An-Najah National University
Faculty of Graduate Studies

The Effectiveness of a Group Counseling Program Based on Prolonged Exposure Therapy (PE) in Reducing Posttraumatic Stress Disorder (PTSD) among a Sample of Traumatized Adolescents

By
Dana Sami Bdair

Supervisor
Dr. Ali Adel Al-Shak'a

Co- Supervisor
Dr. Fayez Aziz Mahamid

This Thesis is Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Psychological and Educational Counseling, Faculty Graduate Studies, An-Najah National University, Nablus, Palestine.
2020

The Effectiveness of A group Counseling Program Based on Prolonged Exposure Therapy (PE) in Reducing Posttraumatic Stress Disorder (PTSD) among a sample of Traumatized Adolescents

By
Dana Sami Bdair

This Thesis was defended successfully on ١٣/٠٢/٢٠٢٠ and approved by:

Defense Committee Members	Signature
1- Dr. Ali Adel Al-Shak'a / Supervisor	.....
2- Dr. Fayez Aziz Mahamid / Co- Supervisor	.....
3- Prof. Husni Awad / External Examiner	.....
4- Dr. Filasteen Nazzal / Internal Examiner	.....

Dedication

I dedicate my humble work to my beloved husband Moath Amir. My precious, my little handsome angel, Jad. My loving parents, Sami Bdair and Iman Badawi. To all those who love and support me unconditionally

Acknowledgment

First of all, I thank Allah for giving me the strength that I needed to finish my thesis.

I would like to express my profound gratitude to Dr. Fayez Mahamid and Dr. Ali Al-Shak’a for their valuable supervision, support, patience, and encouragement.

Special thanks to Dr. Qutaiba Agbaria for his countless support, encouragement, and help.

Also, I would like to thank Dr. Fakher Khalili, and Dr. Omar Ghannam for their effort through my study.

Special thanks to the administration of Dar-AlYateem Al-Arabi Society, and the therapeutic group for their cooperation.

الإقرار

أنا الموقعة أدناه، مقدمة الرسالة التي تحمل العنوان:

فاعلية برنامج ارشاد جمعي قائم على العلاج بالتعريض المطوّل في خفض أعراض اضطراب ضغوط ما بعد الصدمة لدى عينة من المراهقين المصدومين

The Effectiveness of A group Counseling Program Based on Prolonged Exposure Therapy (PE) in Reducing Posttraumatic Stress Disorder (PTSD) among a sample of Traumatized Adolescents

اقر بأن ما اشتملت عليه هذه الرسالة إنما هي نتاج جهدي الخاص، باستثناء ما تمت الإشارة إليه حيثما ورد، وان هذه الرسالة ككل، أو أي جزء منها لم يقدم من قبل لنيل أية درجة علمية أو بحث علمي أو بحثي لدى أية مؤسسة تعليمية أو بحثية أخرى.

Declaration

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:	**Dana Sami Bdair**	اسم الطالب:
Signature:	.....Dana Bdair.....	التوقيع:
Date:	**13/02/2020**	التاريخ:

Table of Contents

List of Tables

List of Appendixes

List of Abbreviations

PE : Prolonged exposure

PTSD : Posttraumatic stress disorder

PTG : Posttraumatic growth

CBT : Cognitive behavioral therapy

TRT : Teaching recovery techniques

CCT : Client-centered therapy

DSM-5 : The diagnostic and statistical manual of mental disorders. Ed. 5

APA : The American psychiatric association

CT : Cognitive therapy

WL : Waiting list

VA : Virtual reality

TLPD : Time-limited dynamic therapy the World Health Organization (WHO), the *International Classification of Diseases* (ICD-11)

WHO : The World Health Organization

ICD-11 : The International Classification of Diseases

The Effectiveness of a Group Counseling Program Based on Prolonged Exposure Therapy (PE) in Reducing Posttraumatic Stress Disorder (PTSD) Among a Sample of Traumatized Adolescents

By
Dana Sami Bdair
Supervisor
Dr. Ali Adel Al-Shak'a
Co- Supervisor
Dr. Fayez Aziz Mahamid

Abstract

The purpose of this study was to examine the effectiveness of a group counseling program based on prolonged exposure therapy (PE) in reducing posttraumatic stress disorder (PTSD) among a sample of traumatized adolescents in Palestine. The sample consisted of 17 adolescents who live at Dar Al-Yateem Al-Arabie society in Tulkarm, Palestine ranging from 11-16 years of age.

One group quasi-experimental design was used, in which the experimental group received counseling program based on prolonged exposure techniques over 7 weeks, 2 sessions per week. The performance of the group was tested before and after the intervention.

Results demonstrated that the group counseling program was effective in reducing PTSD symptoms among the sample members. Moreover, significant differences were showed in PTSD symptoms between males and females in favor of females. These findings support the implementation a of a group counseling program which used prolonged exposure techniques with adolescents who have PTSD or other related problems.

Key words: Group counseling for adolescents, prolonged exposure therapy, posttraumatic stress disorder, Palestine.

Chapter One

Introduction

The aim of this study is to examine the effectiveness of a group counseling program based on prolonged exposure therapy (PE) in reducing posttraumatic stress disorder (PTSD) among a sample of traumatized adolescents.

Palestinian people have witnessed very hard and disastrous events because of the Israeli occupation. These unstable political issues have been affected many areas of the Palestinians life. Such as, economical and social status (Espie et al., 2009). As a result of the difficult political conflict in Palestine, many children and adolescents have become orphans, and they have no place to go except the orphanage. Other children or adolescents were placed in orphanages by their parents who face significant economic pressure (Thabet, Elhelou, & Vostanis, 2017). Orphans are more prone to psychosocial distress and mental health risks (ex. depression, anxiety, and post-traumatic stress disorder) than non-orphaned youth (Thabet & ElRabbaiy, 2018).

Adolescents can develop posttraumatic stress disorder (PTSD) after exposure to a variety of traumatic events, including sexual abuse, interpersonal violence, and motor vehicle accidents. PTSD is associated with substantial impairments in social and academic functioning, even at subclinical levels and, if left untreated, may run a chronic course for at least

5 years in more than one third of children who develop the disorder (Smith et al., 2007).

Many studies have investigated PTSD among Palestinians, for example: Thabet & ElRabbaiy (2018) explored the impact of trauma on war- exposed orphans in Gaza Strip reporting symptoms of posttraumatic stress disorder (PTSD) and posttraumatic growth (PTG), the results showed that 32.5% of children reported partial PTSD, and 18.1% reported full criteria of PTSD. Children in the middle age group (12-14 years) reported higher levels of PTSD than younger and older groups. While Thabet, Elhelou, and Vostanis (2017) investigated the prevalence of PTSD, anxiety and depression among orphaned children in Gaza Strip, they found that 55.6% of orphaned children showed moderate PTSD and 34.6% showed severe PTSD.

Khamis (2005) studied Post-traumatic stress disorder among school age Palestinian children, results found that 34.1% of the children diagnosed with PTSD. Moreover, Qouta, Punamäki, and El Sarraj (2003) investigated the prevalence and determinants of PTSD among Palestinian children exposed to military violence. The results showed that a high percent of the children suffering from PTSD.

By examining the gathered statistics; (Khamis 2005; Qouta, Punamäki, & El Sarraj, 2003; Thabet, Elhelou, & Vostanis, 2017; Thabet ElRabbaiy, 2018), I admit that there is a serious need for therapeutic programs which helped in reducing PTSD symptoms in Palestinian

traumatized children, and this is where the research gets its importance, in which it is going to examine the effectiveness of a group counseling program based on exposure therapy in reducing PTSD among a sample of traumatized adolescents in Palestine.

Post-Traumatic Stress Disorder related to a traumatic stressors including re-experiencing trauma, numbing of responsiveness, or reduced involvement with the external world, and hyper arousal (Mahamid, Rihani & Berte, 2015). While cognitive behavioral therapy is known as a kind of therapy where the client empowers by the therapist to identify their own agency in their emotional and behavioral experiences and to develop skills to manage how their thoughts, feelings and behaviors interact and influence one another (Meichenbaum, Carlson, & Kjos, 2007). By developing self-awareness, performing experiments and monitoring themselves, clients can shift their beliefs about themselves and about the world (Meichenbaum, Carlson, & Kjos, 2007).

According to cognitive behavioral therapy (CBT), the clients with PTSD tend to avoid anything related to the traumatic event such as, places, memories, and people…etc. This is because of their wrong thoughts and perceptions. Thus, the main aim of CBT in dealing with PTSD is to modify those behaviors through restructuring the content of thoughts (Erwin, 2018).

CBT focuses on helping clients to understand processes and how they influence their thoughts, emotions and behavior, to re-assess a

person’s views regarding themselves and disorder. A therapeutic intervention in the CBT approach focuses on the symptoms of PTSD, such as re-experiencing the trauma (intrusive thoughts, flashback, physiological reactions), avoiding activities (forgetfulness, avoidance), symptoms of excessive excitation (sleeping problems, over-sensitiveness and intense reaction to surprise / astonishment) and that how a patient tries to interpret the traumatic event (Rewar, 2015).

CBT uses the followed techniques in dealing with PTSD such as identifying thoughts and beliefs, showing the relationships between physical symptoms, thoughts, emotions and behavio, looking for the evidence for and against the righteousness of dysfunctional beliefs, assumptions, exposure, the alternative hypotheses creation (Shubina, 2015). Many empirical studies have investigated the effectiveness of a therapeutic programs in reducing PTSD among the children in Palestine, for example: Mahamid, Rihani, and Berte, (2015) investigated the efficacy of a group counseling program based on expressive activities in improving the level of self-awareness and reducing symptoms of posttraumatic stress disorders among a sample of traumatized children. The results showed the effectiveness of a group counseling program in improving the level of self-awareness and reducing symptoms of PTSD among participants. While Barron, Abdallah, and Smith (2013) tested a randomized control trial of a CBT trauma recovery program in Palestinian schools, they found that teaching recovery techniques (TRT) program has the potential to ameliorate children's trauma symptoms during situations of ongoing violence.

Literature Review

Some studies were conducted to examine the efficacy of prolonged exposure in reducing PTSD. For example, Smith and others (2015) examined the effectiveness of a group of individual hybrid treatment that was developed based on PE principles, the results showed significant reductions in PTSD and depression symptoms.

Whereas, Blount, Cigrang, Foa, Ford, and Peterson (2014), evaluated the intensive outpatient prolonged exposure for combat-related PTSD in an active-duty military service member, results found that the patient's PTSD, depression, and anxiety were dramatically reduced by the end of treatment.

Also, Foa, Mclean, Capaldi, and Rosenfield (2013), studied the effects of counselor- delivered prolonged exposure therapy compared with supportive counseling for adolescents with PTSD, the results showed that adolescent girls with sexual abuse–related PTSD experience are tended to benefit greater from prolonged exposure therapy than from supportive counseling even when delivered by counselors who typically provide supportive counseling.

In addition to, Capaldi, Asnaani, Zandberg, Carpenter, and Foa (2016), tested the relation between improvements in adolescent ratings of therapeutic alliance and reductions in posttraumatic stress disorder (PTSD) severity over time among adolescent girls during prolonged exposure therapy for adolescents (PE-A) versus client-centered therapy

(CCT), as well as to examine differences in changes in alliance between treatment groups. They concluded that the rate of improvement in adolescent-rated alliance was greater in PE-A than CCT over the course of treatment. In addition, improvement in adolescent - rated alliance significantly contributed to improvements in PTSD (regardless of treatment condition), but not vice versa.

Accordingly, many studies showed the effectiveness of prolonged exposure in reducing trauma symptoms, such as, (Foa, Mclean, Capaldi, & Rosenfield, 2013; Smith et al., 2015).

This study is trying to answer the main question which is whether the group therapeutic program based on PE is going to be effective in reducing (PTSD) among the sample of Palestinian traumatized adolescents or not?

Chapter Two

Theoretical Background

Posttraumatic stress disorder (PTSD)

A traumatic event is defined as the situation or an incident that causes physical, emotional, spiritual or psychological harm. These events or experiences make people feel threatened, anxious, or frightened, in which they do not know how to react and this put them in a denial case. Moreover, as a result of these events people may develop post- traumatic stress disorder (PTSD) (Cafasso, 2016). The diagnosis of PTSD is characterized by persistent re-experiencing of the event, persistent avoidance of stimuli associated with the event, emotional numbing and hyper-arousal (Roberts, Gilman, Breslau, Breslau, & Koenen, 2011).

PTSD is best defined as one of the few disorders which requires an etiological factor (a traumatic event) for its diagnosis (Berg, Tollenaar, Spinhoven, penninx, & Elzing, 2017). This is called in DSM-5 A1 criterion that involves exposure to actual or threatened death, sexual violence or serious injury (American Psychiatric Association, 2013). While in the International Classification of Diseases (ICD-11) that was published by the World Health Organization (WHO), PTSD is defined according to three core symptom clusters, namely re-experiencing (or intrusions), avoidance, and hyper-arousal (Tay, Rees, Chen, Kareth, & Silove, 2015).

PTSD Symptoms

According to the American psychiatric association (2013), PTSD is classified into two different categories, based on age-specific criteria: One includes adults, adolescents, and children who aged 6 years or older; the other category is defined as children who aged 6 years or younger. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for PTSD consists of 20 symptoms that are divided into 4 clusters. The first one is intrusion (Criterion B), the second cluster is avoidance (Criterion C), while the third one is negative alterations in cognitions and mood (Criterion D) and the fourth is alterations in arousal and reactivity (Criterion E).

Criterion A: stressor

The person who was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (1 required)

1. Direct exposure.

2. Witnessing in person.

3. Indirectly, by learning that a close relative or friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.

4. Repeated or extreme indirect exposure to aversive details of the

event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures (Rotaru & Rusu, 2016).

Criterion B: Intrusion symptoms

The traumatic event is persistently re-experienced in the following way(s): (1 required)

1. Intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing trauma-related dreams.
3. Dissociative reactions (e.g., flashbacks).
4. Intense psychological distress when exposed to traumatic reminders.
5. Marked physiological reactions to reminders of the traumatic event(s) (Friedman, 2013).

Criterion C: Avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event: (1 required).

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations) (Edmondson, 2014).

Criterion D: Negative alterations in cognitions and mood

Negative alterations in cognitions and mood that began or worsened after the traumatic event: (2 required).

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs).

2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world.

3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.

4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame). Markedly diminished interest in (pre-traumatic) significant activities.

5. Feeling alienated from others (e.g., detachment or estrangement).

6. Constricted affect: persistent inability to experience positive emotions (DiMauro, Carter, Folk, & Kashdan, 2014).

In addition to the previous symptoms, DSM-5 adds a new subtype, “with dissociative symptoms”. This means that PTSD may contain dissociative features. Moreover, DSM-5 eliminates the acute and chronic, specifies because they lack scientific support (Levin, Kleinman, & Adler, 2014).

PTSD among adolescents

When people are exposed to an unexpected traumatic events, they tend to feel that their lives are endangered and that they have no control on what is happening. As a result, they become scared, angry and confused leading to the development of serious mental health disorders, such as, PTSD (Baddoura & Merhi, 2015).

Adolescents are more vulnerable to traumatic events and prone to develop psychiatric maladaptation. This is because adolescents are maturing in a way in which they must simultaneously deal with significant changes to their physical and psychosocial development (Zhang, Liu, Jiang, Wu, & Tian, 2014). For example, one-fifth of children and adolescents developed PTSD in the aftermath of road traffic accidents (RTAs) (Dai et al., 2018).

The traumatic events that may lead to the developing of PTSD includes war, being kidnapped or taken hostage, confinement as a prisoner of war, terrorist attack, severe car accidents, torture or violent personal sexual or physical assault. Moreover, children may develop PTSD after the death of a loved one, witnessing a serious injury, or being the victim of sexual abuse (Russell, 2011).

Children and adolescents with prior physical, emotional (particularly anxiety), and behavioral difficulties and who come from disorganized, chaotic, or isolated families are at increased risk for developing PTSD.

Moreover, socioeconomic status is considered a risk factor for developing PTSD among children, in which children who are living in poor urban neighborhoods would most likely be exposed to high rates of community violence (Erolin, Wieling, & Parra, 2014). Moreover, children and adolescents who experienced previous victimization, and have a history of psychopathology, or who were exposed to interpersonal types of index trauma are more vulnerable to PTSD (Lewis et al., 2019). However, adolescents are generally at greater risk of PTSD than children (Nooner et al., 2012).

Another risk factor which seems to play a huge role in the intensity of PTSD symptoms is related to the characteristics of the traumatic event (duration, severity and relationship to the perpetrator) (Hébert, Lavoie, & Blais, 2014).

PTSD among children and adolescents is associated with several symptoms that may include depression, anxiety, impulsivity, aggression, hyperactivity, agitation, irritability, behavior problems, sleep difficulties, and attentional deficits that further impair daily functioning (Alisic et al., 2014).

PTSD has a negative effect on adolescent social and academic functioning. For example, a sample of adolescent girls with PTSD were more likely to report having failed a class, have been suspended from school, and have been arrested. Moreover, PTSD symptoms were associated with impairments in friendships and social functioning among

adolescents (McLean, Rosenbach, Capaldi, & Foa, 2013).

Adolescents with PTSD tend to have sleep problems, including general sleep disturbance and fear of sleeping alone. This could be because of the nightmares about the traumatic event. Or because of threats of harming the self, family, and/or home, as well as the threats from actual separations among family members, and in case of natural catastrophes (Brown, Mellman, Alfano, & Weems, 2011).

Traumatized adolescents seem to behave in an aggressive way. Since anxious emotion that is associated with PTSD may foster aggressive acts towards peers in the context of relatively mild peer provocation. Aggressive behaviors are seen as part of a heightened activation of the anxiety and fear response system (Scott, Lapré, Marsee, & Weems, 2014).

PTSD from the perspective of counseling theories

Different theories tried to explain the etiology and maintenance of the disorder (Park, Mills, & Edmondson, 2014). The most important theories are, psychodynamic, attachment, conditioning learning, social cognitive, information processing, emotional processing and dual representation theory (Mahamid, Rihani, & Berte 2015).

As Cash (2006) mentioned, Freud looks to the traumatic events as threaten to the ego, as a result of this threaten individuals start to use repression as a defense mechanism. When traumatic stressors and daily stressors met, the ego won't be able any more to tolerate these stressors, which lead to the appearance of PTSD symptoms.

While PTSD is developing because of the stressors from the surrounding environment according to the social approach. Whereas, person-centered approach relates PTSD to the interpersonal negative feelings such as (shame and guilt), also because of the avoidance behaviors from people towards the traumatized person (Maercker & Hecker, 2016).

According to attachment theory, PTSD can be seen as a result of stressful-related events such as the unresolved loss of a loved one, Bowlby, recognize different negative life events that would be expected to influence the stability of attachment: foster care, divorce, death of beloved ones, and severe illness (O'Connor & Elklit, 2008).

According to the emotional theories, PTSD can be seen as a result of the inability to cope or to adapt emotionally with traumatized events (Suveg & Zeman, 2004). Moreover, individuals with pre-trauma belief systems are more vulnerable to PTSD than those with more flexible belief systems. That is, in the face of trauma, rigid positive beliefs about the self and world are more vulnerable to disruption, and rigid negative beliefs are more vulnerable to confirmation (Park, Mills, & Edmondson, 2014). The model further suggests that negative appraisals of trauma responses (e.g., response of self to trauma, response of others, response to early trauma symptoms) may interact with preexisting beliefs to reinforce the feelings of pervasive threat and incompetence characteristic of chronic PTSD (Park, Mills, & Edmondson, 2014).

The central idea according to the cognitive theories is that there is something special about the way the traumatic event is represented in memory and that if it is not processed in an appropriate way, psychopathology will be resulted (Brewin & Holmes, 2003). While behavioral theories explain PTSD as a result of the classical conditioning, and learning theory, individuals learn the avoidance behaviors which lead to the feelings of anxiety (Abu-Hassan & Hamed, 2016).

Following Mowrer's two-factor learning theory, an initial phase of fear acquisition through classical conditioning results in neutral stimuli presented in the traumatic situation acquiring fear-eliciting properties through their association with the unconditioned stimulus (in this case, those elements of the traumatic situation that directly arouse fear) (Brewin & Holmes, 2003). It was proposed that a wide variety of associated stimuli would acquire the ability to arouse fear through the processes of stimulus generalization and higher order conditioning. Although repeated exposure to spontaneous memories of the trauma would normally be sufficient to extinguish these associations, extinction would fail to occur if the persons attempted to distract themselves or block out the memories, rendering the exposure incomplete, avoidance of the conditioned stimuli, whether through distraction, blocking of memories, or other behaviors, would be reinforced by a reduction in fear, leading to the maintenance of PTSD (Brewin & Holmes, 2003).

Although the conditioning approach does not clearly distinguish the

etiology of PTSD from other anxiety disorders, it does provide a powerful explanation of many prominent symptoms of PTSD, especially the wide range of potential trauma reminders, physiological and emotional arousal elicited by these reminders, and the central role of avoidance in the maintenance of PTSD. The behavioral theory is less useful in explaining the nature of re-experiencing symptoms, effects on attention and declarative memory, the influence of emotions other than fear, and the role of appraisals and coping strategies (Pitman, Shalev, & Orr, 2000).

Behavior therapy is an empirically based treatment approach that has demonstrated efficacy across numerous psychological disorders including mood disorders, anxiety disorders, eating, and substance use disorders. Behavior therapy has also proven its efficiency with numerous "problems with living" including weight management, smoking cessation, and childhood behavior problems, in behavior therapy, the therapist and patient work together to understand the factors that maintain problematic behaviors, and strategies are then initiated to help patients discontinue problematic behaviors and/or initiate new more, adaptive behaviors (Ledely & Huppert, 2007).

Many therapeutic techniques fall under the umbrella of behavior therapy, from systematic desensitization, exposure therapies, aversion therapy, social skills training, and biofeedback, they all are meant to accomplish these same goals (Corey, 2005; Weiten, 2007).

Behavior therapists perform a functional analysis, they evaluate

(assess) the behavior, antecedents and consequences associated with it (assessment). Then, they identify causes (antecedents) of the behavior, the therapist makes hypotheses about what factors contribute to controlling the behavior, information from the functional analysis guides the choice of the behavioral interventions. The functional analysis provides a way to further specify goals. Behavior therapists may not always perform an explicit functional analysis, but they do perform assessments, selecting appropriate goals is done through assessment, as behavior therapists learn more about the antecedents and consequences of the behavior, they are more able to help the client identify specific goals. As assessment continues, clients are able to explore, with the help of the therapist, possible advantages and disadvantages of goals, how the goals can be achieved, and the likelihood of doing so, assessment is a process that continues throughout behavior therapy and after it ends. Measurement of change as it relates to achieving goals, is a continuing part of behavior therapy and functional analysis (Sharf, 2015).

According to (Seligman & Reichenberg, 2013), behavior therapy is based on eleven therapeutic principles. They are:

1. Although genetics play a role, individual differences are derived primarily from different experiences.

2. Behavior is learned and acquired largely through modeling, conditioning, and reinforcement.

3. Behavior has a purpose.

4. Behavior is the major determinant of habits, thoughts, emotions, and other aspects of personality.

5. Behavior therapy seeks to understand and change behavior.

6. Therapy should be based on the scientific method and be systematic, empirical, and experimental, goals should be stated with respect to behavioral, specific, and measurable terms, with progress assessed regularly.

7. The focus of treatment should generally be on the present, even if behaviors are longstanding; they are maintained by factors in the current environment.

8. However, behaviors must be viewed in context, and some exploration of the past is appropriate, and helps people feel understood.

9. Education that promotes new learning and the concept of learning transfer is an important aspect of behavior therapy.

10. Strategies of behavior therapy need to be individualized to the particular person and problem.

11. Clients have primary responsibility for defining their goals and completing homework tasks, the treatment plan is formulated collaboratively, with both client and clinician participating actively in that process.

Cognitive therapy (CT) is a type of psychotherapy developed by American psychiatrist Aaron T. Beck. CT is one of the therapeutic approaches within the larger group of cognitive behavioral therapies (CBT) and was first expounded by Beck in the 1960s. Cognitive therapy is based on the cognitive model, which states that thoughts, feelings and behavior are all connected, and that individuals can move towards overcoming difficulties and meeting their goals by identifying and changing unhelpful or inaccurate thinking, problematic behavior, and distressing emotional responses. This involves the individual working collaboratively with the therapist to develop skills for testing and modifying beliefs, identifying distorted thinking, relating to others in different ways, and changing behaviors (Beck, 2008).

According to Ehlers and Clark, PTSD appears when the person is processing the trauma and its consequences in a way, cause a sense of current threat. Then there are two key processes: 1. negative assessment of trauma and its consequences; 2. coding of traumatic event memories (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005).

Cognitive-behavioral therapy (CBT) is a psycho-social intervention that aims to improve mental health (Beck, 2011; Field, Beeson, & Jones, 2015; Hollon & Beck, 1994). CBT focuses on challenging and changing unhelpful cognitive distortions (e.g. thoughts, beliefs, and attitudes) and behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems. Originally, it was designed to treat depression, but its use has been expanded to include

treatment of a number of mental health conditions, including anxiety (Beck, 2011; Benjamin et al., 2011; McKay et al., 2015; Zhipei et al., 2014).

In dealing with PTSD, several CBT techniques are used: psychoeducation about trauma, relaxation training, identification and modification of cognitive distortions, prolonged exposure (PE), and wait list (WL) (Foa et al., 2005; Pangrazio, 2018).

Prolonged exposure therapy and its techniques

Exposure therapy is a psychological treatment that was developed to help people confront their fears, when people are fearful of something, they tend to avoid the feared objects, activities, or situations, although this avoidance might help reduce feelings of fear in the short term, over the long term it can make the fear become even worse, in such situations, a psychologist might recommend a program of exposure therapy in order to help break the pattern of avoidance and fear, in this form of therapy, psychologists create a safe environment in which to "expose" individuals to the things they fear and avoid, the exposure to the feared objects, activities, or situations in a safe environment helps reduce fear and decrease avoidance (Abramowitz, Deacon, & Whiteside, 2011).

A prolonged exposure therapy (PE) is a cognitive-behavioral therapy (CBT) based on the integration of exposure therapy principles with the framework of emotional processing theory, prolonged exposure therapy is designed specifically to ameliorate posttraumatic stress disorder (PTSD) and related problems through safe confrontation with thoughts, memories,

places, activities and people that have been avoided since a traumatic event occurred (Foa, Hembree, & Rothbaum 2007; Peterson, Foa, & Riggs, 2011).

PE is a trauma-focused approach, which means that the focus is primarily on processing the memory of the trauma and its effects on the patient's life and, accordingly, to directly target trauma-related symptoms such as PTSD (Van Minnen, Zoellner, Harned, & Mills, 2015).

In the context of PTSD, PE is delivered in an individual format and typically consists of 9–12 sessions, each session lasts for about 90 minutes. The treatment includes four procedures: (1) psychoeducation about trauma, reactions to trauma, and PTSD; (2) breathing retraining; (3) in vivo exposure to the feared (but now safe) trauma-related situations that the client avoids; and (4) imaginal exposure that consists of repeatedly recounting memories of the traumatic event, at the end of each imaginal exposure session, the client and therapist process the thoughts and feelings that emerged during the imaginal exposure or as a result of recounting the trauma. Finally, each session ends with a homework assignment that includes in vivo exercises and listening to tape recordings of the imaginal exposure exercise conducted in that session (Riggs, Cahill, & Foa, 2006).

Techniques of prolonged exposure therapy

In case of PTSD exposure-based programs, they include the following techniques, which has to help process the trauma emotionally:

1. Virtual reality (VR) was developed as one of several new computer-based formats for the delivery of exposure therapy. VR is a human-computer interaction paradigm in which users are active participants within a computer generated three-dimensional virtual world (Rothbaum et al., 2006).

2. In vivo exposure: Directly facing a feared object, situation, or activity in real life (Antony, McCabe, Leeuw, Sano, & Swinson, 2001). In vivo therapy consists of two types, the first one in which the client approaches the feared stimuli gradually (similar to systematic desensitization) and the second one in which the client works directly with the feared situation (similar to imaginal flooding). With the gradual approach, clients often learn and practice relaxation techniques that will compete with the exposure to anxious situations (Corey, 2011). In some cases, other competing responses, such as pleasant images, are also used to compete with the anxiety experienced in the actual situation. A client choosing a gradual approach to reducing fears and anxiety would discuss with therapists which situations are likely to arouse varying degrees of anxiety, establishing a hierarchy or list of events. While intense in vivo exposure therapy, the exposure is to a strongly feared situation.

   Before starting the exposure, the therapist assures the client that the therapy is effective, that the therapist will be there with the client, and that some emotional distress will be experienced (Sharf, 2015).

3. Imaginal exposure: Vividly imagining the feared object, situation, or activity (Gros et al., 2012).

4. Interoceptive exposure: Deliberately bringing on physical sensations that are harmless, yet feared (Craske et al., 2011).

More specifically, PE is comprised of three main components: first, in vivo exposure to trauma reminders, typically as homework; second, imaginal exposure to the memory of the traumatic event, both in session and as homework; and third, processing of imaginal exposure, as well as two minor components: psychoeducation about the nature of trauma and trauma reactions, including a clear rationale for the use of exposure therapy, and training in controlled breathing (McLean & Foa, 2011).

The effectiveness of prolonged exposure therapy in decreasing PTSD symptoms

Exposure therapy was first employed with PTSD in combat veterans, while stress inoculation training was used with victims of sexual assault (Foa, Chrestman, & Gilboa-Schechtman, 2008). Later studies indicated that CBT programs included PE techniques were effective in reducing PTSD across a wide range of trauma population, including veterans, and terror related PTSD with moral injury (Eftekhari et al., 2013; Goodson, Lefkowitz, Helstrom, & Gawrysiak, 2013; Held, Klassen, Brennan, & Zalta, 2018; Nacasch et al., 2011; Smith et al., 2015; Tuerk et al., 2011); motor vehicle accident (Popiel, Zawadzki, Pragłowska, & Teichman,

2015), refugees (Paunovic & Öst, 2001), sexual assault (Feeny, Linares, & Foa, 2007), internet based trauma (Spence et al., 2014), and patients with multiple interpersonal trauma (Hendriks, Kleine, Broekman, Hendriks, & Minnen, 2018).

Moreover, PE was found to be very effective in reducing PTSD symptoms among adolescents. For example, Gilboa-Schechtman et al. (2010, 2016) examined the efficacy and maintenance of developmentally adapted prolonged exposure therapy for adolescents (PE-A) compared with active control time-limited dynamic therapy (TLDP-A) for decreasing posttraumatic and depressive symptoms in adolescent victims of single-event traumas. It was found that PE-A more effective in decreasing PTSD and depression symptom severity and more increasing in global functioning than did TDLP-A. Whereas Rossouw, Yadin, Alexander, and Seedat (2018) investigated the effects of prolonged exposure therapy compared with supportive counseling for adolescents with PTSD delivered by nurses trained as counselors, they found that PE is an effective treatment for PTSD in adolescents. So, prolonged exposure is recommended in international guidelines as first choice treatment in PTSD patients (Hendriks, de Kleine, & Minnen, 2015).

Summary

Traumatic experiences (e.g., sexual or physical abuse, severe traffic accidents, natural disasters, experiencing or witnessing violence) are unfortunately quite common among children and adolescents. Most adults

and children are resilient and do not develop long-lasting emotional disturbances after they experience a traumatic event, a minority develop chronic problems. The most negative psychological outcome of trauma is PTSD.

PTSD characterized by symptoms of re-experiencing, avoidance of trauma-related stimuli, and hyperarousal.

Many treatments were found to be effective in reducing PTSD symptoms. One of these treatments is the prolonged exposure therapy in which both exposure therapy principles and framework of emotional processing theory are emerged in the therapeutic process.

Chapter Three

Methodology

Study Design

One group quasi-experimental design (pre-test post-test design) was used to examine the effectiveness of a group-counseling program based on prolonged exposure (PE) in reducing posttraumatic stress disorder (PTSD) among a sample of traumatized adolescents. The performance of the group will be tested before and after the intervention. The following symbols explain the research's design (Montero & León, 2007):

O_1 X_1 O_2

(O1) Pre-test X1: Treatment plan (O2) Post-test

Study Sample

The sample of this study was selected randomly from a population of traumatized adolescents at Dar Al-Yateem Al- Arabei society which is an orphanage situated in the city of Tulkarm. It has a total of 55 resident children aging 6-18 years. The sample was consist of (17) adolescents; (14) males, and (3) females. The orphanage is registered as a non-governmental organization (NGO) which is operating by receiving local donations, and no statutory (local and international) organizations. Large size families who find it difficult to cope after the loss of one parent (usually the father), or have an economical or social problems may

approach orphanage for one or two of their children to be admitted. Children can retain contact with the remaining parent and relatives, and return home during school holidays. They can also be visited at the orphanage, to retain links with their natural extended family. After applying the PTSD scale on all traumatized adolescents at the society, totaling (20). The sample was selected from those who scored the highest scores on PTSD scale, totaling (17). Then, the performance of those who received the therapeutic program (Experimental group) was tested before and after the intervention.

Study Variables

Independent variables

The group counseling program that based on prolonged exposure therapy is defined as a 13 prolonged exposure counseling sessions; the duration of each session is estimated between 90-150 minutes. Each session has its aims and techniques.

Gender which has two levels: males and females.

Dependent Variables

Symptoms of PTSD which defined as the score the adolescents received on the PTSD Scale which will be used in the current study.

Study Instruments

To accomplish the goals of this study, the following instruments were used:

PTSD Scale: Appendix (I)

The current study used Fayez Mahamid's scale for PTSD symptoms. Mahamid (2015) constructed and validated this instrument to test the PTSD symptoms in the Palestinian context. The scale ended up with 47 items distributed on six dimensions; re-experiencing trauma, avoidance and numbing, hyper-arousal, physical symptoms, traumatic play, and psychological symptoms.

Validity of the Scale

First: Content Validity: was tested by using 80% as a percentage of agreement between experts for each item. Accordingly, the researcher dropped 5 items of the scale and changed the language expression for some items (Mahamid, Rihani, & Berte, 2015).

Second: Construct Validity: all correlations between total score of PTSD scale and its items were significant (Mahamid, Rihani, & Berte, 2015).

The final form of the PTSD scale ended up containing 47 items represented in the following dimensions:

1. **Re-experiencing Trauma**: including recurrent and intrusive distressing recollections, such as: images, thoughts, dreams, perceptions, illusions, hallucinations, dissociative flashbacks relevant to the experience. The following items represent the re-experiencing dimension 1, 2, 3, 4, 5, and 6.

2. **Avoidance and Numbing**: Efforts to avoid thoughts, feelings and conversations associated with the trauma activities such as: places, people and things that arouse recollections of the trauma. The following items represent the avoidance and numbing dimension 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 and 17.

3. **Hyperarousal:** A condition in which the patient's nervous system is always alert for the return of danger. This includes hypervigilance, insomnia, and difficulty concentrating, general irritability, and an extreme startle response. The following items represent the hyperarousal dimension 18, 19, 20,21,22,23, and 24.

4. **Physical Symptoms**: This includes sleep difficulties, hyperactivity, abrupt mood swings, and memory disorders and decreased level of energy or resilience. The following items represent the physical symptoms dimension 25, 26,27,28,29 and 30.

5. **Traumatic play**: Children recreate parts of the event that frightened them during their playing, they are deeply driven by the feelings associated with the original trauma. The following items represent the traumatic play dimension 31, 32, 33,34,35,36 and 37

6. **Psychological Symptoms:** This includes the psychological reactions related to trauma such as: lack of self-efficacy, suicidal behaviors, cognitive disorders, trustless, hopeless and aggressive behaviors. The following items represent the Psychological symptoms dimension (38, 39, 40,41,42,43,44,45,46, and 47).

Reliability of the Scale

According to Mahamid, Rihani, and Berte (2015), the reliability of the scale was 0.93, which is appropriate for the purpose of this study.

Scale Scoring

The scale contains five point rating scale (always, mostly, sometimes, rarely and never), the alternative always took five scores, mostly four scores, sometimes three scores, rarely two scores, and never one score . The scores of PTSD scale ranging between 47-235 the score 235 indicating high level of PTSD, on the other hand the score 47 indicating low level of PTSD (Mahamid, Rihani, & Berte, 2015).

Group Prolonged Exposure Counseling Program: Appendix (II)

This program is based on prolonged exposure therapy. The program includes 13 sessions, two sessions per week, every session ranging from 90- 190 minutes, over approximately 2 months. The overall aim of PE is to help trauma survivors emotionally process their traumatic experiences in order to diminish PTSD and other trauma-related symptoms. The name "prolonged exposure" reflects the fact that the treatment program emerged from the long tradition of exposure therapy for anxiety disorders, in which clients are helped to confront safe but anxiety - evoking situations in order to overcome their excessive fear and anxiety. At the same time, PE has emerged from the emotional processing theory of PTSD, which emphasizes the central role of successful processing of the traumatic memory in the amelioration of PTSD symptoms. The following is a brief description of the program sessions:

Session No.	Aims of the Program
1	Build a good rapport with the participants; Introduce the participants to the program and its' aims; Identify the patient's life domains that have been disrupted as a result of the trauma; Agree on the place and the time of the sessions; Identify potential benefits of the patient's participation in therapy; Identify potential obstacles to the patient's participation in therapy; Summarize the session activities.
2	Introduce the rationale of the treatment to patients; Introduce breathing retraining; Give homework.
3	Conduct trauma interview in order to gather information; Give the homework.
4	Discuss the common reactions of trauma; Give the homework
5, 6, 7, 8, 9	Introduce the method for imaginal exposure; Including hierarchy and stress thermometer; Conduct imaginal exposure; Assign the homework.
10, 11, 12	List the avoiding situation of the participants; Introduce the method for in-vivo exposure; Conduct in-vivo exposure; Assign homework.
13	Plan coping strategies for symptom relapse; Discuss the patient's feelings about their accomplishment; Discuss the patient's feelings about Ending the program.

Study procedure

After selecting the population of the study (traumatized adolescents at Dar Al-Yateem Al-Arabei society) in the city of Tulkarm, the researcher applied the PTSD scale on all traumatized adolescents at that society, totaling 20 adolescents. During applying the PTSD scale the counselor

explained all aspects of the PTSD scale for the adolescents, including clarifying the meaning of some items. Then those who received highest scores on PTSD scale were considered as a targeted sample for this study (17) adolescents.

Findings

First: There are no differences at the level of significance (α = 0.05) in the pre-test of PTSD symptoms due to gender.

To test this hypothesis, the data were processed using the Mann-Whitney test to identify the significance of the differences between the averages of the male and female participants on the pre-test, as shown in Table (1).

Table (1): Mann Whitney test to identify the differences in gender on the pre-test

PTSD	Variable	N	Average	Total	U	W	Z	Sig.
Re- experiencing trauma	Male	14	8.54	119.50	14.5	119.5	-.082	0.41
	Female	3	11.17	33.50				
Avoidance and numbing	Male	14	8.11	113.50	8.5	113.5	-1.57	0.11
	Female	3	13.17	39.50				
Hyperarousal	Male	14	9.04	126.50	20.5	0.26.5	-0.06	0.94
	Female	3	8.83	26.50				
Physical symptoms	Male	14	8.07	113.00	8	113	-1.64	0.09
	Female	3	13.33	40.00				
Traumatic play	Male	14	9.71	136.00	11	17	-1.27	0.20
	Female	3	5.67	17.00				
Psychological symptoms	Male	14	9.00	126.00	21	27	0.00	1.00
	Female	3	9.00	27.00				
Total score	Male	14	8.61	120.50	15.5	12.5	-0.69	0.48
	Female	3	10.83	32.50				

Table (1) shows that the value of P is larger than 0.05, indicating that there were no differences in the average of male and female in PTSD symptoms on the pre-test.

Second: There are no differences at the level of significance (α = 0.05) in the post-test of PTSD symptoms due to gender.

To test this hypothesis, the data were processed using the Mann-Whitney test to identify the significance of the differences between the averages of the male and female participants on the pre-test, as shown in Table (2).

Table (2): Mann Whitney test to identify the differences in gender on the post-test

PTSD	Variable	N	Average	Total	U	W	Z	Sig.
Re-experiencing trauma	Male	14	9.39	131.50	15.5	21.5	-0.70	0.48
	Female	3	7.17	21.50				
Avoidance and numbing	Male	14	9.36	131.00	16	22	-0.63	0.52
	Female	3	7.33	22.00				
Hyperarousal	Male	14	9.07	127.00	20	26	-0.12	0.89
	Female	3	8.67	26.00				
Physical symptoms	Male	14	8.46	118.50	13.5	118.5	-0.97	0.33
	Female	3	11.50	34.50				
Traumatic play	Male	14	10.07	141.00	6	12	-1.91	0.05*
	Female	3	4.00	12.00				
Psychological symptoms	Male	14	10.29	144.00	3	9	-2.29	0.02*
	Female	3	3.00	9.00				
Total score	Male	14	9.79	137	10	16	-1.39	0.16
	Female	3	5.33	16				

Table (2) shows significant differences in PTSD symptoms between males and females in favor of females visavie traumatic play dimension, the value of Z reached -1.91, the coefficient of U reached 6 and the value of P reached 0.05, results also show significant differences between males and females on psychological symptoms dimension, the value of Z

reached - 2.29, the coefficient of U reached 3 and the value of P reached 0.02 which is less than 0.05, indicating that there were significant differences in psychological symptoms between males and females participants in favor of females.

Third: There are no differences at the level of significance (α = 0.05) between the pre-test and post-test in the PTSD symptoms among the experimental group members.

To answer this hypothesis, the data were processed using the Wilcoxon test for the associated samples, to identify the significance of the differences between the mean ranks of the two tests on PTSD symptoms scale, as shown in Table (3).

Table (3): Wilcoxon test to examine the differences between the ranks of tests

PTSD	Measures	Rank	N	Mean	Sum	Z	Sig.
Re-experiencing trauma	Pre-test	Negative	17	9	153	-3.626	0.000 *
	Post-test	Positive	0	0	0		
		Equally	0				
Avoidance and numbing	Pre-test	Negative	17	9	153	-3.623	0.000 *
	Post-test	Positive	0	0	0		
		Equally	0				
Hyperarousal	Pre-test	Negative	17	9	153	-3.628	0.000 *
	Post-test	Positive	0	0	0		
		Equally	0				
Physical symptoms	Pre-test	Negative	17	9	153	-3.623	0.000 *
	Post-test	Positive	0	0	0		
		Equally	0				
Traumatic play	Pre-test	Negative	17	9	153	-3.577	0.000 *
	Post-test	Positive	0	0	0		
		Equally	0				
Psychological symptoms	Pre-test	Negative	17	9	153	-3.628	0.000 *
	Post-test	Positive	0	0	0		
		Equally	0				
Total score	Pre-test	Negative	17	9	153	-3.621	0.000 *
	Post-test	Positive	0	0	0		
		Equally	0				

It is clear from the previous table that there are significant differences in PTSD symptoms at the level of significance 0.05 in the test averages of the experimental group, showing an improvement in the post-test. The value of Z on total score is -3.621, the P value is 0.000, and the mean rank for the pre-test was 9 while mean rank for the post-test was 0.00, which is greater than the pre-test average.

Chapter Four

Discussion and Conclusions

Discussion

This study examined the effectiveness of a group counseling program based on prolonged exposure therapy (PE) in reducing posttraumatic stress disorder (PTSD) among a sample of traumatized adolescents at Dar Al-Yateem Al-Arabei society in the city of Tulkarm.

The results of this study emphasized the effectiveness of the treatment plan in reducing PTSD symptoms among the experimental group.

The following paragraphs discuss the questions of the study:

First: Discussion of the results related to the first question which is: Are there differences in PTSD symptoms on pre-test due to gender?

Results of this question showed that there were no differences in the average of male and female in PTSD symptoms on the pre-test among the therapeutic group members.

The average results of male and female showed that there were no differences among the experimental group in all dimensions of PTSD: re-experiencing trauma, avoidance and numbing, hyper-arousal, physical symptoms, traumatic play, and psychological symptoms.

These results reinforce the similarity and homogeneity among the

experimental group members. And it gave us the chance to examine the effectiveness of treatment plan due to gender, in which the results would be more generalized.

Second: Are there differences in PTSD symptoms on post-test due to gender?

The results of this question are consistent with a study for Eftekhari and others (2013) in which they evaluated the effectiveness of PE as implemented with veterans with PTSD in a large health care system. The findings showed that although all veteran subgroups showed clinically and statistically significant improvement, the most improvement was seen in females.

The results showed significant differences in PTSD symptoms between males and females in favor of females on two dimensions; the traumatic play dimension and the psychological symptoms dimension. This is could be because females were more cooperative than males, and because they are living under the same circumstances (in the same place); they are treating the same.

Despite this, the results showed that there were no differences in PTSD symptoms between males and females according to four dimensions. One possible explanation could be because they were exposed to similar traumatic events, and because they all have the same socioeconomic status which is not very good. Also, these similarities

could be because they are receiving the same psychological and physical care at the orphanage.

These results indicated that prolonged exposure could be more beneficial for females more than males, especially in reducing the symptoms that are related to traumatic play dimension and psychological symptoms dimension.

Third: Are there differences in PTSD symptoms between pre and post tests among the experimental group (those who received the treatment)?

The results of this question are consistent with some studies such as: two studies of Gilboa-Schechtman and others (2010, 2016) in which they compared the efficacy and maintenance of developmentally adapted prolonged exposure therapy for adolescents (PE-A) with active control time-limited dynamic therapy (TLDP-A) for decreasing posttraumatic and depressive symptoms in adolescent victims of single-event traumas. It was found that PE-A more effective in decreasing PTSD and depression symptom severity and more increasing in global functioning than did TDLP-A.

The results also agreed with study of Foa and colleagues (2013) also compared the effects of counselor-delivered prolonged exposure therapy with supportive counseling for adolescent's girls with sexual abuse–related PTSD. The results indicated that the adolescent's girls with sexual abuse–related PTSD experienced greater benefit from prolonged exposure therapy

than from supportive counseling.

The results of this study supported Rossouw's and others (2018) in which they compared the efficacy of prolonged exposure therapy with supportive counseling (SC) for adolescents with PTSD. They concluded that PE is an effective treatment for PTSD in adolescents more than SC.

The results fitted with study of Popiel and others study (2015) who compared the efficacy of prolonged exposure (PE), paroxetine (Ph) and their combination (Comb) in a sample of adults diagnosed with PTSD following motor vehicle accidents (MVA). The results showed that the remission rate of PTSD was greater after PE compared with Ph, whereas Comb did not differ from either.

The findings of the study are also consistent with study of van den Berg and others study (2015) who examined the efficacy and safety of prolonged exposure (PE) therapy and eye movement desensitization and reprocessing (EMDR) therapy in patients with psychotic disorders and comorbid PTSD. The results revealed that standard PE and EMDR protocols are effective, safe, and feasible in patients with PTSD and severe psychotic disorders, including current symptoms.

The results of this question showed that there were significant differences among experimental group between pre-test and post-test on the six dimensions of the scale, in favor of the post- test. These results showed the effectiveness of the therapeutic program in reducing PTSD

symptoms. The therapeutic program gave the chance to the patients in order to confront their fears and feelings, so they could overcome them through different techniques such as imaginal exposure and in-vivo exposure.

According to the previous results, the program techniques and activities gave the patients the opportunity to deal with their anger, anxiety, and guilt. Moreover, this program makes them acquire techniques in order to deal with their stress and anxiety, such as breathing retraining technique.

In addition, the results of this question showed that the therapeutic program acquired the patients techniques in which they can think in a rational way, and to deal with similar situations (traumatic events) that may face them in the future.

Conclusions

Prolonged exposure therapy should be adopted as a worthy therapy in decreasing PTSD symptoms with other counseling populations who may suffer from PTSD symptoms. Moreover, it is very important to deal with other problems that may face adolescents with PTSD, such as, anxiety, feelings of anger, shame, sleep problems, and dissociative disorders. In addition, single exposure activities such as: imaginal, and in-vivo should be delivered in an individual and group counseling programs in order to deal with traumatized adolescents and other psychological problems.

Limitations

The study has several limitations: The first one is related to the sample size. The small sample size did not allow inclusion to the entire traumatized adolescents' population in West Bank. Moreover, it did not allow the researcher to have control group during the therapeutic experiment. in addition to that, it was selected only from traumatized children at Dar-Al-Yateem Al-Arabie Assembly in the city of Tulkarm.

Another limitation is related to the study instruments; the therapeutic program, and PTSD scale.

Another limitation is related to the date and the time of sessions. It was not allowed to have sessions at Thursdays, Fridays, and Saturdays. Furthermore, it was not allowed to start the therapeutic session before 02:00 pm.

References

Abramowitz, J. S., Deacon, B. J., & Whiteside, S. P. (2011). **Exposure therapy for anxiety: Principles and practice.** Guilford Press.

Abu-Hassan, W., & Hamed, G. G. (2016). ***Post-Traumatic Stress Disorder and its Psychosocial Impacts on the Palestinian Child***. **The Canadian Journal for Middle East Studies,** 1(2), 1142.

Alisic, E., Zalta, A. K., Van Wesel, F., Larsen, S. E., Hafstad, G. S., Hassanpour, K., & Smid, G. E. (2014). ***Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: Meta-analysis***. **The British Journal of Psychiatry**, 204(5), 335-340.

American Psychiatric Association (2013). **Diagnostic and statistical manual of mental disorders, (5th ed.)**. Washington, DC: American Psychiatric Association.

Antony, M. M., McCabe, R. E., Leeuw, I., Sano, N., & Swinson, R. P. (2001). ***Effect of distraction and coping style on in vivo exposure for specific phobia of spiders***. **Behaviour Research and Therapy**, 39(10),1137-1150.DOI: 10.1016/S0005-7967(00)00089-9.

Baddoura, C., & Merhi, M. (2015). ***PTSD among children and adolescents in the Arab World.*** **The Arab Journal of Psychiatry**, 44(2151), 1-9. (In Arabic).

Barron, I. G., Abdallah, G., & Smith, P. (2013). ***Randomized control trial***

of a CBT trauma recovery program in Palestinian schools. **Journal of Loss and Trauma**, 18(4), 306-321. DOI: 10.1080/ 15325024.2012.688712.

Beck, J. S. (2011). **Cognitive behavior therapy: Basics and beyond**. Guilford press.

Beck, J. S. (2008). **Questions and answers about cognitive therapy**. Diakses Tanggal, 5.

Benjamin, C. L., Puleo, C. M., Settipani, C. A., Brodman, D. M., Edmunds, J. M., Cummings, C. M., & Kendall, P. C. (2011). ***History of cognitive-behavioral therapy in youth***. **Child and Adolescent Psychiatric Clinics**, 20(2),179-189. DOI:10.1016/j.chc.2011.01.011.

Berg, L. J., Tollenaar, M. S., Spinhoven, P., Penninx, B. W., & Elzinga, B. M. (2017). ***A new perspective on PTSD symptoms after traumatic vs stressful life events and the role of gender***. **European Journal of Psychotraumatology,** 8(1), 1380470. DOI:10.1080/20008198. 2017.1380470.

Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. **Clinical Psychology Review**, 23(3), 339-376. DOI:10.1016/S0272-7358(03)00033-3.

Brown, T. H., Mellman, T. A., Alfano, C. A., & Weems, C. F. (2011). ***Sleep fears, sleep disturbance, and PTSD symptoms in minority***

youth exposed to Hurricane Katrina. **Journal of Traumatic Stress**, 24(5), 575-580.

Cafasso, J. (2016). **Lead Poisoning**. Health Line, 1-8.

Capaldi, S., Asnaani, A., Zandberg, L. J., Carpenter, J. K., & Foa, E. B. (2016). ***Therapeutic alliance during prolonged exposure versus client-centered therapy for adolescent posttraumatic stress disorder***. **Journal of Clinical Psychology**, 72(10), 1026-1036. DOI: 10.1002/ jclp.22303.

Cash, A. (2006). **Wiley concise guides to mental health: Posttraumatic stress disorder.** John Wiley & Sons.

Corey, C. (2005). **Theory and practice of counseling & psychotherapy**. (7th ed.). Belmont, CA: Thomson Learning.

Corey, G. (2011). **Theory and practice of group counseling**. Nelson Education.

Craske, M. G., Wolitzky-Taylor, K. B., Labus, J., Wu, S., Frese, M., Mayer, E. A., & Naliboff, B. D. (2011). ***A cognitive-behavioral treatment for irritable bowel syndrome using interoceptive exposure to visceral sensations.*** **Behaviour Research and Therapy**, 49(6-7), 413-421. DOI: 10.1016/j.brat.2011.04.001.

Dai, W., Liu, A., Kaminga, A. C., Deng, J., Lai, Z., & Wen, S. W. (2018). ***Prevalence of posttraumatic stress disorder among children and***

adolescents following road traffic accidents: A meta-analysis. **The Canadian Journal of Psychiatry**, 63(12), 798-808.

DiMauro, J., Carter, S., Folk, J. B., & Kashdan, T. B. (2014). ***A historical review of trauma - related diagnoses to reconsider the heterogeneity of PTSD***. **Journal of Anxiety Disorders**, 28(8), 774-786. DOI: 10.1016/j.janxdis.2014.09.002.

Edmondson, D. (2014). ***An enduring somatic threat model of posttraumatic stress disorder due to acute life-threatening medical events***. **Social and Personality Psychology Compass**, 8(3), 118-134. 10.1111/spc3.12089.

Eftekhari, A., Ruzek, J. I., Crowley, J. J., Rosen, C. S., Greenbaum, M. A., & Karlin, B. E. (2013). ***Effectiveness of national implementation of prolonged exposure therapy in veterans affairs care***. **JAMA Psychiatry**, 70(9), 949-955.

Ehlers, A., Clark, D. M., Hackmann, A., McManus, F., & Fennell, M. (2005). ***Cognitive therapy for post-traumatic stress disorder: Development and evaluation***. **Behaviour Research and Therapy**, 43(4), 413-431.

Erolin, K. S., Wieling, E., & Parra, R. E. A. (2014). ***Family violence exposure and associated risk factors for child PTSD in a Mexican sample.*** **Child Abuse & Neglect**, 38(6), 1011-1022.

Erwin, P. (2018). **Cognitive-behavioral therapy (CBT) for post-traumatic stress disorder (PTSD) on veterans and its relationship to suicidal thoughts**. (Master thesis). California State University.

Espié, E., Gaboulaud, V., Baubet, T., Casas, G., Mouchenik, Y., Yun, O., ... & Moro, M. R. (2009). ***Trauma-related psychological disorders among Palestinian children and adults in Gaza and West Bank, 2005-2008***. **International Journal of Mental Health Systems**, 3(1), 21. DOI: 10.1186/1752-4458-3-21.

Feeny, N. C., Linares, T. J., & Foa, E. B. (2007). **Sexual Assault**.

Field, T. A., Beeson, E. T., & Jones, L. K. (2015***). The new ABCs: A practitioner's guide to neuroscience-informed cognitive-behavior therapy***. **Journal of Mental Health Counseling**, 37(3), 206-220. DOI:10.17744/1040-2861-37.3.206.

Foa, E. B., Chrestman, K. R., & Gilboa-Schechtman, E. (2008**). Prolonged exposure therapy for adolescents with PTSD emotional processing of traumatic experiences, therapist guide.** Oxford University Press.

Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A., Riggs, D. S., Feeny, N. C., & Yadin, E. (2005). ***Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: outcome at academic and community clinics***.

Journal of Consulting and Clinical Psychology, 73(5), 953. DOI: 10.1037/0022-006X.73.5.953.

Foa, E. B., Hembree, E., & Rothbaum, B. O. (2007). ***Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences therapist guide***. Vol. 1 USA: Oxford University Press.

Foa, E. B., McLean, C. P., Capaldi, S., & Rosenfield, D. (2013). ***Prolonged exposure vs. supportive counseling for sexual abuse–related PTSD in adolescent girls: A randomized clinical trial***. **JAMA**, 310(24), 2650-2657. DOI: 10.1001/jama.2013.282829.

Friedman, M. J. (2013). ***Finalizing PTSD in DSM-5: Getting here from there and where to go next***. **Journal of Traumatic Stress**, 26(5), 548-556. DOI: 10.1002/jts.21840.

Gilboa-Schechtman, E., Foa, E. B., Shafran, N., Aderka, I. M., Powers, M. B., Rachamim, L., & Apter, A. (2010). ***Prolonged exposure versus dynamic therapy for adolescent PTSD: A pilot randomized controlled trial***. **Journal of the American Academy of Child & Adolescent Psychiatry**, 49(10), 1034-1042.

Gilboa-Schechtman, E., Foa, E. B., Shafran, N., Aderka, I. M., Powers, M. B., Rachamim, L. & Apter, A. (2016). **Prolonged exposure versus dynamic therapy for adolescent PTSD: A pilot randomized controlled trial**: Corrigendum.

Goodson, J. T., Lefkowitz, C. M., Helstrom, A. W., & Gawrysiak, M. J. (2013). ***Outcomes of prolonged exposure therapy for veterans with posttraumatic stress disorder***. **Journal of Traumatic Stress**, 26(4), 419-425.

Gros, D. F., Price, M., Strachan, M., Yuen, E. K., Milanak, M. E., & Acierno, R. (2012). ***Behavioral activation and therapeutic exposure: An investigation of relative symptom changes in PTSD and depression during the course of integrated behavioral activation, situational exposure, and imaginal exposure techniques***. **Behavior Modification**, 36(4), 580-599. DOI: 10.1177/0145445512448097.

Hébert, M., Lavoie, F., & Blais, M. (2014). ***Post-traumatic stress disorder/PTSD in adolescent victims of sexual abuse: Resilience and social support as protection factors***. **Ciencia & Saude Coletiva**, 19, 685-694.

Held, P., Klassen, B. J., Brennan, M. B., & Zalta, A. K. (2018). ***Using prolonged exposure and cognitive processing therapy to treat veterans with moral injury-based PTSD: Two case examples***. **Cognitive and Behavioral Practice**, 25(3), 377-390. DOI:10.1016/ j.cbpra.2017.09.003.

Hendriks, L., Kleine, R. A. D., Broekman, T. G., Hendriks, G. J., & Minnen, A. V. (2018). ***Intensive prolonged exposure therapy for***

chronic PTSD patients following multiple trauma and multiple treatment attempts. **European Journal of Psychotraumatology**, 9(1), 1425574.

Hendriks, G. J., de Kleine, R. A., & Minnen, A. V. (2015). ***Optimizing the efficacy of exposure in PTSD treatment***. **European Journal of Psychotraumatology.**

Hollon, S. D., & Beck, A. T. (1994). **Cognitive and cognitive-behavioral therapies.**

Khamis, V. (2005). ***Post-traumatic stress disorder among school age Palestinian children***. **Child Abuse & Neglect**, 29(1), 81-95.

Ledley, D. R., & Huppert, J. D. (2007). **Behavior therapy**. In Handbook of homework assignments in psychotherapy (pp. 19-34). Springer, Boston, MA.

Levin, A. P., Kleinman, S. B., & Adler, J. S. (2014). ***DSM-5 and posttraumatic stress disorder***. **Journal of the American Academy of Psychiatry and the Law Online,** 42(2), 146-158.

Lewis, S. J., Arseneault, L., Caspi, A., Fisher, H. L., Matthews, T., Moffitt, T. E., & Danese, A. (2019). ***The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales***. **The Lancet Psychiatry**, 6(3), 247-256.

Maercker, A., & Hecker, T. (2016). ***Broadening perspectives on trauma***

and recovery: A socio-interpersonal view of PTSD. **European Journal of Psychotraumatology**, 7(1), 29303. DOI: 10.3402/ejpt. v7. 29303.

Mahamid, F. A. M., Rihani, S. T., & Berte, D. Z. (2015). ***Expressive group counseling as a model for increasing self-awareness to reduce trauma symptoms experienced by children in Palestine***. **International Journal of Psychology and Counselling**, 7(8), 112-118. DOI: 10.5897/IJPC2015.0306.

McKay, D., Sookman, D., Neziroglu, F., Wilhelm, S., Stein, D. J., Kyrios, M., ... & Veale, D. (2015). ***Efficacy of cognitive-behavioral therapy for obsessive–compulsive disorder***. **Psychiatry Research**, 225(3), 236-246. DOI:10.1016/j.psychres.2014.11.058.

McLean, C. P., & Foa, E. B. (2011). ***Prolonged exposure therapy for post-traumatic stress disorder: A review of evidence and dissemination***. **Expert Review of Neurotherapeutics**, 11(8), 1151-1163.

McLean, C. P., Rosenbach, S. B., Capaldi, S., & Foa, E. B. (2013)**. *Social and academic functioning in adolescents with child sexual abuse-related PTSD***. **Child Abuse & Neglect**, 37(9), 675.

Meichenbaum, D., Carlson, J., & Kjos, D. (2007). **Cognitive-behavioral therapy**. American Psychological Assoc..

Montero, I., & León, O. G. (2007). A ***guide for naming research studies in***

Psychology. **International Journal of Clinical and Health Psychology**, 7(3), 847-862.

Nacasch, N., Foa, E. B., Huppert, J. D., Tzur, D., Fostick, L., Dinstein, Y., ... & Zohar, J. (2011). ***Prolonged exposure therapy for combat-and terror-related posttraumatic stress disorder: A randomized control comparison with treatment as usual***. **Journal of Clinical Psychiatry**, 72(9), 1174.

Nooner, K. B., Linares, L. O., Batinjane, J., Kramer, R. A., Silva, R., & Cloitre, M. (2012). ***Factors related to posttraumatic stress disorder in adolescence.*** **Trauma, Violence & Abuse**, 13(3), 153–167. DOI: 10. 1177/1524838012447698.

O'Connor, M., & Elklit, A. (2008). ***Attachment styles, traumatic events, and PTSD: A cross-sectional investigation of adult attachment and trauma***. **Attachment & Human Development**, 10(1), 59-71. DOI: 10.1080/14616730701868597.

Pangrazio, A. (2018). ***Efficacy of CBT and EMDR in treating PTSD amongst ADF members***. **Psychology**.

Park, C. L., Mills, M. A., & Edmondson, D. (2012). ***PTSD as meaning violation: Testing a cognitive worldview perspective***. **Psychological Trauma: Theory, Research, Practice, and Policy**, 4(1), 66. DOI: 10.1037/a0018792.

Paunovic, N., & Öst, L. G. (2001). ***Cognitive-behavior therapy vs. exposure therapy in the treatment of PTSD in refugees***. **Behaviour Research and Therapy**, 39(10), 1183-1197. DOI:10.1016/S0005-7967(00)00093-0.

Peterson, A. L., Foa, E. B., & Riggs, D. S. (2011). Prolonged exposure therapy. In B. A. Moore & W. E. Penk (Eds.), **Treating PTSD in military personnel: A clinical handbook** (pp.42-58). New York, NY, US: Guilford Press.

Pitman, R. K., Shalev, A. Y., & Orr, S. P. (2000). ***Posttraumatic stress disorder: Emotion, conditioning, and memory.*** **The New Cognitive Neurosciences**, 2, 1133-1147.

Popiel, A., Zawadzki, B., Pragłowska, E., & Teichman, Y. (2015). ***Prolonged exposure, paroxetine and the combination in the treatment of PTSD following a motor vehicle accident. A randomized clinical trial–The "TRAKT" study***. **Journal of** doi.org/10.1016/ j.jbtep.2015.01.002.

Qouta, S., Punamäki, R. L., & El Sarraj, E. (2003). ***Prevalence and determinants of PTSD among Palestinian children exposed to military violence.*** **European Child & Adolescent Psychiatry**, 12(6), 265-272. DOI: 10.1007/s00787-003-0328-0.

Rewar, S. (2015). ***Diagnosis, prevention & treatment of PTSD***. **Indian Journal of Research in Pharmacy and Biotechnology**, 3(3), 204.

Riggs, D. S., Cahill, S. P., & Foa, E. B. (2006). ***Prolonged exposure treatment of posttraumatic stress disorder***. **Cognitive-Behavioral Therapies for Trauma**, 2, 65-95.

Roberts, A. L., Gilman, S. E., Breslau, J., Breslau, N., & Koenen, K. C. (2011). ***Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States.*** **Psychological Medicine**, 41(1), 71-83. DOI:10.1017/ S0033291710000401.

Rossouw, J., Yadin, E., Alexander, D., & Seedat, S. (2018). ***Prolonged exposure therapy and supportive counselling for posttraumatic stress disorder in adolescents in a community-based sample, including experiences of stakeholders: Study protocol for comparative randomized controlled trial using task-shifting***. **BMC Psychiatry**, 18(1), 288.

Rotaru, T. Ș., & Rusu, A. (2016). ***A meta-analysis for the efficacy of hypnotherapy in alleviating PTSD symptoms*****. International Journal of Clinical and Experimental Hypnosis,** *64*(1), 116-136.

Rothbaum, B. O., Anderson, P., Zimand, E., Hodges, L., Lang, D., & Wilson, J. (2006). ***Virtual reality exposure therapy and standard (in vivo) exposure therapy in the treatment of fear of flying***. **Behavior Therapy**, 37(1), 80-90. DOI: 10.1016/j.beth.2005.04.004.

Russell, L. (2011). **Post-traumatic stress disorder (PTSD).** Available at http://www.mental-healthtoday.com/ptsd/dsm.htm .

Scott, B. G., Lapré, G. E., Marsee, M. A., & Weems, C. F. (2014). ***Aggressive behavior and its associations with posttraumatic stress and academic achievement following a natural disaster***. **Journal of Clinical Child & Adolescent Psychology**, 43(1), 43-50.

Seligman, L. W., & Reichenberg, L. W. (2013). **Theories of counseling and psychotherapy: Systems, strategies, and skills**. Pearson Higher Ed.

Sharf, R. S. (2015). **Theories of psychotherapy & counseling: Concepts and cases.** Cengage Learning.

Shubina, I. (2015). ***Cognitive-behavioral therapy of patients with PTSD: Literature review***. **Procedia-Social and Behavioral Sciences**, 165, 208-216.

Smith, E. R., Porter, K. E., Messina, M. G., Beyer, J. A., Defever, M. E., Foa, E. B., & Rauch, S. A. (2015). ***Prolonged exposure for PTSD in a veteran group: A pilot effectiveness study***. **Journal of Anxiety Disorders**, 30, 23-27. DOI:10.1016/j.janxdis.2014.12.008.

Smith, P., Yule, W., Perrin, S., Tranah, T., Dalgleish, T., & 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. DOI: 10.1097/CHI.0b013e318067e288.

Spence, J., Titov, N., Johnston, L., Jones, M. P., Dear, B. F., & Solley, K. (2014). ***Internet-based trauma-focused cognitive behavioural therapy for PTSD with and without exposure components: A randomised controlled trial.*** **Journal of Affective Disorders**, 162, 73-80. DOI:10.1016/j.jad.2014.03.009.

Suveg, C., & Zeman, J. (2004***). Emotion regulation in children with anxiety disorders.*** **Journal of Clinical Child and Adolescent Psychology**, 33(4), 750-759. DOI: 10.1207/s15374424jccp3304_10.

Tay, A. K., Rees, S., Chen, J., Kareth, M., & Silove, D. (2015). ***The structure of post-traumatic stress disorder and complex post-traumatic stress disorder amongst West Papuan refugees***. **BMC Psychiatry**, 15(1), 111.

Thabet, A. A. M. (2017). ***Prevalence of PTSD, depression, and anxiety among orphaned children in the Gaza Strip***. **EC Paediatrics**, 5, 159-169.

Thabet, A. M., & ElRabbaiy, A. (2018). ***Posttraumatic stress and growth among war-exposed orphans in the Gaza Strip***. **Arab Journal of Psychiatry**, 29(2), 131-144. DOI: 10.12816/0051278.

Tuerk, P. W., Yoder, M., Grubaugh, A., Myrick, H., Hamner, M., &

Acierno, R. (2011). ***Prolonged exposure therapy for combat-related posttraumatic stress disorder: An examination of treatment effectiveness for veterans of the wars in Afghanistan and Iraq***. **Journal of Anxiety Disorders**, 25(3), 397-403.

Van Minnen, A., Zoellner, L. A., Harned, M. S., & Mills, K. (2015). ***Changes in comorbid conditions after prolonged exposure for PTSD: A literature review***. **Current Psychiatry Reports**, 17(3), 17.

Van den Berg, D. P., de Bont, P. A., van der Vleugel, B. M., de Roos, C., de Jongh, A., Van Minnen, A., & van der Gaag, M. (2015). ***Prolonged exposure vs. eye movement desensitization and reprocessing vs. waiting list for posttraumatic stress disorder in patients with a psychotic disorder: A randomized clinical trial.*** **JAMA Psychiatry**, 72(3), 259-267.

Weiten, W. (2007). **Psychology: Themes & variations**. (7th ed.). Pacific Grove, CA: Thomson Publishing Inc.

Zhipei, Z. H. U., Zhang, L., Jiang, J., Wei, L. I., Xinyi, C. A. O., Zhirui, Z. H. O. U., & Chunbo, L. I. (2014***). Comparison of psychological placebo and waiting list control conditions in the assessment of cognitive behavioral therapy for the treatment of generalized anxiety disorder: a meta-analysis***. **Shanghai Archives of Psychiatry**, 26(6), 319. DOI: 10.11919/j.issn.1002-0829.214173.

Appendix I

PTSD Scale

Dear respondent,

Here are lists of statements children usually use to describe how they feel, think, believe and behave. Please read each statement carefully and express your opinion toward it frankly and placing signal (x) in the appropriate box. All information will be treated confidentially and will be used for scientific research purposes, as an indicator of confidentiality you are not ask to write your name.

Sex: Male ☐ Female ☐

No.	**Items**	**Always**	**Mostly**	**Sometime**	**Rarely**	**Never**
1	Pictures and past memories which I have experienced dominate my life					
2	I recall thoughts and painful memories about the event that I have experienced					
3	Images of painful events penetrate my mind					
4	I suffer from worrying dreams after I have experienced that event					
5	I suffer from daydreams after the event that I have experienced					
6	I can not prevent my self from thinking of the past events which I had					
7	I avoid things which remind me of the events which I have experienced					
8	I close the T.V and radio when they transmit things collected with events that I have experienced					
9	I stop my self from thinking of the events which I have experienced					
10	I feel lonely after I have experienced that event					
11	I became less concern of others after that event					
12	I became less communicate with others after that event					
13	I became less interested in activities that I was interested in after that event					

No.	**Items**	**Always**	**Mostly**	**Sometime**	**Rarely**	**Never**
14	I feel worried from the future after that event					
15	I avoid places which remind me of that experience					
16	I avoid people who remind me of that event which I have faced					
17	I feel emotionless after the event which I have experienced					
18	I become sad easily after the experience which I have faced					
19	I become furious easily after that event					
20	I face difficulty in concentration after that event					
21	I have difficulty in recalling information after that event					
22	I can't concentrate easily after that event					
23	I have difficulty in sleeping after that event					
24	I have difficulty in accomplishing tasks which I perform after that event					
25	My heart beats faster when I recall that event					
26	I feel trembling in my body when I recall that event					
27	I suffer from lack of appetite after that event					
28	I suffer from headache after that event					
29	I have pains in my abdomen after that event					
30	I have difficulty in breathing when I recall that event					
31	I play games that remind me of that experience					
32	I lose pleasure in plays that I do					
33	I deal with my games aggressively					
34	I prefer playing alone					
35	I find myself repeating what happened with me during my play					
36	I prefer aggressive games more than other games					
37	I feel wishful to cry during my play					
38	I face difficulty in recalling information after that event					
39	I blame myself after the event that I have experienced					
40	I feel unsatisfied about myself after that event					
41	I feel unable to do things after that event					
42	I lost trust in myself after that event					
43	I suffer from horror after that event					
44	I feel guilty after that event					
45	I feel sad after that event					
46	I feel hopeless after that event					
47	I behave aggressively with others after that event					

مقياس ضغوط ما بعد الصدمـــة

الرقم	العبارة	دائماً	غالباً	أحياناً	نادراً	إطلاقاً
1	تسيطر صور وذكريات الأحداث التي مررت بها على حياتي					
2	تراودني أفكار وذكريات مؤلمة عن الحدث واجهته					
3	تقتحم ذهني تخيلات مرتبطة بالخبرة التي مررت بها					
4	أعاني من أحلام مزعجة بعد تعرضي لذلك الحدث					
5	أعاني من السرحان بعد الحدث الذي واجهته					
6	لا أستطيع منع نفسي من التفكير بالخبرة التي مررت بها					
7	أتجنب الأشياء التي تذكرني بالخبرة التي مررت بها					
8	أغلق التلفاز أو المذياع عندما يبث شيء يتعلق بالحدث الذي مررت به					
9	أمنع نفسي من التفكير بالحدث الذي واجهته					
10	أشعر بالعزلة بعد تعرضي لتلك الخبرة					
11	أصبحت اقل اهتماماً بالآخرين بعد الخبرة التي مررت بها					
12	أصبحت أقل تواصلاً مع الآخرين بعد الحدث الذي مررت به					
13	فقدت الاهتمام بالأنشطة التي كنت استمتع بها بعد الحدث الذي تعرضت له					
14	أشعر بالقلق من المستقبل بعد الحدث الذي واجهني					
15	أتجنب الأماكن التي تذكرني بالخبرة التي مررت بها					
16	أتجنب الأشخاص الذين يذكروني بالحدث الذي واجهني					
17	اشعر أني بلا مشاعر بعد الخبرة التي مررت بها					
18	أحزن بسهولة بعد الخبرة التي مررت بها					
19	أغضب بسهولة بعد الحدث الذي تعرضت له					
20	أجد صعوبة في التركيز بعد تلك الخبرة					
21	أجد صعوبة في تذكر المعلومات بعد ذلك الحدث					
22	يتشتت انتباهي بسهولة بعد الحدث الذي تعرضت له					
23	أجد صعوبة في النوم بعد الخبرة التي مررت بها					
24	أجد صعوبة في إتمام المهام التي أقوم بها بعد الحدث الذي واجهني					

الرقم	العبارة	دائماً	غالباً	أحياناً	نادراً	إطلاقاً
25	تزداد دقات قلبي عندما أتذكر ما حدث معي					
26	أشعر برعشة في أطرافي عندما أتذكر الخبرة التي واجهتني					
27	أعاني من فقدان الشهية بعد ذلك الحدث					
28	أعاني من الصداع بعد ذلك الحدث					
29	أعاني من آلام في البطن بعد ذلك الحدث					
30	أشعر بضيق في التنفس عندما أتذكر ذلك الحدث					
31	ألعب ألعاباً تذكرني بالخبرة التي مررت بها					
32	أشعر بفقدان المتعة فيما أقوم به من العاب					
33	أتعامل بعنف مع ألعابي					
34	أفضِّل اللعب لوحدي بعد ما حدث معي					
35	أجد نفسي أكرر ما حدث معي أثناء اللعب					
36	أفضل الألعاب العنيفة على بقية الالعاب					
37	أشعر برغبة في البكاء أثناء اللعب					
38	أعاني من مشكلات في التذكر بعد الحدث الذي واجهني					
39	ألوم نفسي بعد الحدث الذي مررت به					
40	أشعر بعدم الرضا عن نفسي بعد تلك الخبرة					
41	أشعر بعدم القدرة على القيام بالأشياء بعد الخبرة التي مررت بها					
42	فقدت ثقتي بنفسي بعد الحدث الذي واجهني					
43	أشعر بالرعب بعد الخبرة التي حدثت معي					
44	أشعر بالذنب بعد الذي حدث معي					
45	أشعر بالحزن بعد الحدث الذي مررت به					
46	أشعر بفقدان الأمل بعد الخبرة التي واجهتني					
47	أتعامل بعدوانية مع الآخرين بعد الحدث الذي واجهني					

Appendix II

Group Prolonged Exposure Counseling Program

Objectives of the Program:

- **The Overall Objective of the Program:** 3
  - Help the group members in learning how to process their traumatic experiences emotionally in order to diminish PTSD and other related symptoms.
- **The Specific Objectives of the Program**:
  - To build a rapport with the patients
  - Diminish PTSD symptoms through psychoeducation, in vivo exposure, and imaginal exposure.
  - The patients will be able to process their traumatic experiences emotionally
  - To know more about PTSD
  - Help the patients in reclaiming their lives
  - Educate the patients about the common reactions to trauma
  - Teaching the patients how to breathe in a calming way
- **Assumptions about the Program and Sessions:**
  - The researcher assumes full confidentiality for all what is going on in the sessions.
  - The researcher assumes that participation in the program is voluntary for all members of the study.
  - The researcher assumes that members of the experimental group will attend sessions in time and the place agreed upon.

- **Rights and Duties of Participants in the Program:**
    - Allow members of the group to change their seats and move from one seat to another during the session.
    - Allow members to eat some snacks during the sessions.
    - Allow members to meet counselor individually after and before sessions or contact him by telephone or any other form.
    - Members of the group are committed to attending all sessions in the place and the time agreed upon.
    - Members of the group are committed to expressing their problems freely and clearly during the sessions
    - Members of the group are committed to keeping what is going in the sessions strictly confidential.
    - Members of the group are committed to respecting each other during the sessions.
    - Counselor tells members of the group of rights and duties before the intervention

Program Sessions:

The program consists of 13 sessions, each of which lasts from 90 – 150 minutes, the program has used prolonged exposure activities to teach the members how to process their traumatic experiences emotionally and to reduce the symptoms of PTSD among a sample of traumatized teenagers, the following details describe these sessions.

Session (1):

The first session of the program aimed to build a good rapport between the counselor and members of the group. The first session has been held after applying PTSD scale on the members of the therapeutic group at Dar Al-Yateem Al- Arabei, Tulkarm.

The counselor then met each member individually and informed them about their results on PTSD scale, and then he offered them to participate in the program. After accepting the member, the counselor informs him of the terms of participation in the program including: the strict confidentiality of what is going in the sessions, respect of others and unconditional acceptance for group members.

Aims of the Session:

- Build a good rapport with the participants
- Introduce the participants to the program with its' aims.
- Identify the patient's life domains that have been disrupted as a result of the trauma
- Agree on the place and the time of the sessions
- Identify potential benefits of the patient's participation in therapy
- Identify potential obstacles to the patient's participation in therapy
- Summarize the session activities
- Assign homework

Activities of the Session:

- **Build a good rapport and know each another (30 minutes).**

  The counselor asked the participants to sit in a circle. Each participant stand in the center of the circle and identifies himself. After identifying himself, the counselor thanked him. One by one we all know each other. The counselor showed to them that he is so glad for their cooperation.

- **Introduce the participants to the program with its' aims (15 minutes).**

The counselor told the participants the aims of the therapeutic program; how to process their traumatic experiences emotionally , and to reduce PTSD symptoms. After that the counselor told them how many sessions will be held, and what each session will be about.

- **Identify the patient's life domains that have been disrupted as a result of the trauma (50 minutes).**

After discussing the aims of the program the counselor ask the participants about specific life domains before the trauma and after the trauma. The counselor used the life domain for achieving this aim, and discuss about each domain with the participant.

LIFE DOMAINS FORM

For each life domain, describe what your life was like before and after the trauma. Be sure to list positive as well as negative changes.

Emotional health (anxiety, depression, anger, shame, self-confidence, self-esteem, ability to relax):

Before:

After:

Physical health (fitness, diet, exercise, sleep habits, tiredness, injury, and illness):

Before:

After:

Leisure (friends, extracurricular activities, trips):

Before:

After:

School (grades, teachers' assessments, homework, level of concentration):

Before:

After:

Relationship with family members (fights, level of sharing, sense of closeness):

Before:

After:

Relationship with close friends (fights, level of sharing, sense of closeness):

Before:

After:

Social status in class/social circles (popularity, feel appreciated, people turn to for help):

Before:

After:

Independence (for example, going places alone):

Before:

After:

Use of drugs and/or alcohol:

Before:

After:

Body image (how do you feel about the way you look?):

Before:

After:

Sources of pleasure (music, sports, hobbies):

Before:

After:

Are there other things that your friends or other people your age are able to do that you do not do at the present time?

Social outings:

School:

Hobbies:

Travel/Transportation:

Other:

- **Agree on the place and the time of the sessions (5 minutes).**

The counselor with the participants agreed that the sessions always will be held in the meetings room, at Dar Al-Yateem Al- Arabei, Tulkarm. Also, they agreed that the session will begin at 05:00 pm.

- **Identify potential benefits and obstacles of the participants in therapy (15 minutes).**

The counselor with the participants tried to formulate a realistic benefits of the therapy in the terms of PTSD symptoms. For example, improved sleep, less avoidance…etc. During this the counselor tried to ask the participants questions as the follows:

- What would you like to change in your life now?
- What do you wish you could do at the end of the therapy?

Then the counselor with the participants tried to identify potential obstacles of the therapy. For example, they will spend from 30-90 minutes each day doing homeworks related to the program.
The counselor used the following form for achieving these aims.

Pros and Cons of Therapy

Pros	Cons

- **Summarize the session activities (5 minutes).**

At the end of the session the counselor summarize the all information that was mentioned during the session, and emphasized that it is very important to attend the next session on time.

- **Assign homework (5 minutes).**

After summarizing the session activities, the counselor assign the following homework to the participants.

- Asked the participants to review life domain form.
- Asked the participants to review pros and cons of the therapy form.

Session (2):

Aims of the Session:

- Review homework
- Introduce the rationale for the treatment to patients
- Introduce breathing retraining
- Assign homework

Activities of the Session:

- **Review homework (10 minutes)**

The counselor welcome the participants and thanked them for being in the meetings room on time. Then she reminded the participants of what they discussed in the previous session, including the homework. The counselor gives each member the opportunity to introduce his homework and reinforces members who performed homework; she also provides appropriate feedback on performance.

- **Introduce the rationale for the treatment to patients (40 minutes)**

The counselor started with informing the participants the reason and mechanisms behind the persisting of PTSD symptoms. Then, she asked the participants if he can think of things that he has avoided since the trauma. After that, the counselor told the participants that they will learn how to face situations they have been avoiding. Then, the counselor explained the rationale for exposure. For example she told them that the

most important thing in order to get over the things that you are fearing, is to face them. By facing them you will realize that these situations are safe and you should not be afraid of them. By this the symptoms of PTSD will get better.

After that the counselor mentioned the techniques of PE that will be applied during this program. These techniques are imaginal exposure and in vivo exposure.

- **Introduce breathing retraining (30 minutes)**

The counselor started with explaining the rationale of breathing retraining. The counselor explained to the participants how to inhale and exhale. Then she asked the participants to perform the exercise, after performing it in front of them.

- **Assign homework (10 minutes)**

At the end of the session the counselor thanked the participants, then she gave them the followed exercise:

- Asked the participant to practice breathing exercise 3 times per day.

Session (3):

Aims of session:

- Review homework
- Conduct trauma interview in order to gather information
- Assign homework

Activities of session:

- **Review homework (10 minutes)**

The counselor welcome the participants and thanked them for being in the meetings room on time. Then she reminded the participants of what they discussed in the

previous session, including the homework. The counselor gives each member the opportunity to introduce his homework and reinforces members who performed homework; she also provides appropriate feedback on performance.

- **Conduct trauma interview in order to gather information (100 minutes)**

The counselor started the with saying that the aim of this meeting is to talk about the trauma you have experienced and to learn more specific details about the events immediately before, during, and after the trauma. I understand that it may be difficult for you to talk about some things. If there is anything I can do to make it easier for you, please tell me. To start, can you tell me a little bit about what happened to you?

The followed questions were asked by the counselor to conduct the interview:

- When did the trauma occur?
- Where did the trauma occur?
- Did you believe during the event that you may die or injured?
- Did you feel helpless?
- Were you terribly scared?
- Do you blame anyone?
- Were you ashamed about the event?
- Did you suffer from injuries?
- Did you receive medical assistance?
- Did you feel guilty about the trauma?
- Have you experienced changes in your relationships with others?
- Did anybody blame you?
- Have you experienced changes in the way you see yourself?
- How difficult do you find it discussing the trauma with others?

- Would you like to mention anything else about the trauma?
- How was it for you to discuss those issues?

The counselor record these interviews.

- **Assign homework (10 minutes)**

At the end of the session the counselor thanked the participants, then she gave them the followed homework:

- Asked the participants to listen to the recording of the session.
- Asked the participants to continue practicing breathing exercise 3 times per day.

Session (4):

Aims of session:

- Review homework
- Discuss the common reactions of trauma
- Assign homework

Activities of session:

- **Review homework (10 minutes)**

The counselor welcome the participants and thanked them for being in the meetings room on time. Then she reminded the participants of what they discussed in the previous session, including the homework. The counselor gives each member the opportunity to introduce his homework and reinforces members who performed homework; she also provides appropriate feedback on performance.

- **Discuss the common reactions of trauma (120 minutes).**

The counselor started introducing the common reactions trauma to trauma by saying, "As you experienced a traumatic event, you may experience some or all the following reactions". Then the counselor started mentioning the common reactions; fear and anxiety, feeling on edge, re-experiencing, flashbacks, nightmares, avoidance, emotional numbness, anger, guilt and shame, feelings of losing control, changes of perception, and feelings of hopelessness. After that the counselor helped the participants in summarizing their reactions to trauma.

The counselor record this session.

- **Assign homework**

At the end of the session the counselor thanked the participants, then she gave them the followed homework:

- Asked the participants to listen to the recording of the session.
- Asked the participants to complete the Common Reactions to Trauma Form.

Common Reactions to Trauma

Identify which reactions to trauma you have experienced and record details of your experience.

Fear and Anxiety:
Feeling on Edge:
Re-experiencing:
Avoidance:
Emotional Numbness:
Anger:
Guilt and Shame:
Feelings of Losing Control:
Changes of Perception:
Symptoms of Depression:
Other Reactions:

Sessions (5, 6, 7, 8, 9):

Aims of sessions:

- Review homework
- Introduce the method for imaginal exposure; including hierarchy and stress thermometer.
- Conduct imaginal exposure
- Assign homework

Activities of session:

- **Review homework (10 minutes)**

The counselor welcome the participants and thanked them for being in the meetings room on time. Then she reminded the participants of what they discussed in the previous session, including the homework. The counselor gives each member the opportunity to introduce his homework and reinforces members who performed homework; she also provides appropriate feedback on performance.

- **Introduce the method for imaginal exposure; including hierarchy and stress thermometer (20 minutes).**

The counselor started talking about the benefits of imaginal exposure and the rationale of it. Then she started introducing the method for imaginal exposure by asking the participant to recount the memory in first person present tense and to repeat the story several times with eyes closed. And begin with giving the participant the following instructions: Now, I will ask you to tell me the story, as it happened, from the beginning to the end. Try to tell the story in the present time, as it is happening now. Make sure

that your story is detailed as you can remember. Talk about what you were thinking and feeling, and mention all the things that happened to your body.

I will ask you to tell me your distress level according to the stress thermometer after, and before the recounting. The counselor record these ratings for each participant. .

After finishing the recounting, I will ask you to recount the story again and to decide where it is begin and where it is end.

- **Conduct imaginal exposure (110 minutes)**

After introducing the method of imaginal exposure, the counselor started conducting the imaginal exposure with each participant, and she used the following form:

Recounting the Memory Data

Record your stress ratings before and after each time you recount the memory. Also record the highest stress rating that you experienced during recounting the memory.

Date & Time	Before 	After 	Highest 

Notes:

The counselor record the recounting for each participant.

- **Assign homework (10 minutes)**

At the end of the session the counselor thanked the participants, then she gave them the followed homework:

- Asked the participants to listen to the recording of the imaginal exposure daily and write down his level of distress.

Sessions (10, 11, 12):

Aims of the Sessions:

- Review homework
- List the avoiding situation of the participants
- Introduce the method for in vivo exposure
- Conduct in vivo exposure
- Assign homework

Activities of the Session:

- **Review homework (10 minutes)**

The counselor welcome the participants and thanked them for being in the meetings room on time. Then she reminded the participants of what they discussed in the previous session, including the homework. The counselor gives each member the opportunity to introduce his homework and reinforces members who performed homework; she also provides appropriate feedback on performance.

- **List the avoiding situation of the participants (30 minutes)**

With the counselor the participants prepared a list of all the situations they have been avoiding by filling real life experiments form.

Real-Life Experiments Step-by-Step

List the situations you have been avoiding, then rate each situation using the stress thermometer. You will re-rate the situations in the last session of the program.

Real-Life Experiments	Initial Rating	Final Rating

- **Introduce the method for in vivo exposure (15 minutes)**

The counselor started introducing the method for in vivo exposure by saying that in this stage we will confront the scary, and the avoidant situations in real life, but in a safety

environment. The aim of this exposure is to reduce the anxiety rates by showing that these situations or objects are not harmful in reality.

- **Conduct in vivo exposure (90 minutes)**

After introducing the method of in vivo exposure, the counselor with each participant choose a situation from real life experiment form rated from 4-5, then with the counselor they conduct in vivo exposure.

This exposure was recorded.

- **Assign homework (10 minutes)**

At the end of the session the counselor thanked the participants, then she chose with them situations that they have to practice daily. The followed should be used.

Real-life Experiments Data

Record your stress ratings before and after each real-life experiment. Also record the highest stress rating that you experienced during the real-life experiment.
REMINDER: Remain in the situation for at least 30–45 minutes or until the stress ratings have decreased by half.

Situation:_____

Date & Time	**Before**	**After**	**Highest**

Session (13):

Aims of session:

- Discuss the previous homework.
- Plan coping strategies for symptom relapse
- Discuss the patient's feelings about their accomplishment
- Discuss the patient's feelings about ending the program, and remind them with post-test.

Activities of session:

- **Review homework (10 minutes)**

The counselor welcome the participants and thanked them for being in the meetings room on time. Then she reminded the participants of what they discussed in the previous session, including the homework. The counselor gives each member the opportunity to introduce his homework and reinforces members who performed homework; she also provides appropriate feedback on performance.

- **Plan coping strategies for symptom relapse (50 minutes)**

The counselor started discussing with the group members about the problems that may face and what is the possible solutions and coping strategies that could be applied that moment. Then the counselor reminded the members with the techniques and activities that was applied during the program, in which these techniques could be a helpful tools to be applied in other or similar situations or relapses.

The counselor record this session.

- **Discuss the patient's feelings about their accomplishment (20 minutes)**

The counselor gave the opportunity to the group members in order to express their feelings about the accomplishment that they made during the program.

- **Discuss the patient's feelings about ending the program, and remind them with post-test (40 minutes).**

The counselor gave the group member the opportunity to express their feelings about ending the program, in turn the counselor also talked about her feelings from ending it. And she thanked them so much and reminded them with post-test.

جامعة النجاح الوطنية
كلية الدراسات العليا

فاعلية برنامج ارشاد جمعي قائم على العلاج بالتعريض المطوّل في خفض أعراض اضطراب ضغوط ما بعد الصدمة لدى عينة من المراهقين المصدومين

إعداد
دانا سامي محمد بدير

إشراف
د. علي الشكعة
د. فايز محاميد

قدمت هذه الأطروحة استكمالاً لمتطلبات الحصول على درجة الماجستير في الإرشاد النفسي والتربوي بكلية الدراسات العليا في جامعة النجاح الوطنية في نابلس، فلسطين.
2020

فاعلية برنامج ارشاد جمعي قائم على العلاج بالتعريض المطوّل في خفض أعراض اضطراب ضغوط ما بعد الصدمة لدى عينة من المراهقين المصدومين

إعداد

دانا سامي محمد بدير

إشراف

د. علي الشكعة

د. فايز محاميد

الملخص

هدفت الدراسة الحالية إلى الكشف عن فاعلية برنامج إرشاد جمعي قائم على العلاج بالتعريض المطوّل في خفض أعراض اضطراب ضغوط ما بعد الصدمة لدى عينة من المراهقين المصدومين، وقد تكونت عينة الدراسة الحالية من (17) طفل وطفلة من نزلاء جمعية دار اليتيم العربي في مدينة طولكرم، ضمن الفئة العمرية من (11–16) سنة ممن تعرضوا لصدمات نفسية وأظهروا درجة مرتفعة على مقياس الضغوط التالية للصدمة المُستخدم في الدراسة الحالية.

ولأغراض الدراسة الحالية استخدم تصميم المجموعة الواحدة (اختبار قبلي – بعدي) وهي المجموعة التجريبية، إذ تلقى أفرادها برنامج إرشاد جمعي قائم على العلاج بالتعريض المطوّل لمدة (7) أسابيع، بواقع جلستين أسبوعياً، وقد تم قياس أداء أفراد المجموعة على مقياس الضغوط التالية للصدمة قبل وبعد التدخل الإرشادي.

أظهرت نتائج الدراسة الحالية فاعلية البرنامج الإرشادي في خفض أعراض اضطراب ضغوط ما بعد الصدمة لدى عينة الدراسة، وظهرت فروق في مستوى اعراض اضطراب ضغوط ما بعد الصدمة لصالح الإناث. بناء على نتائج الدراسة، أوصت الدراسة بضرورة تطبيق العلاج بالتعريض المطوّل على فئات ارشادية أخرى والتي تعاني من اضطراب ضغوط ما بعد الصدمة. وأيضا نوصي بضرورة العمل على تطبيق برامج ارشادية للحد من مشكلات نفسية أخرى قد يعاني منها المراهقين الذين يعانوا من اضطراب ضغوط ما بعد الصدمة مثل مشكلات النوم، القلق، والغضب.