرح بعض الأسئلة وفتح المجال أمام المجموعة للحديث عن تجاربهم الخاصة
6. **الأنشطة المستخدمة:** استخدام نشاط التنشيط السلوكي، واستخدام نشاط الالهاء، واستخدام نشاط لعب الأدوار، واستخدام نشاط الرسم للاطفال الذي يساعدهم على الالهاء والتفريغ عن مشارعرهم.
7. **الأدوات:** أوراق، أقلام تلوين، بطاقات صغيرة.
8. **طريقة التطبيق:**
   - طرح بعض الأسئلة وفتح المجال أمام المجموعة للحديث عن تجاربهم الخاصة مثل:

     كيف ترى الحدث من وجهه نظرك ؟

     ما مدى خطورة الحدث على سلامتك وأمنك ؟

     ماذا كان أخطر جانب بالحدث؟

     ما هي الجوانب السلبية بالحدث بشكل عام ؟

- ثم بعد ذلك يقوم الباحثة بالتوضيح لأفراد المجموعة بأن أي حدث مهما كـان مـؤلم وصعب يوجد به دائما جوانب إيجابية، قد لا تكون ظاهره في وقت وقوع الحدث بسبب اضطراب القدرة على التفكير المنطقي. ويمكن استيضاح الجوانب الإيجابية عن طريق طرح الباحثة للأسئلة التالية وإتاحة المجال للمناقشة المفتوحة بين الأطفال المعتدى عليهم..
- ما هي الجوانب الإيجابية كما تراها في الحدث ؟
- ما هي الدروس التي يمكن الاستفادة منها بعد مرورك بهذه التجربة؟.
- اشعار الطفل المعتدى عليه بان القلق والخوف والانفعال الشديد تؤدي إلى خفض أداء الشخص، وبالتالي يؤدي الى خفض الكفاءة الذاتية لدى الطفل

9. **التكنيك المستخدم:** قيام الباحثة باستخدام تقنية التعرف على أساليب التفكير الخاطئ وغير الفعال: وجعل أفراد المجموعة الحديث عن تقيمهم لمقدرتهم على التعامل أو التكيف مع الحدث، عن طريق طرح بعض الأسئلة وتـرك المجـال مفتوح للمناقشة مثال
    - كيف ترى قدرتك على التعامل مع هذه الأحداث؟
    - ما هي الجوانب الإيجابية في شخصيتك التي تساعدك على التعامل مع مثل هذه الأحداث؟.
    - ما هي الجوانب الإيجابية حولك التي يمكن أن تلعب دور جيد في مساعدتك على التعامل مع هذه الأحداث ؟
10. **المهام البيتية:** تطلب الباحثة من أفراد المجموعة بواجب بيتي من خلال اعطائهم واجب تعلم الاسترخاء العصبي.
11. **الإنهاء:** في نهاية الجلسة يوضح الباحثة أن على أفراد المجموعة أن يروا الأحداث كما هي بدون أن يبالغوا في تقيمها، والنظر إليها كتجربة لها جوانب إيجابية وسلبية، وتوضيح مصادر القوة لديهم وعدم الاستهانة بمقدرتهم على التعامل مع مثل هذه الأحداث.

الجلسة السادسة

1. **المدة الزمنية للجلسة: ساعة**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** توضيح الحديث الذاتي السلبي وعلاجه لدى الأطفال المعتدى عليهم لاضطراب الضغط ما بعد الصدمة وتعريفهم باسلوب التكيف الذاتي الخاص به
4. **الهدف الفرعي للجلسة:**
    - تعريف الاطفال كيف يتم تعلم اضطراب مابعد الصدمة
    - فهم حقيقة ان الهرب والتجنب يعطي شعور بالارتياح المؤقت لانه يأتي مباشرة بعد الالم
    - كيفية العلاج بالدعم النفسي للطفل المعتدى عليه.
    - تعزيز الجوانب الايجابية عند أفراد المجموعة.

5. **الإجراء:** تقوم الباحثة في بداية الجلسة بالطلب من أفراد المجموعة تلخيص ما جرى في الجلسة السابقة، ثم تقوم بتوضيح دور العوامل الايجابية كعامل وقاية لدى الطفل المعتدى عليه وذلك من خلال تعزيز الروح الايجابية لدى الطفل حيث تقوم الباحثة بتوزيع البالونات الملونه للاطفال وجعلهم يختارون اللون المفضل لديهم، وتوزيع كرات كرستالية جميلة لرفع الروح المعنوية لدى الاطفال.
6. **الأنشطة المستخدمة:** اعطاء التمرين، اللعب بالكرات الكرستالية، اللعب بالبالونات، الرسم على البطاقات.
7. **الأدوات:** أوراق، أقلام، كرات كرستالية ملونة، بالونات ملونة.
8. **طريقة التطبيق:**

- نقوم بتوضيح أهمية التفاؤل والابتعاد عن الامور التي لها اثر سلبي على نفسية الطفل المعتدى عليه، حيث تقوم الباحثة بتوزيع بالونات على الاطفال المعتدى عليهم بالوان مختلفة وتجعل الطفل ان يختار لون البالون المفضل لديه لمعرفة ما هو توجه الطفل وماهي طبيعة افكاره وميوله والعمل على معالجة الامور السلبية لدى الطفل.
- بعد ذلك تقوم الباحثة بتوزيع كرات كرستاليه صغيرة لدى الاطفال باشكال جميله لرفع روح الطفل المعنوية وجعلهم يمررون الكرات فيما بينهم والذس يعمل على نشر الروح الايجابية بين الاطفال وتعزيز روح المنافسة وروح التعاون فيما بينهم
- توضيح كيفية رفع الكفاءة الذاتية لدى الطفل المعتدى عليه من خلال جعله يجيب على البطاقات التي سيقوم بسحبها وشرحها له والتي تشمل:
  1. لدي القدرة على حل المشكلات إذا بذلت الجهد المناسب
  2. لدي القدرة على التكيف بسهولة مع الصعوبات التي تواجهني
  3. عندما أواجه مشكلة أجد حلولاً لها

9. **التكنيك المستخدم:** قامت الباحثة باستخدام تقنية المراقبة الذاتية، وتقنية التعرض، وتقنية فن التخيل، وتقنية الواجب المنزلي الفني.
   - سؤال أفراد المجموعة كيف أثر تعرضهم للصدمة على نفسيتهم.
   - كيف أثرت الصدمة على نظامهم الحياتي واسلوب حياتهم اليومي.
   - وتعزيز هذا التغير إذا كان إيجابيا، وتعديل هذا التغير إذا كان له آثار سلبية على نظامهم اليومي.
10. **المهام البيتية:** تقوم الباحثة بالطلب من أفراد المجموعة القيام بتسجيل كل المعلومات الجديدة التي اكتسبوها في التخفيف من أثار الخبرات الصادمة في نفس الكراسة التي يسجلون فيها الواجب البيتي.
11. **الإنهاء:** أتاح الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم حول البرنامج عامة وما دار في الجلسة خاصةً حيث كانت مشاعرهم صريحة وايجابية بعد انتهاء الجلسة.

الجلسة السابعة

1. **المدة الزمنية للجلسة: ساعة**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** علاج الحديث الذاتي السلبي لدى الأطفال المعتدى عليهم والتكيف الذاتي الخاص به

4. **الهدف الفرعي للجلسة:**

- تعريف الاطفال كيف يتم علاج الحديث الذاتي السلبي
- كيفية العلاج بالدعم النفسي للطفل المعتدى عليه من الحديث الذاتي السلبي.

5. **الإجراء:** تقوم الباحثة بتوضيح دور العوامل الايجابية كعامل وقاية لدى الطفل المعتدى عليه والتعريف بفائدته وكيفية الابتعاد عن الحديث السلبي الذاتي وذلك من خلال تعزيز الروح الايجابية لدى الطفل حيث تقوم الباحثة بتوزيع البالونات الملونه للاطفال وجعلهم يختارون اللون المفضل لديهم، وتوزيع كرات كرستالية جميلة لرفع الروح المعنوية لدى الاطفال.
6. **الأنشطة المستخدمة:** اعطاء التمرين، اللعب بالكرات الكرستالية، اللعب بالبالونات، الرسم على البطاقات.
7. **الأدوات:** أوراق، أقلام، كرات كرستالية ملونة، بالونات ملونة.
8. **طريقة التطبيق:**

- تقوم بتوضـيح أهمية التفاؤل والابتعاد عن الامور التي لها اثر سلبي على نفسية الطفل المعتدى عليه، حيث تقوم الباحثة بتوزيع بالونات على الاطفال المعتدى عليهم بالوان مختلفة وتجعل الطفل ان يختار لون البالون المفضل لديه لمعرفة ما هو توجه الطفل وماهي طبيعة افكاره وميوله والعمل على معالجة الامور السلبية لدى الطفل.
- بعد ذلك تقوم الباحثة بتوزيع كرات كرستاليه صغيرة لدى الاطفال باشكال جميله لرفع روح الطفل المعنوية وجعلهم يمررون الكرات فيما بينهم والذس يعمل على نشر الروح الايجابية بين الاطفال وتعزيز روح المنافسة وروح التعاون فيما بينهم
- توضيح كيفية رفع الكفاءة الذاتية لدى الطفل المعتدى عليه من خلال جعله يجيب على البطاقات التي سيقوم بسحبها وشرحها له والتي تشمل:
- لدي القدرة على حل المشكلات إذا بذلت الجهد المناسب
- لدي القدرة على التكيف بسهولة مع الصعوبات التي تواجهني
- عندما أواجه مشكلة أجد حلولاً لها

9. **التكنيك المستخدم:** قامت الباحثة باستخدام تقنية المراقبة الذاتية، وتقنية التعرض، وتقنية فن التخيل، وتقنية الواجب المنزلي الفني.

- سؤال أفراد المجموعة كيف أثر تعرضهم للصدمة على نفسيتهم.
- كيف أثرت الصدمة على نظامهم الحياتي واسلوب حياتهم اليومي.
- وتعزيز هذا التغير إذا كان إيجابيا، وتعديل هذا التغير إذا كان له آثـار سـلبية علـى نظامهم اليومي.

10. **المهام البيتية:** تقوم الباحثة بالطلب من أفراد المجموعة القيام بتسجيل كل المعلومات الجديدة التـي اكتسبوها في التخفيف من أثار الخبرات الصادمة في نفس الكراسة التي يسجلون فيها الواجب البيتي.
11. **الإنـهاء:** أتاح الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم حول البرنـامج عامة وما دار في الجلسة خاصةً حيث كانت مشاعرهم صريحة وايجابية بعد انتهاء الجلسة.

الجلسة الثامنة

1. **المدة الزمنية للجلسة: ساعتين**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** تعريف الطفل المعتدى عليه ماهية تمكين الذات الخاصة باضطراب الضغط مابعد الصدمة وأسلوب التكيف الذاتي وتعليم الطفل طريقة التخلص من تداعيات الصدمة
4. **الهدف الفرعي للجلسة:**
   - تمكين الاطفال من تبني استراتيجيات الدفاع عن الذات
   - توضيح ما الذي يقصد بوسائل الدفاع والتكيف
   - توضيح وسائل الدفاع والتكيف المستخدمة
   - تعزيز وسائل التكيف الإيجابية، وتعديل الوسائل السلبية واستخدام المجموعة في ذلك.
5. **الإجراء:** تقوم بالباحثة بالتركيز على وسائل الدفاع والتكيف من خلال الحديث عن الصدمة التي تعرض لها كل طفل على حدة، وكيف كانت وسائل التكيف التي استخدمها في البداية، وما هي الوسائل التي يستخدمها حاليا وقيامها بتعريف الطفل باساليب التكيف وطريقة الدفاع عن الذات وذلك من خلال تقسيم الاطفال الى مجموعات وتعليمهم مهارات الدفاع عن النفس باسلوب اللعب الجماعي
6. **الأنشطة المستخدمة:** اللعب من خلال مجموعات، تقسيم الاطفال الى مجموعتين للتنافس، استخدام بطاقات تعريفية باساليب الدفاع عن النفس
7. **الأدوات:** أوراق، أقلام، بطاقات مكتوب عليها طرق الدفاع عن النفس.
8. **طريقة التطبيق:**

- يقوم بالتركيز على وسائل الدفاع والتكيف من خلال الحديث عن الصدمة التي تعرض لها كل طفل على حدة، وكيف كانت وسائل التكيف التي استخدمها في البداية، وما هي الوسائل التي يستخدمها حاليا وذلك عن طريق طرح الأسئلة التالية:
- كيف تصرفت بعد وقوع الحدث ؟
- ما الذي تقوم بعمله عندما تنتابك مشاعر مؤلمة متعلقة بالحدث أو عندما تهاجمك ذكريات متعلقة بالحدث؟
- هل ترى بأن وسائل التكيف التي تستخدمها تساعدك في التعامل مع الحدث؟
- ثم يقوم الباحثة بالتطرق لوسائل الدفاع والتكيف التي كان يستخدمها الطفل عندما مر بأحداث مشابهه في الماضي ويتم توضيح هذه الوسائل وتعزيزها عن طريق طرح الأسئلة التالية:
- كيف كنت تتعامل بالسابق عندما كنت تمر بأحداث مشابهه؟
- هل كانت هذه الوسائل تساعدك في التكيف مع الحدث الذي مررت به وإذا كانت بعض الوسائل تساعد وأخرى لا تساعد على التكيف فما هي الوسائل المساعدة والغير مساعدة على التكيف حسب وجهه نظر الطفل؟ والذي بدوره يعزز الكفاءة الذاتية لدى الطفل
- القيام بتنفيذ النشاط الذي تم تحديده في الجلسة من خلال نشاط اللعب بين الاطفال وتقسيمهم الى مجموعات وتدريبهم على اساليب الدفاع عن النفس

9. **التكنيك المستخدم:** استخدمت الباحثة تقنية النمذجة الفنية، وتقنية التدريب على حل المشكلات الفنية، وتقنية الحديث الذاتي، وتقنية تمثيل الأدوار الفنية، وتقنية دليل الاختبار الفني:

- قيام الباحثة بالتركيز على وسائل الدفاع والتكيف التي تستخدمها المجموعة في التعامل مع الحدث، وكيف يقومها الطفل عن طريق طرح الأسئلة التالية:
- من خلال استماعك لزملائك ما هي الوسائل التي استخدموها ؟
- كيف تقييم وسائل الدفاع التي تستخدمها المجموعة ؟
- ما هي وسائل الدفاع الصحية ؟
- ما هي وسائل الدفاع الغير صحية ؟
- تقوم الباحثة أثناء ذلك بتسهيل الحوار، وتوضيح أن الوسائل الصحية التي قام الشخص باستخدامها في السابق هي أهم وسائل الدفاع التي يمكنها أن تساعده في تخطي الأزمة الحالي، ثم تقوم ببعض الرياضة الخاصة بالدفاع عن النفس من خلال تعليمهم الدفاع عن النفس باليدين والارجل.

10. **المهام البيتية:** تقوم الباحثة بالطلب من أفراد المجموعة بالتدرب على وسائل الدفاع التي تم التعلم عليها من خلال الجلسة وذلك من خلال الملاحظات التي تم تسجيلها في الجلسة العلاجية.
11. **الإنهاء:** تطلب الباحثة من أفراد المجموعة باعادة وسائل الدفاع والتكيف التي سمعوها من خلال النقاش بين أفراد المجموعة ويعتقدون أنها قد تكون مفيدة لهم.

الجلسة التاسعة

1. **المدة الزمنية للجلسة: ساعتين وربع**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** تحديد وتوضيح استراتيجيات خفض الغضب والدفاع عن النفس للطفل المعتدى عليه لاضطراب الضغط ما بعد الصدمة وتعليمه اسلوب التكيف الذاتي لما بعد الصدمة
4. **الهدف الفرعي للجلسة:**

- تمكين الاطفال من خفض مستوى الغضب المتعلق بالحدث الصادم.
- الوعي بسيطرة الغضب على المشاعر.
- إيصال معلومات كافية عن وسائل الدفاع والتكيف وكيفية استخدامها
- توضيح أهمية وسائل الدفاع والتكيف في التخفيف أو زيادة حدة الأعراض
- توضيح كيفية استخدام مثل هذه الوسائل في المستقبل إذا ما تم التعرض لأحداث مشابهه.

5. **الإجراء:** تقوم الباحثة في البداية بالطلب من أفراد المجموعة تلخيص ما جرى في الجلسة السابقة، ثم يقوم بطرح معلومات حول وسائل الدفاع والتكيف واليات استخدام هذه الوسائل بطريق انشطة رياضية من خلال توضيح الاساليب الملائمة للدفاع والتكيف الذاتي.
6. **الأنشطة المستخدمة:** استخدام نشاط لعب دور، اعطاء التمارين للاطفال واستخدام انشطة اللعب.
7. **الأدوات:** أوراق، أقلام، بطاقات، حبل.

8. **طريقة التطبيق:**

- يقوم بطرح معلومات حول وسائل الدفاع والتكيف واليات استخدام هذه الوسائل بطريق النشاط باللعب من خلال قيام مجموعتين من الاطفال وتدريبهم على مهارات الدفاع عن النفس ويتم التركيز علي النقاط التالية
  توضيح والتدرب وسائل الدفاع والتكيف الصحية التي ينصح باستخدامها بعد التعرض لحدث صادم.
  توضيح والتدرب وسائل الدفاع والتكيف التي ينهى عن استخدامها بعد التعرض لحدث صادم
  توضيح كيفية توظيف واستخدام وسائل الدفاع والتكيف مما يرفع الثقة لدى الطفل المعتدى عليه وبالتالي رفع كفاءته الذاتية

9. **التكنيك المستخدم:** استخدمت الباحثة تقنية النمذجة الفنية، وتقنية التدريب على حل المشكلات الفنية، وتقنية الحديث الذاتي، وتقنية تمثيل الأدوار الفنية، وتقنية دليل الاختبار الفني وتقوم الباحثة بتعزيز وسائل الدفاع والتكيف الصحية التي ورد ذكرها في الانشطة السابقة والتي يقوم الطفل باستخدامها أو انه قد قام باستخدامها من قبل في أحداث سابقة وضرورة استخدامها إذا واجهته أحداث أخرى بالمستقبل. وبالإضافة إلى أن هذه المعلومات تساعد الطفل في تخفيف حدة الأعراض الناتجة عن تعرضه لأحداث صادمة في الماضي فهي أيضا تحضره لمواجهة أي أحداث سوف يتعرض لها بالمستقبل. ومن ثم قيام الباحثة بتعليم الاطفال مهارات جديدة للدفاع عن النفس من خلال الحبل وتعليمهم حركات جديدة بالايدي مما يساعد الطفل على رفع روحه المعنوية.
10. **المهام البيتية:** توضيح أهم النقاط التي اكتسبها من خلال الانشطة العلاجية. في الجلسة ومراجعه ما تم في الجلسة
11. **الإنهاء:** يطلب الباحثة من أفراد المجموعة باعادة وسائل الدفاع والتكيف التي تدربو عليها من خلال الانشطة العلاجية بين أفراد المجموعة ويعتقدون أنها قد تكون مفيدة لهم.

الجلسة العاشرة

1. **المدة الزمنية للجلسة: ساعة واحدة**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** توضيح اسلوب ومفهوم ادارة الصدمة للطفل المعتدى عليه والخاص باضطراب الضغط مابعد الصدمة.
4. **الهدف الفرعي للجلسة:**
   - التوعية بعناصر الصدمة
   - التوعية بتراكمية الصدمة
   - تعريف الاطفال بوسائل خفض الصدمة.
5. **الإجراء:** تقوم الباحثة بتعليم الاطفال المعتدى عليهم فن ادارة الصدمة ووسائل خفض الصدمة من خلال مجموعة من الانشطة البدنية والفكرية لتحفيزهم واكسابهم التطيف الذاتي.
6. **الأنشطة المستخدمة:** استخدام نشاط اللعب، استخدام نشاط لعب الأدوار، اعطاء التمرين.
7. **الأدوات:** أوراق، أقلام، رسومات، بطاقات.
8. **طريقة التطبيق:**

- تقوم الباحثة بالطلب من أفراد المجموعة تلخيص ما جرى في الجلسة السابقة، ثم يقوم بتوضيح الانشطة الفكرية الخاصة بادارة الضغط، ووسائل خفض الصدمة. وذلك من خلال عرض التأثيرات قصيرة الأمد والمتوسطة وطويلة الأمد للضغط، وما هي التأثيرات الجسدية والسلوكية والنفسية والوجدانية والمعرفية للضغط واضطرابات الصدمة ما بعد الصدمة والتكيف الذاتي لها، شرح الأعراض التي يمكن أن يخبروها الأطفال حسب مرحلتهم العمرية و كيف يمكن أن تؤثر الصدمة على تطورهم المعرفي والسلوكي، شرح ما هي التغيرات السلوكية التي يشعر بها الأطفال بعد تعرضهم للأحداث الصادمة، وكيف يمكنهم التعرف على هذه التغيرات في السلوك، الحديث عن الضغوط النفسية التي يمكن أن تنتج جراء التعرض لأحداث صادمة، وما هي أعراض هذه الأمراض وكذلك أعراض اضطراب ما بعد الصدمة وكيف يمكن لأفراد المجموعة التعرف على هذه الأعراض، شرح الآثار التي ممكن أن تخلفها الصدمة النفسية على الشخصية وعلى النظام القيمي عند الطفل وعلى ثقته بالآخرين ونظرته لنفسه وللمستقبل، شرح أعراض الضغوط التي تنشأ من مشكلات الحياة اليومية وكيف يمكنهم التفريق بين أعراض الضغوط التي تخلفها الحياة اليومية وأعراض الضغوط التي يخلفها التعرض لصدمة نفسية.

9. **التكنيك المستخدم:** تقنية تمثيل الأدوار الفنية، تقنية دليل الاختبار الفني، تقنية التعرف على أساليب التفكير الخاطئ وغير الفعال، تقنية الإلهاء الفني ويكون دور الباحثة هنا بأن تدرب الأطفال المعتدى عليهم اساليب التعامل مع ادارة الضغط من خلال النشاط الفكري والنشاط البدني للتعامل مع ادارة الضغط واكساب الطفل المعتدى عليه التكيف الذاتي من خلال العاب رياضية تعمل على تفريغ طاقات الطفل المعتدى عليه وقيامه بالركض والقفز في مكانه مما يجعله سعيد وذو طاقة ايجابية عاليه.
10. **المهام البيتية:** تقوم الباحثة بالطلب من أفراد المجموعة بالتدرب في المنزل على الاساليب الفكرية للتعامل مع ادارة الصدمة.
11. **الإنهاء:** أتاح الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم حول البرنـامج عامة وما دار في الجلسة خاصةً واعطائهم الوقت الكافي للتعبير عن مشاعرهم حول الجلسة، ومن ثم قدم الباحثة الشكر والتقدير للاطفال المعتدى عليهم المشاركين.

الجلسة الحادية عشر

1. **المدة الزمنية للجلسة: ساعتين**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** توضيح اسلوب ومفهوم ادارة الصدمة للطفل المعتدى عليه والخاص باضطراب الصدمة مابعد الصدمة وتحديد وسائل واسلوب التكيف الذاتي
4. **الهدف الفرعي للجلسة:**
   - التوعية بعناصر الصدمة
   - التوعية بتراكمية الصدمة
   - تعريف الاطفال بوسائل خفض الصدمة.
5. **الإجراء:** تقوم الباحثة بتعليم الاطفال المعتدى عليهم فن ادارة الضغط ووسائل خفض الضغط من خلال مجموعة من الانشطة البدنية والفكرية لتحفيزهم واكسابهم التطيف الذاتي.
6. **الأنشطة المستخدمة:** استخدام نشاط اللعب، استخدام نشاط لعب الأدوار، اعطاء التمرين.
7. **الأدوات:** أوراق، أقلام، رسومات، بطاقات.
8. **طريقة التطبيق:**

- تقوم الباحثة بالطلب من أفراد المجموعة تلخيص ما جرى في الجلسة السابقة، ثم يقوم بتوضيح الانشطة الفكرية الخاصة بادارة الضغط، ووسائل خفض الضغط. وذلك من خلال عرض التأثيرات قصيرة الأمد والمتوسطة وطويلة الأمد للضغط، وما هي التأثيرات الجسدية والسلوكية والنفسية والوجدانية والمعرفية للضغط واضطرابات الضغط ما بعد الصدمة والتكيف الذاتي لها، شرح الأعراض التي يمكن أن يخبروها الأطفال حسب مرحلتهم العمرية و كيف يمكن أن تؤثر الصدمة على تطورهم المعرفي والسلوكي، شرح ما هي التغيرات السلوكية التي يشعر بها الأطفال بعد تعرضهم للأحداث الصادمة، وكيف يمكنهم التعرف على هذه التغيرات في السلوك، الحديث عن الضغوط النفسية التي يمكن أن تنتج جراء التعرض لأحداث صادمة، وما هي أعراض هذه الأمراض وكذلك أعراض اضطراب ما بعد الصدمة وكيف يمكن لأفراد المجموعة التعرف على هذه الأعراض، شرح الآثار التي ممكن أن تخلفها الصدمة النفسية على الشخصية وعلى النظام القيمي عند الطفل وعلى ثقته بالآخرين ونظرته لنفسه وللمستقبل، شرح أعراض الضغوط التي تنشأ من مشكلات الحياة اليومية وكيف يمكنهم التفريق بين أعراض الضغوط التي تخلفها الحياة اليومية وأعراض الضغوط التي يخلفها التعرض لصدمة نفسية.

9. **التكنيك المستخدم:** تقنية تمثيل الأدوار الفنية، تقنية دليل الاختبار الفني، تقنية التعرف على أساليب التفكير الخاطئ وغير الفعال، تقنية الإلهاء الفني، يكون دور الباحثة هنا بأن تدرب الأطفال المعتدى عليهم اساليب التعامل مع ادارة الضغط من خلال النشاط الفكري والنشاط البدني للتعامل مع ادارة الضغط واكساب الطفل المعتدى عليه التكيف الذاتي من خلال العاب رياضية تعمل على تفريغ طاقات الطفل المعتدى عليه وقيامه بالركض والقفز في مكانه مما يجعله سعيد وذو طاقة ايجابية عاليه.

10. **المهام البيتية:** تقوم الباحثة بالطلب من أفراد المجموعة بالتدرب في المنزل على الاساليب الفكرية للتعامل مع ادارة الصدمة
11. **الإنهاء:** أتاح الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم حول البرنـامج عامة وما دار في الجلسة خاصةً واعطائهم الوقت الكافي للتعبير عن مشاعرهم حول الجلسة، ومن ثم قدم الباحثة الشكر والتقدير للاطفال المعتدى عليهم المشاركين

الجلسة الثانية عشر

1. **المدة الزمنية للجلسة: ساعة**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** توضيح اسلوب الاسترخاء العضلي للتخفيف على الطفل المعتدى عليه باضطراب الضغط مابعد الصدمة واسلوب التكيف الذاتي الخاصة به
4. **الهدف الفرعي للجلسة:**
   - التدريب على استرخاء العضلات.
   - التدريب على تخفيف الضغط والتوتر
5. **الإجراء:** تقوم الباحثة بعمل بعض التمارين للاحماء للاطفال وذلك لتخفيف الضغط النفسي لدى الاطفال المعتدى عليهم مثل تمارين القفز في المكان نفسه ومن ثم جعلهم يركضون حول الغرفة لعدة مرات والذي بدوره يعمل على تجفيز الدورة الدموية.
6. **الأنشطة المستخدمة:** شريط فيديو، اعطاء التمرين، اللعب، القيام بانشطة رياضية مختلفة، استخدام نشاط اللعب
7. **الأدوات:** أوراق، أقلام، بطاقات، حبل، اثقال خفيفة الوزن.
8. **طريقة التطبيق:**
   - تدريب الاطفال على التنفس العميق والذي يعد من أسهل طرق السيطرة التي يمكن تعلمها. وعلى الرغم من أن الأمر يبدو غريبا، إلا أن العديد من الأشخاص لا يعلمون كيفية التنفس الصحيحة. فالتنفس يشمل الحجاب الحاجز، كما أن البطن يجب أن يتوسع أثناء الشهيق. أما عند الزفير، فيجب أن يهبط البطن.
   - تعليم الاطفال استرخاء العضلات التدريجي والذي يعد استخدام أساليب الاسترخاء أسلوبا فعالا للتخفيف من الضغط النفسي والقلق. ويركز أسلوب استرخاء العضلات التدريجي على انتقال الشخص من توتر إلى إرخاء مجموعات معينة من العضلات في الجسم. فالشخص يقوم بشد مجموعة من عضلاته ثم يرخيها، وبذلك يتعلم الجسم مع الوقت كيف يتعامل مع شد العضلات.
9. **التكنيك المستخدم:** تقنية التعرف الآلي على الأفكار والعمل على تصحيحها، تقنية المراقبة الذاتية، تقنية التعرض، تقنية فن التخيل، تقنية الواجب المنزلي الفني، وتمارين العضلات المختلفة والتي تساعد الاطفال على الاسترخاء والتنفس بشكل مريح من خلال رفع الاثقال خفيفة الوزن لعدة مرات، ومن ثم ربط الحبل بين طفلين وتعليمهم كيفية التدريب من خلال الربط بالحبل في الارجل.

10. **المهام البيتية:** القيام بالتدريبات البدنية في المنزل والقيام بالاحماء في الصباح والمساء للعضلات والذي يساعد على الاسترخاء
11. **الإنهاء:** أتاحت الباحثة الفرصة للأطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم حول البرنـامج عامة وما دار في الجلسة خاصة.

الجلسة الثالثة عشر

1. **المدة الزمنية للجلسة: ساعة**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** تعليم الطفل المعتدى عليه آلية الاسترخاء العضلي للجسم والتركيز على الاسترخاء العصبي والفكري
4. **الهدف الفرعي للجلسة:**
   - التدريب على استرخاء الاعصاب.
   - التدريب على تخفيف الصدمة والتوتر
5. **الإجراء:** تقوم الباحثة بعمل بعض التمارين للاحماء للاطفال وذلك لتخفيف الضغط النفسي لدى الاطفال المعتدى عليهم.
6. **الأنشطة المستخدمة:** استخدام نشاط الالهاء، استخدام نشاط اللعب.
7. **الأدوات:** أوراق، أقلام، اثقال، حبل، بطاقات.
8. **طريقة التطبيق:**
   - تقوم الباحثة باجلاس الطفل في مكان هادئ ومسترخيا تماماً لمدة عشر دقائق، ثم يطلب منه الإصغاء الى شريط مسجل عليه خطوات البرنامج بالاسترخاء بصوت الباحثة نفسه، حيث طلب منهم تأدية كافة الخطوات المسجلة على الكاسيت للعشرين دقيقة المتبقية من زمن الجلسة التي استغرقت مدة (30) دقيقة.
   - بعد الانتهاء من كل جلسة، طلب من المشاركين أن يصفوا شعورهم وحالتهم النفسية، وسجل هذا الوصف في ورقة منفصلة خاصة بكل مشارك في البرنامج.
   - استخدام اسلوب التهدئة الذاتية للطفل من خلال الجلوس والتامل والذي بدوره يعمل على تخفيف الصدمة لدى الطفل
9. **التكنيك المستخدم:** تقنية التعرف الآلي على الأفكار والعمل على تصحيحها، تقنية المراقبة الذاتية، تقنية الالهاء، ومن ثم جعل الاطفال القيام بمجموعة من الرياضة المختلفة بهدف التفريغ النفسي لهم وتعزيز الروح الايجابية لديهم.
10. **المهام البيتية:** طلب من المشاركين بعد الانتهاء من تنفيذ الجلسة العلاجية، ان يعيد في بيته ما أجري له مرتين في اليوم صباحاً ومساء.
11. **الإنهاء:** أتاحت الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم حول البرنـامج عامة وما دار في الجلسة خاصةً.

الجلسة الرابعة عشر

1. **المدة الزمنية للجلسة: ساعتين**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** تعليم الطفل التفريغ الإنفعالي للأطفال المعتدى عليهم باضطراب الضغط ما بعد الصدمة.
4. **الهدف الفرعي للجلسة:** الكشف عن المشاعر المؤلمة المتعلقة بالحدث الصادم والتعرف على تفاصيل الحادث الذي وقع على الطفل المعتدى عليه.
5. **الإجراء:** قياس مدى فعالية التفريغ الانفعالي في التخفيف من حدة الصدمات النفسية ومعرفة مدى ملائمة هذا الأسلوب، من خلال المشاركة في الاحداث والمشاعر بين الاطفال ومن خلال قيام الطفل برسم التجربة التي حصلت معه على ورقة وكتابة انفعالاته على الورقة
6. **الأنشطة المستخدمة:** استخدام نشاط اللعب للاطفال المعتدى عليهم، استخدام نشاط لعب الادوار.
7. **الأدوات:** أوراق، أقلام تلوين، بطاقات.
8. **طريقة التطبيق:**

- إعطاء فرصة للتنفيس عن المشاعر: إخراج المشاعر المتعلقة بالخبرات الصادمة والناتجة عنها بطريقة مهنية، موجهة، مدروسة، وفي بيئة آمنة
- إعطاء الفرصة للتعبير عن الحدث الصادم بالكلمات: باستخدام هذه التقنية يتم إخراج الحدث الصادم من صورة الذكريات المرعبة إلى كلمات يشارك فيها الشخص المجموعة
- دعم المجموعة: الدعم النفسي الذي تقدمه المجموعة عن طريق المشاطرة بالمشاعر ونقل الخبرات والمعلومات بطريقة صحية وموجهة وتقوية الجوانب الضعيفة عند الشخص وإعطاء نماذج صحيحة من السلوكيات المساعدة في مواجهة الخبرات الصادمة، وخلق جو من الأمل.

9. **التكنيك المستخدم:** تقنية التعرف الآلي على الأفكار والعمل على تصحيحها، تقنية المراقبة الذاتية، تقنية النشاط الحركي، وهذا التعليم يكون من نفس المجموعة وأيضا من الباحثة القائمه بتنفيذ البرنامج، وتكون التوعية غالبا في طبيعة الصدمة النفسية وأعراضها وأفضل الطرق للتكيف مع الأحداث الضاغطة.
10. **المهام البيتية:** قيام الطفل بالتدريب على التفريغ الانفعالي حسب ما ورد في الجلسة الخاصة بها
11. **الإنهاء:** أتاحت الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم حول البرنامج عامة وما دار في الجلسة خاصةً.

الجلسة الخامسة عشر

1. **المدة الزمنية للجلسة: ساعتين**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** تحديد طريقة التعريض لدى الاطفال المعتدى عليهم باضطراب الضغط ما بعد الصدمة ومساعدتهم بالتفكير بايجاد حل للمشكلات.
4. **الهدف الفرعي للجلسة:**
   - مساعدة الاطفال في تبني فكرة ان التجنب والهرب من الموقف المؤلم ليس الحل
   - التفكير بايجاد حل للمشكلات.
   - التوصل الى حلول ايجابية لدى الطفل المعتدى عليه
5. **الإجراء:** تعريض الطفل الى حدث مماثل من خلال اساليب القصص واسلوب التمثيل واللعب حيث تقوم الباحثة بجعل الاطفال يروون الاحداث التي حدثت معهم وقيام الاطفال بعد ذلك بالاسترخاء لاكتساب طاقة ايجابية والتركيز على استرجاع الاحداث
6. **الأنشطة المستخدمة:** نشاط اللعب، اللعب بالادوار التنشيط السلوكي، ونشاط الدعم الاجتماعي.
7. **الأدوات:** أوراق، أقلام، بطاقات، ألوان.
8. **طريقة التطبيق:**
   - ان نعرض الاطفال للحدث الراض من خلال تقنيات التخيل أو اعادة التجربة بشكل حي، وهذا التعريض يجب أن يكون إما
     1- شديد: كطريقة العلاج التفجيرية أو ما يسمى بالاغراق.
     2- تدريجي: كطريقة ازالة الحساسية المنظمة.
     3- أن نعلم المرضى طرق تدبير الشدة عن طريق
     4- تقنيات الاسترخاء.
     5- تطبيق النموذج الاستعرافي للتعامل مع الشدة.
   - التعرض الشديد للحدث (الطريقة العلاجية): إن هذه الطريقة مفيدة في معالجة اضطراب ما بعد الصدمة وخاصة في الشكل المزمن منه، فالمريض يعيش التجربة من جديد ولكن في مكان آمن (غرفة المعالج) الأمر الذي يساعده على تحمل الضغط، ويطبق الاغراق عادة عن طريق التخيل السار أو المؤلم مترافقاً مع الاسترخاء، ولكن من الأفضل عدم تطبيق هذه الطريقة لمن يعانون من آفات قلبية.
9. **التكنيك المستخدم:** تقنية الحديث الذاتي، تقنية تمثيل الأدوار الفنية، تقنية دليل الاختبار الفني، تقنية التعرف على أساليب التفكير الخاطئ وغير الفعال، تقنية الإلهاء الفني، إعلام المريض بأنه سيتعرض لخبرات مؤلمة تعود به إلى الصدمة السابقة ولكن ذلك سيكون مفيداً له. تأمين الظروف الفيزيائية الملائمة: غرفة هادئة وآمنة وكرسي مريح يجلس يجلس عليه المريض ويجب ان يكون المعالج مزوداً بساعة وبجهاز لقياس نبضات القلب وأيضاً ان يقوم بتسجيل نسبة القلق خلال الجلسة

10. **المهام البيتية:** قيام الطفل بالتدريب على التعريض حسب ما ورد في الجلسة الخاصة بها
11. **الإنهاء:** أتاح الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم حول البرنـامج عامة وما دار في الجلسة خاصة.

الجلسة السادسة عشر

1. **المدة الزمنية للجلسة: ساعة**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** تعريف الطفل مفهوم التعريض لاضطراب الضغط مابعد الصدمة لدى الطفل المعتدى عليه ومحاولة التعامل مع الحدث
4. **الهدف الفرعي للجلسة:**
   - مساعدة الاطفال في تبني فكرة ان التجنب والهرب من الموقف المؤلم ليس الحل
   - التفكير بايجاد حل للمشكلات.
5. **الإجراء:** تحفيز الطفل المعتدى عليه من خلال اساليب القصص واللعب والتمثيل ومحاولة اخراج ذكريات الطفل الخاصة بالحادث لكي يتفاعل معه ويحاول التغلب عليه من خلال تحويل فكرة الحدث الى تجربة سابقة لن تتكرر من خلال مساعدة زملائه الاطفال في الجلسة باسلوب تعاوني بين الجميع للخروج من هذه الازمة لدى الاطفال المعتدى عليهم.
6. **الأنشطة المستخدمة:** أشكال توضيحية، نشاط لعب الأدوار الفنية، نشاط فن الخيال، التمارين الجسدية.
7. **الأدوات:** أوراق، أقلام، بطاقات، حبل، عصا.
8. **طريقة التطبيق:**

- التعريض التدريجي للحدث أو (خفض الحساسية المنظم): تقتضي هذه الطريقة تعريض المريض للمنبه المؤلم لكن بصورة تدريجية وليس دفعة واحدة كما في الاغراق، وتشيع استخدام هذه الطريقة لدى حالات اضطراب الضغوط التالية للصدمات التي تعاني من الكوابيس والخوف والقلق، ويصف شيلدر الأحلام المزعجة التي كانت تراود المحاربين القدامى في الفيتنام بأنها استعادة حية للخبرات الصدمية ويقوم الطور الأول في العلاج على تعليم الفرد اساليب الاسترخاء والتدريب على التخيل الساريلي ذلك سبع مراحل متدرجة هرمياص تستند إلى التدرج الزمني للأحداث وصولاً إلى الصدمة مثلاً مشاهدة زميل له انفجر فيه لغم أرضي، وبناء على هذا الأسلوب يطلب إلى الحالة الاسترخاء، ثم التخيل ثم الاسترخاء ثم ايقاف التخيل ثم الاسترخاء وهكذا حتى يتم التعلم بعد الممارسة المتكررة أن يسترخي المريض مع تصور تلك الحلام وفقاً لتدرج المنبهات التي تستدعي القلق أي يتم الربط بين الاسترخاء الذي هو خبرة تبعث على الاثابة في مقابل الخبرة المؤلمة للقلق وتدريجياً يحل الاسترخاء مكان القلق.

9. **التكنيك المستخدم:** تقنية الحديث الذاتي، تقنية تمثيل الأدوار الفنية، تقنية دليل الاختبار الفني، تقنية التعرف على أساليب التفكير الخاطئ وغير الفعال، تقنية الإلهاء الفني، تدريب الاطفال على خفض الحساسية المنظم في

مواقف فعلية حية ويمارس طرق الاسترخاء في كل مرة ثم شجع على ذلك فيما بعد وذلك باستخدام شرائط تسجيلية لهذه الأصوات والاصغاء إليها في المنزل مع استخدام الاسترخاء أيضاً، وجعل الاطفال يقومون بالقفز واللعب وذلك للتفريغ عن الطاقات السلبية لديه وبث روح الايجابية لدى الاطفال

10. **المهام البيتية:** قيام الطفل بالتدريب على التعريض حسب ما ورد في الجلسة الخاصة بها
11. **الإنهاء:** أتاح الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم حول البرنـامج عامة وما دار في الجلسة خاصةً، ومن ثم قدم الباحثة الشكر والتقدير للاطفال المعتدى عليهم المشاركين.

الجلسة السابعة عشر

1. **المدة الزمنية للجلسة: 3 ساعات**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** توضيح مفهوم العجز المتعلم وتمكين الطفل المعتدى عليه من كيفية التغلب على العجز.
4. **الهدف الفرعي للجلسة:**
   - تحديد مسؤولية الحدث الصادم.
   - خفض مشاعر الالم المرتبط بالحدث.
   - التمييز بين السلوك العدواني والسلوك المؤكد.
5. **الإجراء:** تقوم الباحثة بتعليم الاطفال المعتدى عليهم مسؤولية الحدث الصادم من خلال لعب الدور والقيام بانشطة خاص بذلك، من خلال اللعب وتمثيل الادوار والركض والقفز وتقسيم الاطفال الى مجموعات واللعب فيما بينهم بالحبل والقفز من خلال الحبل والقيام ببعض التمارين الرياضية.
6. **الأنشطة المستخدمة**: لعب دور، نشاط التثميل ولعب الادوار، نشاط التحفيز الايجابي، نشاط القفز، ونشاط الرسم.
7. **الأدوات:** أوراق، أقلام تلوين، حبل، اوزان، عصا
8. **طريقة التطبيق:**

- شرح الأعراض التي يمكن أن يخبروها الأطفال حسب مرحلتهم العمرية وكيف يمكن أن تؤثر الصدمة على تطورهم المعرفي والسلوكي
- شرح ما هي التغيرات السلوكية التي يشعر بها الأطفال بعد تعرضهم للأحداث الصادمة، وكيف يمكنهم التعرف على هذه التغيرات في السلوك
- الحديث عن الأمراض النفسية التي يمكن أن تنتج جراء التعرض لأحداث صادمة، وما هي أعراض هذه الأمراض وكذلك أعراض اضطراب ما بعد الصدمة وكيف يمكن لأفراد المجموعة التعرف على هذه الأعراض

- شرح الآثار التي ممكن أن تخلفها الصدمة النفسية على الشخصية وعلى النظام القيمي عند الطفل وعلى ثقته بالآخرين ونظرته لنفسه وللمستقبل.
- شرح أعراض الضغوط التي تنشأ من مشكلات الحياة اليومية وكيف يمكنهم التفريق بين أعراض الضغوط التي تخلفها الحياة اليومية وأعراض الضغوط التي يخلفها التعرض لصدمة نفسية.

9. **التكنيك المستخدم:** تقنية التعرف الآلي على الأفكار والعمل على تصحيحها، تقنية المراقبة الذاتية، تقنية التعرض، تقنية فن التخيل، تقنية الواجب المنزلي الفني، تقنية النمذجة الفنية، تقنية التدريب على حل المشكلات الفنية، تقنية الحديث الذاتي، تقنية تمثيل الأدوار الفنية، تقنية دليل الاختبار الفني، تقنية التعرف على أساليب التفكير الخاطئ وغير الفعال، تقنية الإلهاء الفني: يكون دور الباحثة هنا بأن يدرب الأطفال المعتدى عليهم ويناقش جميع الاساليب والطرق المستخدمة في النشاط الخاص بهذه الجلسة. ومحاولة تعزيز روح الايجابية لدى الاطفال من خلال اللعب والركض والقيام بمهارات رياضية مختلفة ترفع من روحه العنوية وتزيز طاقاته الايجابية
10. **المهام البيتية:** قيام الطفل بالتدريب على كيفية التغلب على عجز المتعلم حسب ما ورد في الجلسة الخاصة بها
11. **الإنهاء:** أتاح الباحثة الفرصة للاطفال المعتدى عليهم لتوجيه تساؤلاتهم واستفساراتهم والتعبير عن مشاعرهم حول البرنـامج عامة وما دار في الجلسة خاصة.

الجلسة الثامنة عشر

1. **المدة الزمنية للجلسة: ساعتين**
2. **عدد الأطفال المشاركين: 15 طفل**
3. **الهدف الرئيسي للجلسة:** تقييم البرنامج
4. **الهدف الفرعي للجلسة:**
   - اختتام البرنامج
   - التعرف على تقييم أفراد المجموعة للبرنامج
   - القيام بالقياس البعدي للبرنامج.
5. **الإجراء:** في هذه المرحلة يقوم الباحثة بإنهاء كل المواضيع التي تم التطرق إليها أثناء الجلسات التفريغ النفسي
6. **الأنشطة المستخدمة**: نقاش وحوار
7. **الأدوات:** أوراق، أقلام، الواجب البيتي، ورق بريستول، ورق ملون صغير، اقلام فلوماستر
8. **طريقة التطبيق:**

- في هذه المرحلة يقوم الباحثة بإنهاء كل المواضيع التي تم التطرق إليها أثناء جلسات التفريغ النفسي. ذلك لخلق جو إيجابي للمستقبل، واستقبال أي ملاحظات أو اقتراحـات علي البرنامج من قبل أفراد المجموعة. ويتم في هذه المرحلة

الثناء علي الاطفال أفراد المجموعة واستمرار يتهم في الالتزام بالجلسات

السؤال عن أي نقطة لم يكتمل النقـاش فيهـا أو أي استفسار يرغـب أفـراد المجموعة بطرحه

إعادة تذكيرهم بضرورة المحافظة علي السرية

استقبال ملاحظاتهم وتقييمهم علي خطوات وتقنيات البرنامج العلاجي، عـن طريق سؤالهم عن النقاط التي لم تكن مريحة لهم في البرنامج أو عن التي كانت غامضة بالنسبة لهم، وهل كان ملبيا لتوقعاتهم أم لا.

توزيع استمارات القياس البعدي التي تكون محضرة سلفا من قبل الباحثه

الاتفاق علي طريقة للتواصل بعد انتهاء البرنامج.

9. **التكنيك المستخدم:** تقنية التعرف الآلي على الأفكار والعمل على تصحيحها، تقنية المراقبة الذاتية، تقنية التعرض، تقنية فن التخيل، تقنية الواجب المنزلي الفني، تقنية النمذجة الفنية
10. **المهام البيتية:** مراجعة ما تم اخذه في الجلسات السابقة
11. **الإنهاء:** تشكر الباحثة الاطفال على المشاركة الفعالة. ويتم تطبيق الاستبانتين في نهاية الجلسة (المقياس البعدي لاضطراب ما بعد الصدمة والكفاءة الذاتية للأطفال).

رقم الجلسة	المدة الزمنية للجلسة	الهدف الرئيسي والفرعي	الأدوات	الإجراءات	الأنشطة الملائمة	الوظائف البيتية
الجلسة الأولى	**ساعتين**	التعرف على أفراد المجموعة، وإتاحة الفرصة لأفراد المجموعة التعرف علـى بعضهم البعض خلق جو من الثقة ما بين الباحثة وأفراد المجموعة وتخفيف حدة القلق. اعطاء أفراد المجموعة فكرة كاملة عن البرنامج وأهمية البحث. وضع القواعد الأساسية التي سوف يتم إتباعها أثناء عملية التفريغ. التعرف على توقعات أفراد المجموعة من البرنامج المقترح	قنينة فارغة، بطاقات عليها اسماء الاطفال في الجلسة	استخدمت الباحثة أسلوب التفاعل مع الاطفال المعتدى عليهم وطريقة العصف الذهني من خلال أنشطة خاصة بالاطفال المعتدى عليهم ومحاولة التودد اليهم وكسر الجليد بينها وبين الاطفال المعتدى عليهم.	تم اعطاء التعليمات للاطفال المعتدى عليهم بطبيعة الجلسة وما هي فوائدها من خلال بطاقات تم توزيعها عليهم حيث حصل كل طفل على بطاقة خاصة به مكتوب عليها اسمه للتعرف عليه، وتم استخدام طريقة المناقشة الجماعية لدى الاطفال المعتدى عليهم، واستخدام اسلوب اللعب عن طريقة اللعب بالقنينة الدوارة وعند وقوف القنينة عند الطفل يتحدث عن تجربته امام الجميع حيث تم استخدام نشاط اللعب للاطفال لكسر حاجز الخجل لدى الاطفال المعتدى عليهم.	تمارين الاسترخاء
الجلسة الثانية	**ساعتين ونصف**	تعريف اضطرابات ما بعد الصدمة تعريف الاطفال المعتدى عليهم بطبيعة العلاج المعرفي للصدمة الذي يركز على ان الاحداث التي وقعت لا تتغيير ولكن نستطيع تغيير تفسير ماحدث. التعريف بمحتويات البرنامج العلاجي الخاص بالاطفال المعتدى عليهم واسلوب التكيف الذاتي لدى الاطفال	أوراق بيضاء، بطاقات، أقلام تلوين، ورق ملون صغير	تقوم الباحثة في البداية بمراجعة ما جرى في الجلسة السابقة ومشاركة الاطفال بمجموعة من الاسئلة تطرحها عليهم ومن ثم تدخل في الجلسة من خلال التوزيع على الاطفال اوراق واقلام ملونة لكي يقوم الطفل المعتدى عليهم بالرسم على تلك الاوراق والتلوين وذلك بهدف التخفيف النفسي عن الطفل المعتدى عليه وتفريغ طاقاته الايجابية وتغيير النمط الفكري لدى الطفل المعتدى عليه	تم استخدام نشاط الرسم للاطفال، واستخدام نشاط التلوين على الاوراق التي تم توزيعها في الجلسة واستخدام نشاط الحوار مع الاطفال، وتم عمل نشاط من خلال تقسيم الاطفال الى مجموعات عمل مع الطلاب وتقسيمهم الى مجموعات، عصف الأفكار من خلال أنشطة يقوم بها الأطفال المعتدى عليهم باشراف الباحثة	تطلب الباحثة من كل طفل القيام بتوضيح الأحداث الصادمة التي مر بها وما تـزال تتردد على ذاكرته. ثم بعد ذلك يقوم بتوضيح الاستجابات التي قام بها بعد وقوع الحدث مباشرة، ثم الاستجابات التي يقوم بها عند تذكره للحدث في الوقت الراهن
الجلسة الثالثة	**ساعة واحدة**	تحديد الأفكار والمشاعر المتعلقة باضطراب ضغط مابعد الصدمة وتعليمهم اسلوب التكيف الذاتي. تعرف أعراض اضطراب ضغط مابعد الصدمة، حيث وضعت الاعراض ضمن أربعة أصناف: اعراض اعادة التعرض للحدث الصادم، اعراض التجنب،	أوراق، أقلام تلوين، بطاقات	تقوم الباحثة في البداية باحصاء الاطفال المعتدى عليهم في الجلسة والتاكد من اكتمال عددهم، ثم تقوم الباحثة بتهيئة الاطفال بشكل نفسي للجلسة من خلال التمهيد بموضوع الجلسة واعطائهم نبذة صغيرة عن موضوع الجلسة، ومن ثم تقوم ببدأ الجلسة من خلال العاب تقوم	استخدام نشاط التعزيز الايجابي للاطفال، تم استخدام نشاط التغذية الراجعة من الاطفال المعتدى عليهم توزيع بطاقات صغيرة للاطفال، واستخدام نشاط تمثيل الادوار للاطفال المعتدى عليهم	يطلب الباحثة من كل طفل القيام بتسجيل ما يفكرون به عندما تنتابهم مشاعر مؤلمة، وما هي الانطباعات الحسية (ذاكرة الحواس) التي ما تزال تهاجمهم دائما، بعد ذلك يطلب الباحثة من أفراد

		أعراض فقدان الإهتمام، أعراض الاستثارة. استيعاب ان الأعراض هي ردود فعل طبيعية تجاه الضغط النفسي الشديد. تصحيح الأفكار السلبية المتعلقة بالحدث. تفعيل دعم المجموعة رفع الكفاءة الذاتية لدى الطفل المعتدى عليه.		بها مع الاطفال المعتدى عليهم ومجموعة من النشاطات		المجموعة القيام بالتمرين التالي: أن يقوموا باستحضار الصور المتعلقة باضطرابات ضغط مابعد الصدمة ، ويتخيلوا أن هذه الصور تعرض أمامهم على شاشة كبيرة، وهم يمسكون بجهاز التحكم عن بعد، وعندما يصل عرض هذه الصور إلى حد مزعج أن يقوموا بإيقاف العرض عن طريق جهاز التحكم عن بعد الموجود لديهم. وأن يعيدوا هذا التمرين يومياً أكثر من مرة.
الجلسة الرابعة	**ساعة وربع**	التعرف على آلية التفريغ الإنفعالي للطفل المعتدى عليه والتعرف على طريقة التعامل مع التفريغ الإنفعالي استخراج المشاعر المؤلمة المتعلقة بالحدث الصادم للطفل المعتدى عليه ومعالجته	أوراق، أقلام، بطاقات	توجيه الطفل المعتدى عليه للقيام بامور ايجابية تساعده على المضي قدماً ورفع روحه المعنوية وكفاءته الذاتية من خلال تعليمه اساليب التكيف الذاتي مع الحدث وتعزيز الروح الايجابية لدى الطفل المعتدى عليه وترسيخ فكرة ان الذي حدث عبارة عن تجربة قد مضت وجعل الطفل المعتدى عليه القيام بتدوين افكاره في بطاقات قامت الباحثة بتوزيعها على الاطفال المعتدى عليهم.	الحوار مع الاطفال المعتدى عليهم، استخدام بطاقات صغيرة، استخدام اسلوب لعب الادوار بين الاطفال المعتدى عليهم في الجلسة الحالية	قيام الطفل بالتدريب على التفريغ الانفعالي من خلال واجب بيتي تقوم الباحثة باعطاءه للاطفال المعتدى عليهم
الجلسة الخامسة	**ساعة ونصف**	كيف يتم تعلم اضطراب ضغط ما بعد الصدمة توضيح العلاقة بين سؤال لماذا والشعور بالذنب توضيح العلاقة بين سؤال لماذا والشعور بالعجز ملاحظة الافكار اللاعقلانية التي تتعلق بالاجابة على اسئلة لماذا.	أوراق، أقلام تلوين، بطاقات صغيرة	قيام الباحثة في البداية باحصاء الموجودين بالجلسة العلاجية، ثم تقوم بالطلب من المجموعة تقييم الحدث ومدى خطورته وتهديده لهم عن طريق طرح بعض الأسئلة وفتح المجال أمام المجموعة للحديث عن تجاربهم الخاصة	استخدام نشاط التنشيط السلوكي، واستخدام نشاط الالهاء، واستخدام نشاط لعب الأدوار، واستخدام نشاط الرسم للاطفال الذي يساعدهم على الالهاء والتفريغ عن مشاعرهم.	تطلب الباحثة من أفراد المجموعة بواجب بيتي من خلال اعطائهم واجب تعلم الاسترخاء العصبي

		تعديل الصورة المشوهة التي قد تكون موجودة عن اضطرابات ضغط مابعد الصدمة توضيح المعاني الإيجابية لاضطرابات ضغط مابعد الصدمة تحويل الحدث الصادم من حدث استثنائي إلى خبرة يمكن إدراجها ضمن خبرات الحياة				
الجلسة السادسة	**ساعتين**	توضيح الحديث الذاتي السلبي وعلاجه لدى الأطفال المعتدى عليهم لاضطراب الضغط ما بعد الصدمة وتعريفهم باسلوب التكيف الذاتي الخاص به تعريف الاطفال كيف يتم تعلم اضطراب مابعد الصدمة فهم حقيقة ان الهرب والتجنب يعطي شعور بالارتياح المؤقت لانه يأتي مباشرة بعد الالم كيفية العلاج بالدعم النفسي للطفل المعتدى عليه. تعزيز الجوانب الايجابية عند أفراد المجموعة.	أوراق، أقلام، كرات كرستالية ملونة، بالونات ملونة.	تقوم الباحثة في بداية الجلسة بالطلب من أفراد المجموعة تلخيص ما جرى في الجلسة السابقة، ثم تقوم بتوضيح دور العوامل الايجابية كعامل وقاية لدى الطفل المعتدى عليه وذلك من خلال تعزيز الروح الايجابية لدى الطفل حيث تقوم الباحثة بتوزيع البالونات الملونه للاطفال وجعلهم يختارون اللون المفضل لديهم، وتوزيع كرات كرستالية جميلة لرفع الروح المعنوية لدى الاطفال	اعطاء التمرين، اللعب بالكرات الكرستالية، اللعب بالبالونات، الرسم على البطاقات.	تقوم الباحثة بالطلب من أفراد المجموعة القيام بتسجيل كل المعلومات الجديدة التي اكتسبوها في التخفيف من أثار الخبرات الصادمة في نفس الكراسة التي يسجلون فيها الواجب البيتي
الجلسة السابعة	**ساعة**	علاج الحديث الذاتي السلبي لدى الأطفال المعتدى عليهم والتكيف الذاتي الخاص به تعريف الاطفال كيف يتم علاج الحديث الذاتي السلبي كيفية العلاج بالدعم النفسي للطفل المعتدى عليه من الحديث الذاتي السلبي	أوراق، أقلام، كرات كرستالية ملونة، بالونات ملونة	تقوم الباحثة بتوضيح دور العوامل الايجابية كعامل وقاية لدى الطفل المعتدى عليه والتعريف بفائدته وكيفية الابتعاد عن الحديث السلبي الذاتي وذلك من خلال تعزيز الروح الايجابية لدى الطفل حيث تقوم الباحثة بتوزيع البالونات الملونه للاطفال وجعلهم يختارون اللون المفضل لديهم، وتوزيع كرات كرستالية جميلة لرفع الروح المعنوية لدى الأطفال	اعطاء التمرين، اللعب بالكرات الكرستالية، اللعب بالبالونات، الرسم على البطاقات	تقوم الباحثة بالطلب من أفراد المجموعة القيام بتسجيل كل المعلومات الجديدة التي اكتسبوها في التخفيف من أثار الخبرات الصادمة في نفس الكراسة التي يسجلون فيها الواجب البيتي

الجلسة الثامنة	**ساعتين**	تعريف الطفل المعتدى عليه ماهية تمكين الذات الخاصة باضطراب الضغط مابعد الصدمة وأسلوب التكيف الذاتي وتعليم الطفل طريقة التخلص من تداعيات الصدمة	أوراق، أقلام، بطاقات مكتوب عليها طرق الدفاع عن النفس	تقوم بالباحثة بالتركيز على وسائل الدفاع والتكيف من خلال الحديث عن الصدمة التي تعرض لها كل طفل على حدة، وكيف كانت وسائل التكيف التي استخدمها في البداية، وما هي الوسائل التي يستخدمها حاليا وقيامها بتعريف الطفل باساليب التكيف وطريقة الدفاع عن الذات وذلك من خلال تقسيم الاطفال الى مجموعات وتعليمهم مهارات الدفاع عن النفس باسلوب اللعب الجماعي	اللعب من خلال مجموعات، تقسيم الاطفال الى مجموعتين للتنافس، استخدام بطاقات تعريفية باساليب الدفاع عن النفس	تقوم الباحثة بالطلب من أفراد المجموعة بالتدرب على وسائل الدفاع التي تم التعلم عليها من خلال الجلسة وذلك من خلال الملاحظات التي تم تسجيلها في الجلسة العلاجية
الجلسة التاسعة	**ساعتين وربع**	تحديد وتوضيح استراتيجيات خفض الغضب والدفاع عن النفس للطفل المعتدى عليه لاضطراب الضغط ما بعد الصدمة وتعليمه اسلوب التكيف الذاتي لما بعد الصدمة تمكين الاطفال من خفض مستوى الغضب المتعلق بالحدث الصادم. الوعي بسيطرة الغضب على المشاعر. إيصال معلومات كافية عن وسائل الدفاع والتكيف وكيفية استخدامها توضيح أهمية وسائل الدفاع والتكيف في التخفيف أو زيادة حدة الأعراض توضيح كيفية استخدام مثل هذه الوسائل في المستقبل إذا ما تم التعرض لأحداث مشابهه	أوراق، أقلام، بطاقات، حبل	تقوم الباحثة في البادية بالطلب من أفراد المجموعة تلخيص ما جرى في الجلسة السابقة، ثم يقوم بطرح معلومات حول وسائل الدفاع والتكيف واليات استخدام هذه الوسائل بطريق انشطة رياضية من خلال توضيح الاساليب الملائمة للدفاع والتكيف الذاتي	استخدام نشاط لعب دور، اعطاء التمارين للاطفال واستخدام انشطة اللعب	توضيح أهم النقاط التي اكتسبها من خلال الانشطة العلاجية. في الجلسة ومراجعه ما تم في الجلسة
الجلسة العاشرة	**ساعة واحدة**	توضيح اسلوب ومفهوم ادارة الصدمة للطفل المعتدى عليه والخاص باضطراب الضغط مابعد الصدمة	أوراق، أقلام، رسومات، بطاقات	تقوم الباحثة بتعليم الاطفال المعتدى عليهم فن ادارة الصدمة ووسائل خفض الصدمة من خلال مجموعة من الانشطة البدنية والفكرية لتحفيزهم واكسابهم التطيف الذاتي	اعطاء التعليمات، أشكال توضيحية، التغذية الراجعة، اعطاء التمرين	تقوم الباحثة بالطلب من أفراد المجموعة بالتدرب في المنزل على الاساليب الفكرية للتعامل مع ادارة الصدمة
الجلسة الحادية عشر	**ساعتين**	توضيح اسلوب ومفهوم ادارة الصدمة للطفل المعتدى عليه والخاص باضطراب الصدمة	أوراق، أقلام، رسومات، بطاقات	تقوم الباحثة بتعليم الاطفال المعتدى عليهم فن ادارة الضغط ووسائل خفض الضغط من خلال مجموعة من الانشطة	اعطاء التعليمات، أشكال توضيحية، التغذية الراجعة، اعطاء التمرين،	تقوم الباحثة بالطلب من أفراد المجموعة بالتدرب في المنزل على الاساليب

		مابعد الصدمة وتحديد وسائل واسلوب التكيف الذاتي		البدنية والفكرية لتحفيزهم واكسابهم التطيف الذاتي.		الفكرية للتعامل مع ادارة الصدمة
الجلسة الثانية عشر	**ساعة ونصف**	توضيح اسلوب الاسترخاء العضلي للتخفيف على الطفل المعتدى عليه باضطراب الضغط مابعد الصدمة واسلوب التكيف الذاتي الخاصة به	أوراق، أقلام، بطاقات، حبل، اثقال خفيفة الوزن	تقوم الباحثة بعمل بعض التمارين للاحماء للاطفال وذلك لتخفيف الضغط النفسي لدى الاطفال المعتدى عليهم مثل تمارين القفز في المكان نفسه ومن ثم جعلهم يركضون حول الغرفة لعدة مرات والذي بدوره يعمل على تجفيز الدورة الدموية	شريط فيديو، اعطاء التمرين، اللعب، القيام بانشطة رياضية مختلفة، استخدام نشاط اللعب	القيام بالتدريبات البدنية في المنزل والقيام بالاحماء في الصباح والمساء للعضلات والذي يساعد على الاسترخاء
الجلسة الثالثة عشر	**ساعة**	الاسترخاء العضلي والعصبي والفكري	أوراق، أقلام، اثقال، حبل، بطاقات	تقوم الباحثة بعمل بعض التمارين للاحماء للاطفال وذلك لتخفيف الضغط النفسي لدى الاطفال المعتدى عليهم	استخدام نشاط الالهاء، استخدام نشاط اللعب	طلب من المشاركين بعد الانتهاء من تنفيذ الجلسة العلاجية، ان يعيد في بيته ما أجري له مرتين في اليوم صباحاً ومساء
الجلسة الرابعة عشر عشر	**ساعتين**	تعليم الطفل التفريغ الإنفعالي للأطفال المعتدى عليهم باضطراب الضغط ما بعد الصدمة	أوراق، أقلام تلوين، بطاقات	قياس مدى فعالية التفريغ الانفعالي في التخفيف من حدة الصدمات النفسية ومعرفة مدى ملائمة هذا الأسلوب، من خلال المشاركة في الاحداث والمشاعر بين الاطفال ومن خلال قيام الطفل برسم التجربة التي حصلت معه على ورقة وكتابة انفعالاته على الورقة	استخدام نشاط اللعب للاطفال المعتدى عليهم، استخدام نشاط لعب الادوار.	قيام الطفل بالتدريب على التفريغ الانفعالي حسب ما ورد في الجلسة الخاصة بها
الجلسة الخامسة عشر	**ساعتين**	تحديد طريقة التعريض لدى الاطفال المعتدى عليهم باضطراب الضغط ما بعد الصدمة ومساعدتهم بالتفكير بايجاد حل للمشكلات	أوراق، أقلام، بطاقات، الوان	تعريض الطفل الى حدث مماثل من خلال اساليب القصص واسلوب التمثيل واللعب حيث تقوم الباحثة بجعل الاطفال يروون الاحداث التي حدثت معهم وقيام الاطفال بعد ذلك بالاسترخاء لاكتساب طاقة ايجابية والتركيز على استرجاع الاحداث	نشاط اللعب، اللعب بالادوار التنشيط السلوكي، ونشاط الدعم الاجتماعي	قيام الطفل بالتدريب على التعريض حسب ما ورد في الجلسة الخاصة بها
الجلسة السادسة عشر	**ساعة**	التعرف على مفهوم التعريض لدى الطفل المعتدى عليه ومحاولة التعامل مع الحدث والتكيف الذاتي لديه	أوراق، أقلام، بطاقات، حبل، عصا	تعريض الطفل الى حدث مماثل من خلال اساليب القصص واللعب والتمثيل ومحاولة اخراج ذكريات الطفل الخاصة بالحادث لكي يتفاعل معه ويحاول التغلب عليه من خلال تحويل فكرة الحدث الى تجربة سابقة لن تتكرر من خلال مساعدة زملائه الاطفال في الجلسة	اشكال توضيحية، نشاط لعب الأدوار الفنية، نشاط فن الخيال، التمارين الجسدية.	قيام الطفل بالتدريب على التعريض حسب ما ورد في الجلسة الخاصة بها

				باسلوب تعاوني بين الجميع للخروج من هذه الازمة لدى الاطفال المعتدى عليهم		
الجلسة السابعة عشر	**3 ساعات**	توضيح مفهوم العجز المتعلم وتمكين الطفل المعتدى عليه من كيفية التغلب على العجز المتعلم	أوراق، أقلام تلوين، حبل، اوزان، عصا	تقوم الباحثة بالطلب من أفراد المجموعة بتوضيح ما جرى في الجلسة السابقة، ثم يقوم بتعليم الاطفال المعتدى عليهم مسؤولية الحدث الصادم من خلال التعزيز ولعب الدور والقيام بانشطة خاص بذلك، من خلال اللعب والركض والقفز وتقسيم الاطفال الى مجموعات واللعب فيما بينهم بالحبل والقفز من خلال الحبل والقيام ببعض التمارين الرياضية	لعب دور، نشاط التثميل ولعب الادوار، نشاط التحفيز الايجابي، نشاط القفز، ونشاط الرسم	قيام الطفل بالتدريب على كيفية التغلب على عجز المتعلم حسب ما ورد في الجلسة الخاصة بها
الجلسة الثامنة عشر والأخيرة	**ساعتين**	تقييم البرنامج اختتام البرنامج التعرف علي تقييم أفراد المجموعة للبرنامج القيام بالقياس البعدي للبرنامج	أوراق، أقلام، الواجب البيتي	في هذه المرحلة يقوم الباحث بإنهاء كل المواضيع التي تم التطرق إليها أثناء الجلسات	نقاش وحوار	مراجعة ما تم اخذه في الجلسات السابقة

Appendix F

CBT – Program (Eng. Version)

First Session

1. Duration of the session: 2 hours
2. Number of participants: 15 children
3. The main objective of the session: Introducing the PTSD program and its objectives
4. Sub-objective of the session:
    - Getting to know the group members, and giving the group members the opportunity to get to know each other
    - Creating an atmosphere of trust between the researcher and the group members and alleviating anxiety.
    - Explaining the program and the importance of the research.
    - Setting the basic rules that will be followed during the unloading process.
    - Identifying the expectations of the group members regarding the proposed program
5. Procedure: The researcher used the method of interaction with the abused children and the method of brainstorming through activities specifically for the abused children. She tried to woo them and break the ice between herself and the children.
6. Activities used: The children were instructed about the nature of the session and its benefits through cards distributed to them. Each child received his own card with his name written on it to identify him. The method of group discussion was used among the abused children. Play activity for children was used to break the barrier of shame among the abused children. The method of playing was with a rotating bottle, and when the bottle stopped rotating, the child located by the top of the bottle talked about his experience in front of the group.
7. Tools: an empty bottle, cards with the names of the children in the session.
8. Application method:

- The researcher started the session by introducing herself to the group, the nature of her work, and her goal in carrying out this activity
- She then described and presented the program, explained the general outline of the program and the expectations from it. She described the number of sessions (18 sessions), the duration of each session (from one hour to 3 hours) and the location of the session.
- The researcher emphasized the confidentiality and privacy of information. She emphasized that no member of the group was allowed to talk about what happened during the unloading sessions outside the unloading hall.
- The researcher confirmed that freedom of participation is guaranteed to everyone, but no one is allowed to participate unless permission is obtained from the researcher. She also explained that while a participant is talking, the rest of the group members must wait their turns to participate.
- The researcher explained that the participant may feel pain as a result of talking about painful experiences, but that the feeling of pain is normal and expected in such circumstances.
- The researcher mentioned that each person is required to talk about his own experience and is not required to talk about others or their experiences.
- The researcher reminded participants that leaving the session is allowed only in emergency or for a personal need, and that everyone must adhere to the dates of convening and ending the sessions.
- No person except the researcher in charge of the unloading process and the children of the group are allowed to be in the unloading room during the session. Others, whether they are from the administration, media professionals or any other person regardless of his position are not allowed.
- The researcher gave the children the opportunity to talk about their expectations from this program, or to share if they had any ideas about psychological relief programs or any crisis intervention programs, or if any of them had received previous services in this field.
- The researcher informed the group members that the she would remain for half an hour after the end of each session, so that whoever wants to speak individually with the researcher can do so during that time.

- The researcher conducted another activity with the abused children with the aim of melting the ice and breaking the stalemate among the abused children and with the researcher, in order to create an atmosphere full of trust, familiarity, joy and pleasure. The children sat in a circle and placed an empty plastic “bottle” in the center of the circle and spun it, and whoever was sitting by the mouth of the bottle answered a question or performed a task asked of him by the person sitting by the back of the bottle. After that the student whose direction the mouth of the bottle fell turned it to get the ball back. Here, the researcher tried to encourage the abused children to ask some questions related to the problems, feelings and daily lives of the abused children.

9. The researcher used the technique of self-monitoring of children, which is a technique for dealing with abused children. The technique of automatic identification of ideas was used and she worked to correct them for the abused children.

10. Household tasks: relaxation exercises.

11. Termination: The researcher gave the abused children the opportunity to direct their questions and inquiries and express their feelings about the program in general and about what transpired in the session in particular. The researcher expressed thanks and appreciation to the abused children for participating.

Second Session

1. Duration of the session: two and a half hours

2. Number of children participating: 15 children

3. Main objective of the session: Define PTSD and the topics covered in the program, help the children understand PTSD symptoms and self-adaptation

4. Sub-objective of the session:

    - Introducing abused children to the nature of cognitive therapy for trauma, which focuses on the fact that the events that occurred do not change, but that we can change the interpretation of what happened.

- Introducing the contents of the treatment program for abused children and the method of self-adaptation for children

5. Procedure: At first, the researcher reviewed what happened in the previous session, and the children participated by answering a set of questions that she asked them. She then distributed papers and colored pens to the children so that they could draw and color with the aim of psychological relief for the children.

6. Activities used: The drawing activity was used for the children, the coloring activity used the papers that were distributed in the session, the dialogue activity was used with the children, and the activity was done by dividing the children into working groups with the students

7. Tools: white papers, cards, crayons, small colored paper.

8. Application method:

    - The researcher asked specific questions and then each child had the opportunity to talk about his own experience and how he perceived the event.
    - The questions asked by the researcher: What happened? Where were you at the time of the event? Who was with you at the time of the event? What was your first reaction after the event? What did you see, hear, smell during the event?
    - The researcher intervened with questions during the narration of experiences in order to encourage the child to continue talking about the same point if the researcher felt that it was important, or if she felt there was a need for personal guidance towards a certain point. It is also necessary for the therapist to show her understanding of what happened with the children and her sympathy for them through feedback, or through non-verbal communication
    - Enabling the children to invent new roles and gain the necessary self-efficacy to overcome the effects of violence.

9. The techniques used: the technique of technical modeling, the technique of training to solve technical problems, the technique of self-talk: where the necessary support was provided to an individual if the researcher felt the need to do so. The researcher focused only on the facts related to the traumatic event and avoided entering into any branching that may have consumed a lot of time.

10. Household tasks: The researcher asked each child to explain the traumatic events that he experienced and that continue to recur in his memory. The child was then asked to explain his response immediately after the event, and then his responses when remembers the event at the moment.

11. Termination: The researcher gave the abused children the opportunity to direct their questions and inquiries and express their feelings through the emotions they wish to express about the program in general and what happened in the session in particular. The researcher then expressed thanks and appreciation to the abused children participating.

Third Session

1. Duration of the session: 1 hour

2. Number of children participating: 15 children

3. The main objective of the session: To identify thoughts and feelings related to PTSD and to teach them the method of self-adaptation.

4. Sub-objective of the session:

    - Know the symptoms of post-traumatic stress disorder; there are four categories of symptoms: re-exposure to the traumatic event, avoidance, loss of interest, and agitation.
    - Understand that symptoms are normal reactions to severe stress.
    - Correct negative thoughts related to the event.
    - Activate group support
    - Raising the self-efficacy of the abused child.

5. Procedure: The researcher first took attendance to verify that all participants were present. The researcher prepared the children psychologically for the session by introducing and providing a brief overview of the topic of the session. She then began the session with games and a range of activities appropriate for abused children.

6. Activities: Positive reinforcement activities for children, feedback, distribution of small cards for the children, and role-playing activities.

7. Tools: papers, crayons, cards.

8. Application method:

    - The researcher asked specific questions with clear scope for open discussion such as:

      What thoughts came to your mind at the time of the event?

      What thoughts about the event are still in your mind today?

      What thoughts came to your mind after the first session?

      What feelings did you feel at the time of the event?

      How do you feel when these thoughts come to you?

      How do you deal with these feelings?
    - Then the researcher intervened as follows:

      Demonstrated verbal or nonverbal understanding and sympathy for feelings and ideas that arose during the session.

      Asked some specific questions when she felt that the child had reached a stage where he could not continue

      Searched for elements that reflect cognitive work towards adaptation. The researcher also focused on decisions and activities

      The researcher attached importance to the feelings that the group members tried to hide, especially with regard to feelings of guilt

      The researcher also used the group to modify negative thoughts by focusing light on them and asking the group members to comment on them.

      Maintained a degree of silence that allowed the child to talk more deeply about his or her feelings, and enhancing sources of self-efficacy regarding how abused children perceive and interpret their emotional and physical states.

      Encouraged the child to describe his social skills and explained to the child that these social skills have a great impact on raising the self-efficacy.

9. The technique used: The researcher used the self-monitoring technique, the exposure technique, the imagination technique, and the technical homework technique to encourage the participants to talk, and to make them feel that what they feel is a

natural response to an abnormal event they were exposed to. Phrases that were used include: You are not alone with these thoughts, it is normal to feel that way after everything you have been through.

10. Household tasks: the researcher asked each child to record what they think when they feel painful feelings, and what sensory impressions (memory of the senses) they regularly continue to experience. The researcher then asked the group members to do the following exercise: evoke the images related to their PTSD, imagine that these images are shown in front of them on a large screen, while they were holding a remote control. When the display of these images became annoying, they turned off the display with their remote control. This exercise was repeated more than once daily.

11. Termination: The researcher gave the abused children the opportunity to direct their questions and inquiries and express their feelings about the program in general and about what took place in the session in particular. The researcher then expressed thanks and appreciation to the abused children for participating.

Fourth Session

1. Duration of the session: one hour and fifteen minutes

2. Number of children participating: 15 children

3. The main objective of the session: To identify the emotional discharge mechanism of the abused child and to identify the method of dealing with emotional discharge

4. Session sub-objective: To extract and process the distressing feelings related to the traumatic event of the abused child

5. Action: Directing the abused child to do positive things that help him to move forward and raise his morale and self-efficacy. This is done by teaching him the methods of self-adaptation with the event, strengthening the positive spirit of the abused child and consolidating the idea that what happened is an experience that has passed. The researcher encouraged the abused child to write his ideas on the cards that the researcher distributed.

6. Activities used: Dialogue with the abused children, the use of small cards, the use of role-playing

7. Tools: papers, pens, cards.

8. Application method:

    - Children were trained to deal with the past, or with expected problems as if the conflict was happening in the present. Strong feelings emerge in a typical way. This process has been designed so that it is a sound emotional experience. After achieving a high level of insight, emotional emptying occurs to liberate feelings of despair, sadness, and sin. All participants in psychodrama, including children in the treatment session achieve a new safe level for understanding the problematic conflict situation. There is an integrated process of relief in psychodrama treatment, because the individual is encouraged to identify with the situations and problems of others. In this way, the children realize that they are unable to escape from emotional isolation. The researcher informed the abused child of the importance of their achievements in raising his self-efficacy. If the abused child feels that he is advancing successfully, his expectations of the extent of his self-efficacy will increase.

9. The technique used: The use of play in the emotional discharge of the child, where play represents a projective discharge of the child's feelings at the stage of post-traumatic stress disorder.

10. Home tasks: The child practiced emotional emptying via homework assigned by the researcher.

11. Termination: The researcher gave the abused children the opportunity to direct their questions and inquiries and express their feelings through their responses to the events that occurred, and to the current in the session in particular., The researcher then expressed thanks and appreciation to the participants.

Fifth Session

1. Duration of the session: ninety minutes

2. Number of children participating: 15 children

3. The main objective of the session: To encourage the abused child to interact with the events that occurred and to try to overcome them through the treatment program

4. Sub-objective of the session:

    - Clarify the relationship between asking why and guilt
    - Clarify the relationship between asking why and feeling helpless
    - Note irrational thoughts related to answering the why questions.
    - Modify the distorted image that may exist in PTSD
    - Clarify the positive meanings of PTSD
    - Transforming the traumatic event from an exceptional event into an experience that can be included in life experiences.

5. Procedure: The researcher first took attendance, then asked the group to evaluate the event and the extent of its danger and threat to them by asking some questions and opening the way for the group to talk about their own experiences

6. Activities used: Behavioral activation activity, distraction activity, role-playing activity, drawing activity for children that helped them to distract and unload their emotions.

7. Tools: papers, crayons, small cards.

8. Application method:

    - Asking some questions and opening the way for the group to talk about their own experiences, such as:
      How do you see the event from your point of view?
      How dangerous is the event to your safety and security?
      What was the most dangerous aspect of the event?
      What are the negative aspects of the event in general?

- Then the researcher explained to the group members that any event, no matter how painful and difficult, always has positive aspects, that may not be apparent at the time of the event due to the disturbance to the ability to think logically. The positive aspects can be clarified the researcher asking the following questions and allowing an open discussion between the abused children.
  What are the positive aspects you can see in the event?
  What are the lessons that can be learned after going through this experience?
  Notifying the abused child that anxiety, fear and intense emotion lead to a decrease in the person's performance, and thus lead to a decrease in the child's self-efficacy

9. The technique used: The researcher used the technique of identifying wrong and ineffective thinking methods: Encouraging the group members to talk about their assessments of their ability to deal with or adapt to the event, by asking some questions and leaving the field open for discussion, for example:

   - How do you see your ability to deal with these events?
   - What are the positive aspects of your personality that help you deal with such events?
   - What are the positive aspects around you that can contribute to helping you deal with these events?

10. Homework: The researcher asks the group members to practice nervous relaxation.

11. Ending: At the end of the session, the researcher explained that the group members should see the events as they are without exaggerating, and look at them as an experience that has positive and negative aspects, and clarify their sources of strength and not underestimate their ability to deal with such events.

Sixth Session

1. Duration of the session: 1 hour

2. Number of children participating: 15 children

3. The main objective of the session: Clarifying negative self-talk and introducing them to the self-adaptation method.

4. Sub-objective of the session:

    - Show children how PTSD is learned
    - Understanding the fact that escape and avoidance give temporary relief because it comes right after the pain
    - Provide psychological support for the abused child.
    - Enhance the positive aspects of the group members.

5. Procedure: At the beginning of the session, the researcher asked the group members to summarize what happened in the previous session, then she clarified the role of positive factors as protective factors for the abused child, by promoting the child's positive spirit. The researcher distributed colored balloons to the children and asked them to choose their favorite color. She also distributed beautiful crystal balls to raise the morale of the children.

6. Activities used: Exercises, playing with crystal balls, playing with balloons, drawing on cards.

7. Tools: papers, pens, colored crystal balls, colored balloons.

8. Application method:

    - Clarification of the importance of optimism and staying away from things that have a negative impact on the psyche of the abused child, The researcher distributed balloons to the abused children in different colors and asked the children to choose their favorite colors. This helped the researcher become aware of the child's orientation and the nature of his thoughts and inclinations and helped her address negative things about the child.
    - The researcher then distributed to the children small crystal balls in beautiful shapes to raise the children’s morale. She asked them to pass the balls among themselves, an activity that worked to spread the positive spirit among the children and enhance the spirit of competition and the spirit of cooperation among them.

- Clarification of how to raise the self-efficacy of the abused child by encouraging him to answer the cards that he withdrew.

The statements on the cards included::

I have the ability to solve problems if I make the right effort

I have the ability to easily adapt to my difficulties

When I face problems, I find solutions

9. The technique used: The researcher used the self-monitoring technique, the exposure technique, the imagination technique, and the technical homework technique.

    - Ask the group members how their exposure to trauma affected their psychological well-being.
    - How the trauma affected their daily life and lifestyle.
    - Enhancing this change if it is positive, and modifying this change if it had negative effects on their daily routine.

10. Homework: The researcher asked the group members to record all the new information they have acquired regarding mitigating the effects of traumatic experiences in the same notebook in which they record their homework.

11. Termination: The researcher provided an opportunity for the abused children to direct their questions and inquire and express their feelings about the program in general and what happened in the session in particular. Their feelings were frank and positive after the session ended.

Seventh Session

1. Duration of the session: 1 hour

2. Number of children participating: 15 children

3. The main objective of the session: Treatment of negative self-talk in abused children and its self-adaptation

4. Sub-objective of the session:

    Teaching children how to treat negative self-talk

- How to enable the abused child to overcome negative self-talk with psychological support.

5. Procedure: The researcher clarified the role of positive factors as a protective factor for the abused child and introduced its benefit and how to avoid negative self-talk by strengthening the child's positive spirit. The researcher distributed colored balloons to children and asked them choose their favorite color, and distributed beautiful crystal balls to raise morale.

6. Activities used: Exercise, playing with crystal balls, playing with balloons, drawing on cards.

7. Tools: papers, pens, colored crystal balls, colored balloons.

8. Application method:

   - Clarification of the importance of optimism and staying away from things that have a negative impact on the psyche of the abused child. The researcher distributed balloons to the abused children in different colors and asked the child to choose his favorite color to help understand the nature of his thoughts and what his inclinations are and to work to address negative issues concerning the child.
   - The researcher then distributed small crystal balls to the children in beautiful shapes to raise the children's morale and asked them to pass the balls among themselves. This worked to spread the positive spirit among the children and enhance the spirit of competition and the spirit of cooperation among them.
   - Clarify how to raise the self-efficacy of the abused child by asking him to respond to the statements on the cards that he draws
     Examples of the statements on the cards:
     I have the ability to solve problems if I make the effort
     I have the ability to easily adapt to my difficulties
     When I face a problem, I find solutions to it

9. The technique used: The researcher used the self-monitoring technique, the exposure technique, the imagination technique, and the technical homework technique.

- Ask the group members how their exposure to trauma affected their psychological well-being.
- How the trauma affected their daily life and lifestyle.
- Enhancing this change if it is positive, and modifying this change if it has negative effects on their daily routine.

10. Homework: The researcher asked the group members to record all the new information that they acquired to reduce the effects of traumatic experiences in the same notebook in which they record their homework.

11. Termination: The researcher provided an opportunity for the children to direct their questions and inquiries and express their feelings about the program in general and about what happened in the session in particular. Their expressed feelings were frank and positive after the session ended.

Eighth Session

1. Duration of the session: 2 hours

2. Number of children participating: 15 children

3. The main objective of the session: To introduce the concept of self-empowerment of PTSD, the method of self-adaptation, how to discard the consequences of trauma

4. Sub-objective of the session:

    - Enabling children to adopt self-defense strategies
    - Clarify what is meant by means of defense and adaptation
    - Clarify the means of defense and adaptation used
    - Strengthening the positive means of coping, modifying the negative means, and using the group to do so.

5. Procedure: The researcher focused on the means of defense and adaptation by talking about the trauma that each child was exposed to, the coping methods he used in the beginning, and the means he uses now. The researcher introduced the child to the

methods of adaptation and the method of self-defense, by dividing the children into groups and teaching them self-defense skills in group play.

6. Activities used: playing in groups, dividing children into two groups to compete, using self-defense cards

7. Tools: papers, pens, cards with written methods of self-defense.

8. Application method:

- Focused on the means of defense and adaptation by talking about the trauma that each child was exposed to, the coping methods he used in the beginning, and the means he uses now, by asking the following questions:
  How did you act after the event?
  What do you do when you have painful feelings about the event or when memories of the event attack you?
  Do you think that the means of adaptation that you use help you in dealing with the event?
- The researcher then addressed the means of defense and adaptation that the child used when he went through similar events in the past, and these means were clarified and strengthened by asking the following questions:
- How did you deal in the past when you were going through similar events?
- Did these means help you in adapting to the event that you endured, and if some of the means help and others do not help in adapting, what are the auxiliary and non-helpful means of adaptation according to the child's point of view? Which in turn enhanced the child's self-efficacy?
- The researcher conducted the activity that was identified in the session through play activity, divided them into groups and trained them in using self-defense methods.

9. The technique used: The researcher used the technical modeling technique, the training technique for solving technical problems, the self-talk technique, the technical role-playing technique, and the technical test guide technique:

- The researcher focused on the means of defense and adaptation that the group used in dealing with the event, and how the child performed them by asking the following questions:

  After listening to your peers, what are the means they used?
  How do you evaluate the means of defense used by the group?
  What are the healthy defenses?
  What are the unhealthy defenses?

- In the meantime, the researcher facilitated the discussion, and clarified that the healthy means that a person used in the past are the most important means of defense that can help him overcome the current crisis, and then she showed the children sports for self-defense by teaching them self-defense with hands and feet.

10. Household tasks: the researcher asked the group members to practice the means of defense that were taught during the session, using the notes that were recorded in the treatment session.

11. Ending: The researcher asked the group members to repeat the means of defense and adaptation that they learned through discussion between group members and that they think might be useful to them.

Ninth Session

1. Duration of the session: two hours and fifteen minutes

2. Number of children participating: 15 children

3. The main objective of the session: To identify and clarify strategies for reducing anger and self-defense for the abused child with PTSD and to teach him the method of post-traumatic self-adaptation

4. Sub-objective of the session:

   - Enabling children to reduce the level of anger related to the traumatic event.
   - Awareness of anger's control over feelings.

- Communicate sufficient information about defense and adaptation methods and how to use them
- Clarify the importance of defense and adaptation in mitigating or exacerbating symptoms
- Clarify which means should be used in the future if similar events are exposed.

5. Procedure: The researcher in the begging asked the group members to summarize what happened in the previous session, and then presented information about the means of defense and adaptation and the mechanisms for using these means through sports activities by clarifying the appropriate methods of defense and self-adaptation.

6. Activities used: role-playing, teaching exercises to children, play activities.

7. Tools: papers, pens, cards, rope.

8. Application method:

    - Presentation of information about the means of defense and adaptation and the mechanisms for using these means through activity by playing with two groups of children and teaching them self-defense skills, focusing on the following points

      Demonstrate and practice the healthy defenses and coping strategies recommended for use after a traumatic event.

      Illustrate and rehearse defense and coping mechanisms that are contraindicated after exposure to a traumatic event

      Clarify how to employ and use means of defense and adaptation, that raise the confidence of the abused child, and thus raise his self-efficacy

9. The techniques used: The researcher used the technical modeling technique, the training technique to solve technical problems, the self-talk technique, the technical role-playing technique, and the technical test guide technique. The researcher strengthened the means of defense and health adaptation that were mentioned in the previous activities and which the child used or that he was using. The child used it before in previous events and learned the necessity for using it if he encounters new traumatic situations in the future. In addition, this information helped the child alleviate the symptoms resulting from exposure to traumatic events in the past. It also

prepared him to face any events that he will encounter in the future. The researcher then taught the children new self-defense skills with a rope and taught them new movements with hands, which help raise the child's morale.

10. Household tasks: To review what happened in the session and clarify the most important points gained through therapeutic activities in the session.

11. Termination: The researcher asked the group members to repeat the means of defense and adaptation that they trained through therapeutic activities with the group members. The researcher then asked what think may be useful to them.

Tenth Session

1. Duration of the session: 1 hour

2. Number of children participating: 15 children

3. The main objective of the session: To clarify the style and concept of trauma management for the abused child, related to PTSD.

4. Sub-objective of the session:

    - Awareness of the elements of trauma
    - Awareness of cumulative trauma
    - Introducing children to ways to reduce trauma.

5. Procedure: The researcher taught the abused children the art of trauma management and means of reducing trauma through a set of physical and intellectual activities to motivate them and teach them self-discipline.

6. Activities used: play activity, role-playing, exercises

7. Tools: papers, pens, drawings, cards.

8. Application method:

    - The researcher asked the group members to summarize what happened in the previous session. She then clarified the intellectual activities related to stress

management, and the means to reduce trauma. By presenting the short-term, medium and long-term effects of stress, the researcher explained the physical, behavioral, psychological, emotional and cognitive effects of stress and PTSD followed by self-adaptation. She then explained the symptoms that children recognize according to their age and how trauma can affect their cognitive and behavioral development. The researcher explained what behavioral changes children feel after exposure to traumatic events, and how they can identify these changes in behavior. She then explained the psychological stress that can result from exposure to traumatic events, and the symptoms of post-traumatic stress disorder To help the group members identify these symptoms, she explained the effects that psychological trauma can have on the personality, the value system of the child, his confidence in others and his view of himself and the future. She further explained the symptoms of stress that arise from the problems of daily life and how they can differ from symptoms of stress caused by psychological trauma.

9. The technique used: Technical role-playing, the technical test guide technique, the technique of identifying the methods of wrong and ineffective thinking, the technique of artistic distraction. The role of the researcher here is to train the abused children in methods of dealing with stress through intellectual activity and physical activity. Self-adaptation can be achieved through sports games that use the abused child's energies such as running and jumping in place, making them happy and with high positive energy.

10. Home tasks: The researcher asked the group members to practice at home the intellectual methods of trauma management.

11. Termination: The researcher gave the abused children the opportunity to direct their questions and inquiries and express their feelings about the program in general and what took place in the session in particular, giving them enough time to express their feelings about the session. The researcher then expressed thanks and appreciation to the abused children for participating.

Eleventh Session

1. Duration of the session: 2 hours

2. Number of children participating: 15 children

3. The main objective of the session: Clarifying the style and concept of trauma management for the abused child with PTSD and identifying the means and method of self-coping

4. Sub-objective of the session:
   • Awareness of the elements of trauma
   • Awareness of cumulative trauma
   • Introducing children to ways to reduce trauma.
5. Procedure: The researcher taught abused children the art of stress management and ways to reduce stress through a set of physical and intellectual activities to motivate them and to promote self-discipline.

6. Activities used: play activity, role-playing activity, exercise,

7. Tools: papers, pens, drawings, cards.

8. Application method:

   - The researcher asked the group members to summarize what happened in the previous session. She then clarified the intellectual activities related to stress management, and the means to reduce trauma. By presenting the short-term, medium and long-term effects of stress, and the researcher explained the physical, behavioral, psychological, emotional and cognitive effects of stress and PTSD followed by self-adaptation. She then explained the symptoms that children recognize according to their age and how trauma can affect their cognitive and behavioral development. The researcher explained what behavioral changes children feel after exposure to traumatic events, and how they can identify these changes in behavior. She then explained the psychological stresses that can result from exposure to traumatic events, and the symptoms of post-traumatic stress disorder. To help the group members identify these symptoms, she explained the effects that psychological trauma can have

on the personality, the value system of the child, his confidence in others and his view of himself and the future. She further explained the symptoms of stress that arise from the problems of daily life and how they can differ from symptoms of stress caused by psychological trauma.

9. The techniques used: Role-playing technique, the technical test guide, identifying the methods of wrong and ineffective thinking, artistic distraction. The role of the researcher here was to train the abused children in methods of dealing with stress management through intellectual activity and physical activity. The abused child learns self-adaptation through sports games that release his energies and make him happy with high positive energy.

10. Home tasks: The researcher asked the group members to practice intellectual methods to deal with trauma management

11. Termination: The researcher gave the abused children the opportunity to direct their questions and inquiries and express their feelings about the program in general and what took place in the session in particular. She gave them enough time to express their feelings about the session, and then the researcher expressed thanks and appreciation to the abused children for participating.

Twelfth Session

1. Duration of the session: 1 hour

2. Number of children participating: 15 children

3. The main objective of the session: To clarify the method of muscle relaxation to relieve the abused child of stress, and to encourage self-adaptation.

4. Sub-objective of the session:

   - Training to relax the muscles.
   - Training to relieve stress and tension

5. Procedure: The researcher performed some warm-up exercises with the children in order to relieve e psychological pressure, such as jumping exercises in the same

place, and then running around the room several times, which in turn stimulates blood circulation.

6. Activities used: a video tape, exercise, playing, doing various sports activities,

7. Tools: papers, pens, cards, rope, light weights.

8. Application method:

    - Training children to breathe deeply, which is one of the easiest methods of control that can be learned. Although it may seem strange, many people do not know how to breathe properly. Breathing involves the diaphragm, and the abdomen should expand while inhaling. As for exhaling, the abdomen should fall.
    - Teaching children progressive muscle relaxation. Using relaxation techniques is an effective method for relieving stress and anxiety. Progressive muscle relaxation focuses on moving a person from tension to relaxation of specific muscle groups in the body. A person tightens a group of his muscles and then relaxes them, and thus the body learns over time how to deal with muscle tension.

9. Techniques used: automatic recognition technology and correcting thoughts, self-monitoring technology, exposure technology, visualization technique, technical homework technique, and various muscle exercises that help children relax and breathe comfortably by lifting light weights several times,

10. Household tasks: Physical exercises at home that include warm ups in the morning and evening for muscle relaxation.

11. Termination: The researcher gave the abused children the opportunity to direct their questions and inquiries and express their feelings about the program in general and what happened in the session in particular.

Thirteenth Session

1. Duration of the session: 1 hour
2. Number of children participating: 15 children
3. The main objective of the session: to teach the abused child the mechanism of muscle relaxation of the body and to focus on nervous and intellectual relaxation
4. Sub-objective of the session:
    - Training to relax the nerves.
    - Shock and stress relief training
5. Procedure: The researcher did some warm-up exercises with the children in order to relieve their psychological pressure.
6. Activities used: distraction activity, play activity.
7. Tools: papers, pens, weights, rope, cards.
8. Application method:
    - The researcher sat the child in a quiet and completely relaxed place for ten minutes, then asked him to listen to a tape recording of the program's steps in the researcher's own voice. She asked them to perform all the steps recorded on the cassette for the remaining twenty minutes of the session.
    - After completing each session, the participants were asked to describe their feelings and psychological state, and this description was recorded on a separate sheet of paper for each participant in the program.
    - The children employed a self-soothing method by sitting and meditating, which in turn worked to relieve trauma
9. Technique used: automatic identification technology for ideas and for correcting them, self-monitoring technology, distraction technology
    - An additional 15 minutes were allocated after the end of the last session for self-evaluation of the program by the participants. The children were then encouraged to participate in various sports with the aim of psychologically calming them and enhancing their positive spirit.

10. Household tasks: After completing the treatment session, the participants were asked to repeat at home, in the morning and in the evening, the exercises performed in the session.

11. Termination: The researcher gave the abused children the opportunity to direct their questions and inquiries and express their feelings about the program in general and what happened in the session in particular.

Fourteenth Session

1. Duration of the session: 2 hours

2. Number of children participating: 15 children

3. The main objective of the session: Teaching the child about emotional release when suffering from PTSD.

4. Sub-objective of the session: To reveal the painful feelings related to the traumatic event and to identify the details of the accident that affected the abused child.

5. Procedure: Measuring the effectiveness of emotional discharge in mitigating psychological trauma. This was achieved by having the child draw the traumatic experience on a sheet of paper and by having him write down his emotions on the paper.

6. Activities used: play activity for abused children, role playing activity.

7. Tools: papers, crayons, cards.

8. Application method:

    - Providing an opportunity to vent feelings: expressing feelings related to traumatic experiences and resulting from them in a professional, directed, thoughtful manner, and in a safe environment

- Giving the children the opportunity to express the traumatic event in words: using this technique, the traumatic event is extracted from the image of terrifying memories into words in which the child shares with the group
- Group support: the psychological support provided by the group through sharing feelings, transferring experiences and information in a healthy and directed manner. This strengthens the weak sides of the person by offering correct models of behaviors that help in facing traumatic experiences, and creating an atmosphere of hope.

9. The technique used: Automatic identification of thoughts and work on correcting them, self-monitoring, motor activity.

10. Household tasks: The child was asked to practice emotional emptying, according to what was learned in the session

11. Termination: The researcher gave the abused children the opportunity to direct their questions and inquiries and express their feelings about the program in general and what happened in the session in particular.

Fifteenth Session

1. Duration of the session: 2 hours

2. Number of children participating: 15 children

3. The main objective of the session: To determine the method of exposure of abused children suffering from PTSD and to help them think about finding a solution to their problems.

4. Sub-objective of the session:

    - Helping children embrace the idea that avoiding and escaping a traumatic situation is not the answer
    - Thinking about solving problems.
    - Reaching positive solutions for the abused child

5. Procedure: Exposing the child to a similar event using the methods of stories, acting and playing, where the researcher encourages the children narrate the events that happened with them and the children then relax to gain positive energy and focus on recalling the events

6. Activities used: play activity, role play, behavioral activation, and social support.

7. Tools: papers, pens, cards, colors.

8. Application method:

    - To expose children to the satisfactory event through imaginative techniques or to re-experience live. This exposure is one of the following:
        a) Severe: a method of explosive treatment, which is called dumping.
        b) Gradual: as a systematic desensitization method.
        c) To teach patients the ways of managing distress
        d) Relaxation techniques.
        e) Apply the cognitive model to deal with distress.
    - High exposure to the event (explosive therapeutic method): This method is useful in treating post-traumatic stress disorder, especially in its chronic form. Pleasant or painful visualization is accompanied by relaxation, but it is preferable not to apply this method to those with cardiac lesions.

9. Technique used: Self-talk technique, technical role-playing, technical test guide, identifying incorrect and ineffective thinking methods, artistic distraction, informing the patient that he will be exposed to painful experiences that bring him back to the previous trauma, but that it will be beneficial for him. Securing the appropriate physical conditions: a quiet and safe room and a comfortable chair for the patient to sit on. The therapist must be equipped with a watch and a device to measure the heart rate, and also to record the level of anxiety during the session.

10. Household tasks: the child does exposure training according to what was learned in the session

11. Termination: The researcher provided an opportunity for the abused children to direct their questions and inquiries and express their feelings about the program in general and what happened in the session in particular.

Sixteenth Session

1. Duration of the session: 1 hour
2. Number of children participating: 15 children
3. The main objective of the session: Introducing the child to the concept of exposure to PTSD.
4. Sub-objective of the session:
    - Helping children embrace the idea that avoiding and escaping a traumatic situation is not the answer
    - Thinking about solving problems.
5. Action: Stimulating the abused child through the telling of stories, playing and acting, and trying to elicit the child's memories of the traumatic event in order to interact with him and try to overcome the trauma by transforming the idea of the event into a previous experience that will not be repeated.
6. Activities used: illustrations, artistic role-playing, fantasy art activity, physical exercises.
7. Tools: papers, pens, cards, rope, stick.
8. Application method:
    - Gradual exposure to the event or (regulated desensitization): This method requires exposing the patient to the painful stimulus gradually. This method is commonly used in cases of post-traumatic stress disorder for individuals that suffer from nightmares, fear and anxiety. That described disturbing dreams that soldiers in Vietnam considered a vivid recovery of traumatic experiences. The first phase of treatment is based on teaching the individual relaxation techniques and training in Sarelian imagination. The method asks the client to relax, then imagine, then relax, then stop the imagination, then relax, and so on. The patient ultimately relaxes with the visualization of those dreams according to the gradation of stimuli that cause anxiety, that is, the link between relaxation, which

is a rewarding experience, versus the painful experience anxiety and gradually relaxation replaces anxiety.

9. Technique used: Self-talk, artistic role-playing, technical test guide, identifying wrong and ineffective thinking methods, artistic distraction technique, training children to reduce sensitivity in real, live situations and in practicing relaxation methods.

10. Household tasks: The children are encouraged to listen to tapes of these sounds at home to practice relaxation. The children are encouraged to review exposure training according to what they learned in the session.

11. Termination: The researcher gave the abused children the opportunity to direct their questions and inquiries and express their feelings about the program in general and what happened in the session in particular. Then the researcher expressed thanks and appreciation to the abused children for participating.

Seventeenth Session

1. Duration of the session: 3 hours

2. Number of children participating: 15 children

3. The main objective of the session: To clarify the concept of learned helplessness and to enable the abused child to overcome the learned helplessness

4. Sub-objective of the session:

   - Determine the responsibility of the traumatic event.
   - Reduce feelings of pain associated with the event.
   - Distinguish between aggressive behavior and assertive behavior.

5. Procedure: The researcher taught the abused children the responsibility of the traumatic event through role-playing and conducting special activities including

running, jumping, dividing the children into groups, playing with each other, jumping rope, and doing exercising.

6. Activities used: role playing, positive stimulus, jumping, and drawing.

7. Tools: paper, crayons, rope, weights, stick

8. Application method:

    - Explain the symptoms that children may have, appropriate to their ages, and how the trauma may affect their cognitive and behavioral development
    - Explain what behavioral changes children feel after experiencing traumatic events, and how they can recognize these changes in behavior
    - Talk about mental illnesses that can result from exposure to traumatic events, what the symptoms of these diseases are, as well as the symptoms of post-traumatic stress disorder, and how group members can identify these symptoms.
    - Explaining the effects that psychological trauma can have on the personality, the value system of the child, his confidence in others and his view of himself and the future.
    - Explain the symptoms of stress that arise from the problems of daily life and how they can differ from the symptoms of stress caused by exposure to psychological trauma.

9. Technique used: Automatic idea recognition and correcting technique, self-monitoring technique, exposure technique, visualization technique, technical homework technique, technical modeling technique, training technique for solving technical problems, self-talk technique, artistic role-playing technique, technical Test Guide technique, Recognizing wrong and ineffective thinking methods, technical distraction technique. The role of the researcher was to train the abused children and discuss all the methods used in the activity of this session and to enhance the spirit of positivity in children through playing and jogging and doing various sports that raise their morale and enhance their positive energies.

10. Household tasks: The child was trained to overcome learner's disability, according to what was mentioned in the session

11. Termination: The researcher provided an opportunity for the abused children to direct their questions and inquiries and express their feelings about the program in general and what happened in the session in particular.

Eighteenth Session

1. Duration of the session: 2 hours
2. Number of children participating: 15 children
3. The main objective of the session: program evaluation
4. Sub-objective of the session:
    - Closing of the program
    - Getting to know the group members' evaluation of the program
    - Carry out dimensional measurement of the program.
5. Procedure: At this stage, the researcher finishes all the topics that were discussed during the psychological discharge sessions
6. Activities used: discussion and debate
7. Tools: papers, pens, homework, Bristol paper, small colored paper, felt-tip pens
8. Application method:
    - At this stage, the researcher completed all the topics that were discussed during the psychological discharge sessions. This was done to create a positive atmosphere for the future, and to listen to any comments or suggestions regarding the program from the group members.
    - The researcher praised the children of the group for adhering to the sessions
    - The researcher asked if at any point discussions were incomplete or if there were any questions that the group members would like to ask
    - Participants were reminded of the need to maintain confidentiality
    - The researcher listened to the comments and the participants' evaluations of the steps and techniques of the program, by asking them about the situations that

were not comfortable for them in the program or about materials that were ambiguous to them, and whether or not the program met their expectations.

- Distribution of post-measurement forms that were prepared in advance by the researcher.
- The researcher and participants agreed on a method of communication following completion of the program.

9. The technique used: Automatic idea recognition and correcting technology, self-monitoring technology, exposure technique, visualization technique, technical homework technique, artistic modeling technique

10. Household tasks: review what was learned in previous sessions

11. Finish: Thank the children for their active participation. And two questionnaires are passed at the end of the session (Post-Scale PTSD and Self-Efficacy).

Home jobs	Appropriate activities	Procedures	Tools	The main and sub-objective	Session duration	Session number
relaxation exercises	Instructions were given to the abused children about the nature of the session and what are its benefits through cards distributed to them, where each child got his own card with his name written on it to identify him. Standing the bottle at the child talks about his experience in front of everyone, as the children's play activity was used to break the barrier of shyness among the abused children.	The researcher used the method of interaction with the abused children and the method of brainstorming through activities specific to the abused children and trying to woo them and break the ice between them and the abused children.	An empty bottle, cards with the names of the children in the session	Getting to know the group members, allowing the group members to get to know each other Create an atmosphere of trust between the researcher and the group members and reduce anxiety. Giving the group members a complete idea of the program and the importance of the research. Set the basic rules that will be followed during the unloading process. Identify the expectations of the group members from the proposed program	**Two hours**	**First session**
The researcher asks each child to explain the traumatic events that he experienced and that are still recurring in his memory .Then he explains the responses he made immediately after the event, and then the responses he makes when he remembers the event at the moment	The drawing activity was used for children, the coloring activity was used on the papers that were distributed in the session and the dialogue activity was used with the children. An activity was done by dividing the children into working groups with the students and dividing them into groups, brainstorming ideas through activities carried out by the abused children under the supervision of the researcher	At first, the researcher reviews what happened in the previous session and the participation of the children with a set of questions that she asks them, and then enters the session by distributing papers and colored pens to the children so that the abused child draws on those papers and coloring, with the aim of psychologically relieving the abused child and unloading his energies Positivity and changing the mental pattern of the abused child	White papers, cards, crayons, small colored paper	Defining post-traumatic stress disorder Introducing abused children to the nature of cognitive trauma therapy, which focuses on the fact that the events that occurred do not change, but that we can change the interpretation of what happened. Introducing the contents of the treatment program for abused children and the method of self-adaptation for children	**two and half hours**	**second session**

The researcher asks each child to record what they think when they experience painful feelings, and what sensory impressions (memory of the senses) are still attacking them, then the researcher asks the group members to do the following exercise: to evoke images related to PTSD, They imagine that these images are displayed in front of them on a large screen, while they are holding the remote control, and when the display of these images gets to the point of annoying that they stop the show through the remote control they have .And repeat this exercise more than once daily.	The use of the positive reinforcement activity for children, the feedback activity of the abused children was used, the distribution of small cards for the children, and the use of the role-playing activity for the abused children	The researcher first counts the abused children in the session and makes sure that their number is complete, then the researcher prepares the children psychologically for the session by introducing the topic of the session and giving them a small overview of the topic of the session, and then starting the session through games you play with the abused children and a group Activities	Papers, crayons, cards	Identifying thoughts and feelings related to PTSD and teaching them how to self-adapt. The symptoms of post-traumatic stress disorder are known, as the symptoms are placed into four categories: symptoms of re-exposure to the traumatic event, symptoms of avoidance, symptoms of loss of interest, and symptoms of agitation. Understand that symptoms are normal reactions to severe stress. Correct negative thoughts about the event. Activate group support Raising the self-efficacy of the abused child.	**One hour**	**third session**
The child's training on emotional emptying through a homework that the researcher gives to the abused children	Dialogue with abused children, use of small cards, use of role-playing style among abused children in the current session	Directing the abused child to do positive things that help him to move forward and raise his morale and self-efficacy by teaching him methods of self-	Papers, pens, cards	Identifying the emotional discharge mechanism of the abused child and identifying the way to deal with the emotional discharge	**hour and a quarter**	**Fourth session**

		adaptation to the event and strengthening the positive spirit of the abused child and consolidating the idea that what happened is an experience that has passed and making the abused child write down his thoughts in cards The researcher distributed it to the abused children.		Extracting and treating distressing feelings related to the traumatic event of the abused child		
The researcher asks the group members to do a homework by giving them the duty to learn nervous relaxation	The use of behavioral activation activity, the use of distraction activity, the use of role-playing activity, and the use of drawing activity for children that helps them to distract and unload their projects.	The researcher first counts those present in the treatment session, then asks the group to evaluate the event and the extent of its danger and threat to them by asking some questions and opening the way for the group to talk about their own experiences	Papers, crayons, small cards	How is PTSD learned? Clarify the relationship between a question of why and guilt Clarify the relationship between asking why and feeling helpless Notice irrational thoughts related to answering the questions why. Modify the distorted image that may exist of PTSD Clarify the positive meanings of PTSD Transforming a traumatic event from an exceptional event into an experience that can be included in life experiences	**An hour and a half**	**Fifth session**

The researcher asks the group members to record all the new information that they have acquired in mitigating the effects of traumatic experiences in the same brochure in which they record the homework.	Giving exercise, playing with crystal balls, playing with balloons, drawing on cards.	At the beginning of the session, the researcher asks the group members to summarize what happened in the previous session, then she clarifies the role of positive factors as a protective factor for the abused child, by promoting the child's positive spirit, where the researcher distributes colored balloons to the children and makes them choose their favorite color, and distribute Beautiful crystal balls to raise the morale of children	Papers, pens, colored crystal balls, colored balloons.	Clarification of negative self-talk and its treatment among abused children for post-traumatic stress disorder and introducing them to its own self-adaptation method Teaching children how post-traumatic stress disorder is learned Understand the fact that escape and avoidance give temporary relief because it comes right after the pain How to treat psychological support for the abused child. Enhancing the positive aspects of the group members.	**Two hours**	**Sixth session**
The researcher asks the group members to record all the new information that they have acquired in mitigating the effects of traumatic experiences in the same brochure in which they record the homework.	Giving exercise, playing with crystal balls, playing with balloons, drawing on cards	The researcher clarifies the role of positive factors as a protective factor for the abused child and defines its benefit and how to stay away from negative self-talk by strengthening the positive spirit of the child.	Papers, pens, colored crystal balls, colored balloons	Treatment of negative self-talk in abused children and its self-adaptation Teaching children how to treat negative self-talk How to treat a child abused with psychological support from negative self-talk	**hour**	**Seventh session**
The researcher asks the group members to practice the means of defense that were learned during the session, through the notes that were	Playing in groups, dividing children into two groups to compete, using identification cards with self-defense methods	The researcher focuses on the means of defense and adaptation by talking about the trauma to which each child was subjected, and how the means of adaptation he used in the beginning, and what are	Papers, pens, cards with self-defense written on it	Defining the abused child, what is the self-empowerment of post-traumatic stress disorder and the method of self-adaptation, and teaching the child how to get rid of the consequences of trauma	**Two hours**	**Eighth session**

recorded in the treatment session		the means he uses now and introducing the child to the methods of adaptation and the method of self-defense, by dividing the children into Groups and teaching them self-defense skills in a team play style				
Clarify the most important points gained through therapeutic activities.In the session and review what happened in the session	Use role playing activity, give exercises to children and use play activities	The researcher in the Badia asks the group members to summarize what happened in the previous session, and then presents information about the means of defense and adaptation and the mechanisms for using these means through sports activities by clarifying the appropriate methods of defense and self-adaptation	Papers, pens, cards, rope	Identify and clarify strategies for reducing anger and self-defense for the abused child for post-traumatic stress disorder and teaching him the method of post-traumatic self-adaptation Enabling children to reduce anger related to the traumatic event. Awareness of the control of anger over feelings. Communicate sufficient information about defense and adaptation methods and how to use them Explain the importance of defense and adaptation in mitigating or exacerbating symptoms Clarify how to use such means in the future if similar events are exposed	**two and a quarter hours**	**ninth session**
The researcher asks the group members to practice at home intellectual methods to deal with trauma management	Giving instructions, illustrations, feedback, giving the exercise	The researcher teaches abused children the art of managing trauma and ways to reduce trauma through a set of physical and intellectual activities to motivate them and give them self-discipline.	Papers, pens, drawings, cards	Clarifying the method and concept of trauma management for the abused child and for post-traumatic stress disorder	**One hour**	**tenth session**

The researcher asks the group members to practice at home intellectual methods to deal with trauma management	Giving instructions, illustrations, feedback, giving exercise,	The researcher teaches abused children the art of stress management and ways to reduce stress through a set of physical and intellectual activities to motivate them and give them self-discipline.	Papers, pens, drawings, cards	Clarify the method and concept of trauma management for the abused child with post-traumatic stress disorder and identify the means and method of self-adaptation	**Two hours**	**eleventh session**
Doing physical exercises at home and warming up in the morning and evening for the muscles, which helps to relax	Videotape, give exercise, play, do different sports, use play activity	The researcher does some exercises to warm up the children in order to relieve the psychological pressure of the abused children, such as jumping exercises in the same place and then making them run around the room for several times, which in turn works to stimulate the blood circulation	Papers, pens, cards, rope, light weights	Clarifying the method of muscle relaxation to relieve the abused child with post-traumatic stress disorder and its own self-adaptation method	**An hour and a half**	**Twelfth session**
The participants were asked, after completing the treatment session, to repeat at home what was done to him twice a day, in the morning and in the evening	using a distraction activity, using a play activity.	The researcher does some exercises to warm up the children in order to relieve the psychological pressure of the abused children	Papers, pens, weights, rope, cards	Muscular, nervous and intellectual relaxation	**hour**	**Thirteenth session**
The child's training on emotional emptying according to what was mentioned in her session	Use of play activity for abused children, use of role playing activity.	Measuring the effectiveness of emotional discharge in mitigating psychological trauma and knowing the appropriateness of this method, through participation in events and	Papers, crayons, cards	Teaching children the emotional release of children abused with post-traumatic stress disorder	**Two hours**	**Fourteenth session**

		feelings among children and through the child drawing the experience that happened with him on a paper and writing his emotions on the paper				
The child's training on exposure according to what was mentioned in her session	Play activity, role play, behavioral activation, and social support activity	Exposing the child to a similar event through the methods of stories, acting and playing, where the researcher makes the children narrate the events that occurred with them and the children then relax to gain positive energy and focus on retrieving the events	Papers, pens, cards, colors	Determine exposure to abused children with PTSD and help them think about problem-solving	**Two hours**	**fifteenth session**
The child's training on exposure according to what was mentioned in her session	illustrations, artistic role-playing activity, fantasy art activity, physical exercises	Exposing the child to a similar event through the methods of stories, playing and acting, and trying to bring out the child's memories of the accident in order to interact with him and try to overcome it by turning the idea of the event into a previous experience that will not be repeated by helping his fellow children in the session in a cooperative manner among everyone to get out of this crisis in the children the abused	Paper, pens, cards, rope, stick	Recognize the concept of exposure in the abused child and try to deal with the event and self-adaptation to him	**hour**	**Sixteenth session**

The child's training on how to overcome the learner's disability, according to what was mentioned in its session	role playing, role playing, positive stimulus, jumping, and drawing.	The researcher asks the members of the group to clarify what happened in the previous session, then he teaches the abused children the responsibility of the traumatic event through reinforcement and role-playing and doing activities for that, by playing, running, jumping, dividing the children into groups, playing among themselves with the rope, jumping through the rope, and doing Some exercise	Paper, crayons, rope, weights, stick	Clarify the concept of learned helplessness and enable the abused child to overcome the learned helplessness	**3hours**	**seventeenth session**
Review what was taken in previous sessions	discussion and dialogue	At this stage, the researcher finishes all the topics that were discussed during the sessions	Papers, pens, homework	Program evaluation Program Closing Get to know the group members' evaluation of the program Do a dimensional measurement of the program	**Two hours**	**The eighteenth and last session**

Appendix G

Informed Consent Form

(Arabic Version)

انا _____, والد/ة _____

انا اتطوع للتسجيل كجزء من دراسة تهدف لتطبيق برنامج علاجي سلوكي معرفي (CBT) للتقليل من اعراض اضطراب ما بعد الصدمة النفسية والتحسين من الكفاءة الذاتية لدى الأطفال.

انا على علم بما يلي:

1. تشمل هذه الدراسة استبانتين موافق عليهما من قبل وزاره الصحة، يتم تطبيقهما بشكل قبلي وبعدي. الاستبانة الأولى (اعراض اضطراب ما بعد الصدمة للأطفال – PTSD) والاستبانة الثانية (حول الكفاءة الذاتية).
2. سيتم تطبيق برنامج علاجي سلوكي معرفي على شكل جلسات اسبوعيه (مده الجلسة ما بين 1-3 ساعات).
3. مشاركتي هي من اختياري (تطوعية) ولن تؤثر على الخدمات التي يتلقاها طفلي في العيادة للصحة النفسية بأي شكل من الأشكال.
4. خلال الجلسات سيطلب من طفلي تنفيذ بعض المهام البسيطة الملائمة لجيله.
5. جميع المواد المكتوبة والمنشورة ستنظر في النتائج ككل ولن تقدم اي معلومات حولي، حول طفلي، او حول عائلتي كفرد.
6. جميع الاستبيانات سوف يتم تشفيرها بالأرقام ولن يتم ادراج اسمي، اسم طفلي واسم عائلتي.
7. جميع المواد ستكون في منطقة امنة وموثوقة وسيتم فحصها فقط من قبل اعضاء الهيئة الخاصة بالمشروع.

الفوائد المتوقعة من مشاركتي هي ما يلي:

1. زيادة المعلومات حول اعراض اضطراب ما بعد الصدمة لدى طفلي.
2. زيادة المعرفة حول تحسين الكفاءة الذاتية لدى طفلي.
3. معلومات حول الاحالة إذا لوحظ شيء مقلق بأي مجال لدى طفلي.

لا توجد نتائج سلبية متوقعه من المشاركة في هذه الدراسة.

1. إذا قرر اي شخص انه لا يمكنه الاستمرار بالتزامه بالمشاركة سيتم اخراجه من الدراسة بدون عواقب.

2. إذا شعر اي شخص بعدم الارتياح او أصبح منزعج بسبب المشاركة سيقدم له الدعم الفوري من اخصائيين الصحة النفسية وتوصيات لاستمرار خدمات الصحة النفسية المجتمعية بالشكل المناسب.

انا على علم بالنقاط السابقة وانا اوافق بشكل تطوعي على المشاركة في الدراسة لتطبيق برنامج علاجي معرفي سلوكي. يمكنني سحب موافقتي في أي وقت.

الاسم: _____

رقم الهاتف: _____

التوقيع: _____

التاريخ: _____

☺شكرا لتعاونكم

Appendix H

Parents Satisfaction Survey

استبيان لقياس درجة الرضا لدى الأهالي

أحط بدائرة على الإجابة التي تتوافق مع رأيك.

كيف كانت تجربتك العامة خلال المقابلة	مفيد جداً	مفيد نوعاً ما	محايد	غير مفيد	غير مفيد بتاتاً
محتوى الأسئلة	مفيد جداً	مفيد نوعاً ما	محايد	غير مفيد	غير مفيد بتاتاً
طريقة تقديم النتائج (مكتوبة)	مفيد جداً	مفيد نوعاً ما	محايد	غير مفيد	غير مفيد بتاتاً
المعلومات الواردة في النتائج	مفيد جداً	مفيد نوعاً ما	محايد	غير مفيد	غير مفيد بتاتاً
مدة المقابلة	مناسب جداً	مناسب نوعاً ما	محايد	غير مناسب	غير مناسب بتاتاً

أي ملاحظات أو اقتراحات للتحسين والتغيير:

_____

_____

_____

_____.

شكرا لتعاونكم ☺

Appendix I

Independent - Sample t-test Results for PTSD

Scale	Group	NO#	Mean	Standard Deviation	T value	Significance level
PTSD	Male	9	11.22621	60.5556	0.660	0.521
	Female	6	5.41910	63.8333		

جامعة النجاح الوطنية
كلية الدراسات العليا

أثر فاعلية برنامج علاجي سلوكي معرفي في خفض اعراض اضطراب ما بعد الصدمة وتحسين الكفاءة الذاتية المدركة لدى الأطفال المعتدى عليهم

إعداد
سجود محمود محمد سلطان

إشراف
د. فايز عزيز محاميد
د. دنيس زيا بيرتي

قدمت هذه الاطروحة استكمالاً لمتطلبات الحصول على درجة الماجستير في علم النفس الإكلينيكي،
كلية الدراسات العليا، جامعة النجاح الوطنية، نابلس، فلسطين.

2022

أثر فاعلية برنامج علاجي سلوكي معرفي في خفض اعراض اضطراب ما بعد الصدمة وتحسين الكفاءة الذاتية المدركة لدى الأطفال المعتدى عليهم

اعداد

سجود محمود محمد سلطان

اشراف

د. فايز عزيز محاميد

د. دنيس زيا بيرتي

الملخص

سعت هذه الدراسة إلى تحديد فاعلية برنامج العلاج السلوكي المعرفي في الحد من أعراض اضطراب ما بعد الصدمة وتحسين الكفاءة الذاتية المدركة لدى الأطفال المعتدى عليهم الذين يتعرضون لسوء المعاملة. اتبعت الدراسه المنهج التجريبي، اختيرت العينة المكونة من (30) طفل وطفله وتتراوح أعمارهم بين (10–15 عاما)، تم تشخيصهم باضطراب ما بعد الصدمة، والذين كانوا يتلقون العلاج في "عيادة الصحة العقلية في مدينه الطيرة". تضمت أدوات الدراسه مقياسين تم تطبيقهن بشكل قبلي وبعدي للمجموعتين، مقياس الذي يقيس اضطراب ما بعد الصدمة لدى الأطفال المعنفين، ومقياس الكفاءة الذاتية المدركة لدى الأطفال. تم تقسيم العينة بشكل عشوائي إلى مجموعتين، مجموعة تجريبية مكونه من (15) طفل، ومجموعة ضابطة مكونه أيضا من (15) طفل. كشفت نتائج الدراسة عن آثار إيجابية ذات دلالة إحصائية للعلاج السلوكي المعرفي في الحد والتقليل من الأعراض المرتبطه باضطراب ما بعد الصدمة وتحسين الكفاءة الذاتية المدركة لدى الأطفال المعتدى عليهم في المجموعة التجريبية. تشير نتائج الدراسة إلى ان العلاج المعرفي السلوكي فعال في علاج الأطفال بالتقليل من اعراض اضطراب ما بعد الصدمة بالإضافة إلى تحسين مستوى الكفاءه الذاتيه المدركة لديهم، الا ان كانت نتيجه تقليل اعراض الاضطراب قبل العلاج كان الوسط الحسابي 64.00% وبعد العلاج كانت

النتيجة 48.80%. وأيضا تم تحسين الكفاءه الذاتيه المدركه للاطفال من الوسط الحسابي 39.533% قبل العلاج وأصبحت بعد العلاج 56.40% وهذا يشير الى فاعليه البرنامج العلاجي السلوكي معرفي. أوصت الدراسة بضرورة الاهتمام بالعلاج السلوكي المعرفي ودمجه في المجالات العلاجية كافة، وتطوير المزيد من برامج العلاج السلوكي المعرفي لتناسب علاج الاضطرابات النفسية عند الأطفال.

الكلمات المفتاحية: البرنامج العلاجي السلوكي معرفي، اضطراب ما بعد الصدمة، الأطفال المعتدى عليهم، العنف، الكفاءة الذاتية.