# PENGARUH *COGNITIVE BEHAVIORAL THERAPY* TERHADAP *POSTTRAUMATIC STRESS DISORDER* AKIBAT KEKERASAN SEKSUAL PADA ANAK USIA 7-12 TAHUN
## *LITERATURE REVIEW*

**SKRIPSI**

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**PROGRAM STUDI ILMU KEPERAWATAN**
**FAKULTAS ILMU KESEHATAN**
**UNIVERSITAS dr. SOEBANDI**
**2021**

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## *LITERATURE REVIEW*

**SKRIPSI**

Untuk Memenuhi Persyaratan
Memperoleh Gelar Sarjana Ilmu Keperawatan (S.Kep)


**Oleh:**

**Kiki Kumalasari**
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**PROGRAM STUDI ILMU KEPERAWATAN**
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**2021**

# HALAMAN PERSEMBAHAN

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# MOTTO

*"Allah Tidak Membebani Seseorang itu Melainkan Dengan Kesanggupannya"*

**(Q.S. Al Baqarah : 286)**

*"Barangsiapa Menempuh Jalan Untuk Mendapatkan Ilmu, Allah Akan Memudahkan Baginya Jalan Menuju Surga"*

**(HR. Muslim)**

*"Amalan yang Lebih Dicintai Allah Adalah Amalan Yang Terus Menerus Dilakukan Walaupun Sedikit"*

**(Kiki Kumalasari)**

# LEMBAR PERNYATAAN ORISINILITAS

Saya yang bertanda tangan dibawah ini, menyatakan dengan sesungguhnya bahwa Skripsi yang berjudul "Pengaruh *Cognitive Behavioral Therapy* Terhadap *Posttraumatic Stress Disorder* Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun : *Literatur Review*" adalah karya sendiri dan belum pernah diajukan untuk memperoleh gelar kesarjanaan disuatu perguruan tinggi manapun.

Nama : Kiki Kumalasari

Nim : 17010104

Adapun bagian-bagian tertentu dalam penyusunan Skripsi ini yang saya kutip dari hasil karya orang lain telah dituliskan sumbernya secara jelas sesuai dengan norma, kaidah dan etika penulisan ilmiah. Apabila dikemudian hari terdapat penyimpangan dan ketidak benaran dalam pernyataan ini, maka saya bersedia menerima sanksi akademik dan atau sanksi lainnya, sesuai dengan norma yang berlaku dalam perguruan tinggi ini.

Jember, 4 Agustus 2021


Kiki Kumalasari

17010104

# LEMBAR PERSETUJUAN

Skripsi *Literatur Review* ini telah diperiksa oleh pembimbing dan telah disetujui untuk mengikuti seminar hasil pada Program Ilmu Sarjana Keperawatan Universitas dr. Soebandi

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# HALAMAN PENGESAHAN

Skripsi yang berjudul *Pengaruh Cognitive Behavioral Therapy Terhadap Posttraumatic Stress Disorder Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun* : *Literature Review* telah di uji dan di sahkan pada :

Hari : Selasa

Tanggal : 07 September 2021

Tempat : Program Studi Ilmu Keperawatan Universitas dr. Soebandi

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# SKRIPSI

# PENGARUH *COGNITIVE BEHAVIORAL THERAPY* TERHADAP *POSTTRAUMATIC STRESS DISORDER* AKIBAT KEKERASAN SEKSUAL PADA ANAK USIA 7-12 TAHUN
## *LITERATURE REVIEW*


Oleh :

Kiki Kumalasari

NIM. 17010104


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Dosen Pembimbing Utama : I.G.A Karnasih S.Kep.,Ns.,M.Kep.,Sp.Mat

Dosen Pembimbing Anggota : Ns. Wike Rosalini S.Kep.,M.Kes

# ABSTRAK

Kumalasari, Kiki* Karnasih, I.G.A** Rosalini, Wike***. 2021. **Pengaruh *Cognitive Behavioral Therapy* Terhadap *Posttraumatic Stress Disorder* Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun dengan *Literature Review*.** Program Studi Ilmu Keperawatan Universitas dr. Soebandi.

Masalah kekerasan seksual pada anak usia 7-12 tahun menjadi faktor pemicu anak mengalami PTSD. Penatalaksanaan terapi untuk anak yang mengalami PTSD akibat kekerasan seksual dapat dilakukan dengan terapi CBT. Tujuan untuk mengetahui pengaruh CBT terhadap PTSD akibat kekerasan seksual pada anak usia 7-12 tahun. Pencarian database di *Researcgate* dan Pubmed, artikel tahun 2016-2020 yang telah dilakukan seleksi menggunakan PICOS dengan kriteria inklusi anak usia sekolah 7-12 tahun yang mengalami PTSD, diberikan intervensi CBT dan menggunakan study design eksperimen. Tingkat PTSD sebelum intervensi CBT pada kelompok eksperimen kategori sedang (56,7%) dan kelompok kontrol kategori sedang (60%), sedangkan menurut jenis PTSD kelompok eksperimen terdapat 3 artikel yang memiliki standart deviasi tertinggi pada aspek sosial dan 1 artikel pada aspek kognitif, pada kelompok kontrol didapatkan 1 artikel memiliki standart deviasi tertinggi pada aspek sosial, 1 artikel pada aspek akademik, 1 artikel pada aspek motivasi dan 1 artikel pada aspek kognitif. Tingkat PTSD setelah intervensi CBT pada kelompok eksperimen kategori ringan (53,3%) dan kelompok kontrol kategori sedang (60%), sedangkan menurut jenis PTSD pada kelompok eksperimen didapatkan 4 artikel terjadi peningkatan pada aspek sosial, kognitif, emosi, akademik dan emosional dan pada 4 artikel kelompok kontrol terjadi penurunan pada aspek sosial, kognitif, emosi, akademik dan emosional. Dengan demikian dari 5 artikel yang direview ada pengaruh CBT terhadap PTSD akibat kekerasan seksual pada anak usia 7-12 tahun. Tenaga kesehatan dapat menerapkan CBT sebagai upaya menurunkan PTSD, dan orang tua perlu mendampingi saat anak diberikan CBT, agar apabila muncul suatu kekambuhan pada anak tersebut, orang tua bisa membantunya untuk kembali tenang.

Kata Kunci : *Cognitive Behavioral Therapy, Posttraumatic Stress Disorder,* Kekerasan Seksual, Anak Usia 7-12 Tahun

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# *ABSTRACT*

Kumalasari, Kiki* Karnasih, I.G.A** Rosalini, Wike***. 2021. ***The Effect of Cognitive Behavior Therapy on Post-Traumatic Stress Disorder Due to Sexual Violence in Children Age 7-12 Years with a Literature Review.*** *Nursing Science Study Program, University of dr. Soebandi.*

*The problem of sexual violence in children aged 7-12 years is a factor that triggers children to experience PTSD. Therapeutic management for children who experience PTSD due to sexual violence can be done with CBT therapy. The purpose of this study was to determine the effect of CBT on PTSD due to sexual violence in children aged 7-12 years. Search databases in Researchgate and Pubmed, 2016-2020 articles that have been selected using PICOS with the inclusion criteria of school age 7-12 years experiencing PTSD, given CBT intervention and using an experimental study design. The level of PTSD before the CBT intervention in the experimental group was in the moderate category (56.7%) and the control group was in the moderate category (60%), while according to the type of PTSD in the experimental group there were 3 articles that had the highest standard deviation on the social aspect and 1 article on the cognitive aspect. in the control group, 1 article has the highest standard deviation on the social aspect, 1 article on the academic aspect, 1 article on the motivational aspect and 1 article on the cognitive aspect. The level of PTSD after CBT intervention in the experimental group was in the mild category (53.3%) and the control group was in the moderate category (60%), while according to the type of PTSD in the experimental group, it was found that in 4 articles there was an increase in social, cognitive, emotional, academic and emotional aspects. 4 articles in the control group experienced a decline in social, cognitive, emotional, academic and emotional aspects. Thus, from 5 articles reviewed, there is an effect of CBT on PTSD due to sexual violence in children aged 7-12 years. Health workers can apply CBT as an effort to reduce PTSD, and parents need to help when the child is given CBT, so that if a relapse occurs in the child, parents can help him calm down.*

*Keywords: Cognitive Behavior Therapy, Posttraumatic Stress Disorder, Sexual Violence, 7-12 Years Old*

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Jember, 4 Agustus 2021

**Kiki Kumalasari**
**17010104**

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**CPSS** : *Child ptsd symptom scale*

**CBT** : *Cognitive behavioral therapy*

**EMDR** : *Eye movement desensitization and reprocessing*

**PTSD** : *Post traumatic stress disorder*

**LPA** : Lembaga perlindungan anak

**PPA** : Pelayanan perempuan dan anak

**Permenkes** : Peraturan mentri kesehatan

**WHO** : *World Health Organisasi*

**P2TP2A** : Pusat pelayanan terpadu pemberdayaan perempuan dan anak

**MAOI** : *Monoamin Oksidase Inhibitor*

**SSRI** : *Selective serotonin reuptake inhibitor*

# BAB 1

# PENDAHULUAN

## 1.1 Latar Belakang

Masalah kekerasan seksual pada anak usia 7-12 tahun memerlukan keterlibatan institusi kesehatan, dan saat ini kekerasan seksual pada anak usia 7-12 tahun masih menjadi perhatian dunia, padahal anak merupakan generasi penerus bangsa (Suharto, 2015). Faktor penyebab korban kekerasan seksual anak usia 7-12 tahun dipengaruhi oleh usia karena semakin muda umur maka semakin rentan untuk menajdi korban kekerasan seksual, tingkat ekonomi yang rendah dapat berhubungan dengan tingkat pengawasan dari orang tua, anak yang pernah mengalami kekerasan seksual cenderung mengalaminya lagi, dan anak dalam pengaruh obat – obatan atau alkohol sehingga menurunkan tingkat kesadaran dan menurunkan potensi perlindungan terhadap dirinya (Wilkins, 2014). Kekerasan seksual yang terjadi pada anak usia 7-12 tahun akan berakibat terjadinya *post traumatic stress disorder* (PTSD) yaitu kecemasan karena traumatik yang menakutkan dan tidak menyenangkan dimana terdapat perasaan terancam dan merasa tidak berdaya (Endiyono *et al*, 2018). *Post traumatic stress disorder* merupakan suatu stres emosional yang besar yang dapat terjadi pada setiap anak usia 7-12 tahun yang mengalami kejadian traumatik (Triantoro *et al*, 2012).

Prevalensi secara global terjadinya *post traumatic stress disorder* (PTSD) akibat kekerasan seksual pada anak usia 7-12 tahun sebesar 12%, terutama pemerkosaan 9,0% (Kessler *et al*, 2017). Negara Indonesia angka kejadian anak usia 7-12 tahun yang mengalami *post traumatic stress disorder* (PTSD) akibat

kekerasan seksual sebesar 20% dengan kategori ringan 22,64% dan kategori berat 77,36% (Andini, 2020). Provinsi Jawa Timur angka kekerasan seksual pada anak usia 7-12 tahun sebesar 30% (LPA, 2019). Data tersebut selaras dengan penelitian yang menjelaskan bahwa pada tahun 2016 *post traumatic stress disorder* (PTSD) akibat kekerasan pada anak sebesar 45% dari data unit PPA (Fifi, 2020).

Gejala *post traumatic stress disorder* (PTSD) yang dialami anak usia 7-12 tahun akibat kekerasan seksual terjadi stres emosional dan sosial ditandai dengan perasaan mengalami kembali dengan pengalaman yang menyakitkan, sikap menghindar dari hal-hal yang berkaitan dengan peristiwa trauma, suasana hati yang negatif dengan menyalahkan diri sendiri, sering menyendiri, malu dan reaksi yang berlebihan seperti sulit berkonsentrasi dan gangguan tidur (*American Psychiatric Association*, 2013). Dampak dari *post traumatic stress disorder* (PTSD) juga dapat menyebabkan gangguan emosi pada anak usia 7-12 tahun sehingga terjadi perubahan perilaku dan pemikiran yang negatif (Hatta, 2015). *Post traumatic stress disorder* (PTSD) menempatkan anak pada peningkatan resiko kondisi kejiwaan dan medis lainnya sehingga sangat dibutuhkan sebuah terapi untuk mengurangi gejala tersebut (Cohen *et al*, 2015).

Solusi terapi untuk anak yang mengalami trauma kekerasan seksual dapat dilakukan dengan terapi *cognitive behavioral therapy* (CBT) yang dapat membantu anak dalam mengatasi trauma yang bertujuan untuk mengurangi emosi negatif dan respon perilaku terkait dengan kejadian traumatis pada *post traumatic stress disorder* (PTSD) akibat kekerasan pada anak *(Child Welfare Information Gateway*, 2018). Tindakan *cognitive behavioral therapy* (CBT), anak belajar

mengidentifikasi pikiran yang membuat mereka merasa takut atau kesal dan menggantinya dengan pikiran yang positif, tujuannya agar anak memahami bagaimana pikiran tersebut dapat menyebabkan stres terkait PTSD (*American Psychiatric Association,* 2017). Terapi *cognitive behavioral therapy* (CBT) sebagai pendekatan konseling yang dirancang untuk menyelesaikan permasalahan trauma pada anak dengan cara melakukan restrukturisasi kognitif dan perilaku yang menyimpang (Yahya *et al*, 2016). Efektivitas *cognitive behavioral therapy* (CBT) dalam mengurangi gejala *post traumatic stress disorder* (PTSD) dibuktikan dengan penelitian yang menjelaskan bahwa *cognitive behavioral therapy* (CBT) efektif diterapkan pada anak usia 7-12 tahun untuk jenis trauma seperti kekerasan, bencana, perang, trauma pasca kematian, dan trauma kompleks (Cohen *et al*, 2015).

Berdasarkan latar belakang diatas penulis tertarik untuk melakukan *literature review* dengan judul pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun.

## 1.2 Rumusan Masalah

"Adakah Pengaruh *Cognitive Behavioral Therapy* Terhadap *Posttraumatic Stress Disorder* Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun ?

## 1.3 Tujuan Penelitian

### 1.3.1 Tujuan Umum

Menganalisis pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun melalui *literature review.*

1.3.2 Tujuan Khusus

Tujuan Khusus dari penelitian ini adalah :

a. Mendeskripsikan *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun sebelum *cognitive behavioral therapy*
b. Mendeskripsikan *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun setelah *cognitive behavioral therapy*
c. Menjelaskan analisis pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun melalui *literature review*.

## 1.4 Manfaat Penelitian

1.4.1 Bagi Masyarakat

Memberikan informasi kepada masyarakat khususnya pada orang tua yang memiliki anak saat mengalami kekerasan seksual agar dapat diberikan *cognitive behavioral therapy* untuk mengurangi *posttraumatic stress disorder* pada anak usia 7-12 tahun.

1.4.2 Bagi Instansi Keperawatan

Hasil review penelitian ini dapat dijadikan sebagai sumber bacaan dan meningkatkan pengetahuan serta kemampuan dan pengembangan ilmu mengenai pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun.

1.4.3 Bagi Peneliti

Mampu menerapkan berfikir kritis dalam penerapan teori yang didapat selama perkuliahan ke dalam dunia kerja atau nyata dan dapat meningkatkan pengetahuan serta kemampuan dalam melakukan penelitian tentang pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun.

# BAB 2

# TINJAUAN PUSTAKA

## 2.1 Konsep Anak Usia Sekolah

### 2.1.1 Definisi Anak Usia Sekolah

Anak merupakan individu yang unik, yang memiliki kebutuhan yang berbeda sesuai dengan tahapan usianya dan mengalami pertumbuhan fisik yang lambat, namun terjadi peningkatan pada pertumbuhan dan perkembangan sosial (Cahyaningsih, 2011). Anak usia sekolah merupakan anak yang berumur lebih dari 6 tahun sampai sebelum berusia 12 tahun, pada masa ini anak belajar di dalam sekolah maupun di luar sekolah (Permenkes, 2014). Anak sekolah dasar yaitu yang berusia diantara 6-11 tahun dan berada pada fase kanak-kanak tengah (Sumantri, 2015).

### 2.1.2 Karakteristik Anak Usia Sekolah

Menurut Supariasa (2012), karakteristik anak usia sekolah umur 6-12 tahun terbagi menjadi empat bagian, yaitu :

a. Fisik/Jasmani : pertumbuhan lambat dan teratur, anak wanita biasanya lebih tinggi dan lebih berat dibanding laki-laki dengan usia yang sama, anggota-anggota badan memanjang sampai akhir masa ini, peningkatan koordinasi besar dan otot-otot halus, pertumbuhan tulang, tulang sangat sensitif terhadap kecelakaan, pertumbuhan gigi tetap, gigi susu tanggal, nafsu makan besar, senang makan dan aktif serta fungsi penglihatan normal, timbul haid pada akhir masa ini.

b. Emosi : suka berteman, ingin sukses, ingin tahu, bertanggung jawab terhadap tingkah laku dan diri sendiri, mudah cemas jika ada masalah di dalam keluarga, tidak terlalu ingin tahu terhadap lawan jenis.
c. Sosial : senang berada di dalam kelompok, berminat di dalam permainan yang bersaing, mulai menunjukkan sikap kepemimpinan, mulai menunjukkan penampilan diri, jujur, sering punya kelompok teman-teman tertentu, sangat erat dengan teman-teman sejenis, laki-laki dan wanita bermain sendiri-sendiri.
d. Intelektual : suka berbicara dan mengeluarkan pendapat minat besar dalam belajar dan keterampilan, ingin coba-coba, selalu ingin tahu sesuatu dan perhatian terhadap sesuatu sangat singkat (Supariasa *et al*, 2012).

### 2.1.3 Kebutuhan Anak

Menurut Novi (2015), tiga kebutuhan dasar yang tidak bisa terlepas dari anak yaitu :

a. Asuh

   Kebutuhan asuh ini merupakan kebutuhan biomedis yang menyangkut asupan gizi anak selama dalam kandungan dan setelah ia lahir, kebutuhan akan tempat tinggal, pakaian yang layak dan aman, perawatan kesehatan dini berupa imunisasi dan intervensi dini akan timbulnya gejala penyakit

b. Asih

   Kebutuhan asih ini meliputi kebutuhan emosional, orang tua harus memberikan rasa aman *(emosional security)* dengan kontak fisik dan mental, kebutuhan akan kasih sayang, mendapatkan perhatian dan rasa

dihargai, adanya rasa dihargai, adanya rasa kepercayaan anatara orang tua dan anak, kebutuhan stimulasi, memberikan pengalaman baru, mendapatkan pujian, serta tanggung jawab untuk kemandirian merupakan beberapa diantaranya.

c. Asah

Kebutuhan stimulasi mental mulai sejak dini, hal ini merupakan cikal-bakal proses pembelajaran pendidikan, dan pelatihan yang diberikan, ini sangat penting karena anak akan memiliki keperibadian yang baik, kecerdasan, kemandirian, etika, keterampilan dan produktivitas yang baik (Novi, 2015).

## 2.2 Konsep Kekerasan Seksual

### 2.2.1 Definisi Kekerasan Seksual

Kekerasan seksual merupakan setiap tindakan seksual, usaha melakukan tindakan seksual, komentar atau menyarankan untuk berperilaku seksual yang tidak disengaja ataupun sebaliknya, tindakan pelanggaran untuk melakukan hubungan seksual dengan paksaan kepada seseorang (WHO, 2017). Kekerasan seksual adalah segala kegiatan yang terdiri dari aktivitas seksual yang dilakukan secara paksa oleh orang dewasa pada anak atau oleh anak kepada anak lainnya yang meliputi penggunaaan atau pelibatan anak secara komersial dalam kegiatan seksual, bujukan ajakan atau paksaan terhadap anak untuk terlibat dalam kegiatan seksual, pelibatan anak dalam media audio visual dan pelacuraran anak (UNICEF, 2014).

### 2.2.2 Jenis Kekerasan Seksual

Menurut WHO (2017) jenis kekerasan seksual dapat berupa tindakan :

a. Pemerkosaan (termasuk pemerkosaan oleh warga negara asing, dan pemerkosaan dalam konflik bersenjata) sodomi, kopulasi oral paksa, serangan seksual dengan benda, dan sentuhan atau ciuman paksa.
b. Pelecehan seksual secara mental atau fisik menyebut seseorang dengan sebutan berkonteks seksual, membuat lelucon dengan konteks seksual.
c. Menyebarkan vidio atau foto yang mengandung konten seksual tanpa izin, memaksa seseorang terlibat dalam pornografi.
d. Tindakan penuntutan/pemaksaan kegiatan seksual pada seseorang atau penebusan/persyaratan mendapatkan sesuatu dengan kegiatan seksual.
e. Melarang seseorang untuk menggunakan alat kontrasepsi ataupun alat untuk mencegah penyakit menular seksual.

### 2.2.3 Faktor yang Mempengaruhi Kekerasan Seksual

Menurut Wilkins (2014) kekerasan seksual dapat dipicu dari beberapa faktor, yaitu :

a. Jenis kelamin : perempuan lebih rentan menjadi korban kekerasan seksual
b. Usia : semakin muda umur maka semakin rentan untuk menajdi korban kekerasan seksual, biasanya usia dibawah 15 tahun rentan menjadi korban kekerasan seksual
c. Faktor individu : pendidikan rendah, kurangnya pengetahuan dan keterampilan menghindar dari kekerasan seksual, kontrol perilaku buruk,

pernah mengalami riwayat kekerasan, pernah menyaksikan kejadian kekerasan seksual, dan penggunaan obat - obatan.

d. Lingkungan sosial : kebudayaan atau kebiasaan yang mendukung adanya tidakan kekerasan seksual, kekerasan yang dilihat melalui media, kelemahan kesehatan, pendidikan, ekonomi dan hukum, aturan yang tidak sesuai atau berbahaya untuk sifat individu wanita atau laki - laki.
e. Faktor hubungan: kelemahan hubungan antara anak dan orangtua, konflik dalam keluarga, berhubungan dengan seorang penjahat atau pelaku kekerasan, dan tergabung dalam geng atau komplotan.
f. Pengalaman terhadap kekerasan seksual : anak yang pernah mengalami kekerasan seksual cenderung mengalaminya lagi dan berpotensi untuk menjadi pelaku kekerasan seksual.

### 2.2.4 Dampak Kekerasan Seksual

Menurut WHO (2017) dampak dari kekerasan seksual yaitu :

a. Dampak fisik
    1. Masalah pada organ reproduksi seperti perdarahan, infeksi saluran reproduksi, iritasi pada alat kelamin, nyeri pada saat senggama, dan masalah reproduksi lainnya.
    2. Meningkatnya penularan penyakit menular seksual
b. Dampak psikologis
    1. Depresi/stress tekanan pasca trauma
    2. Kesulitan tidur
    3. Penurunan harga diri

4. Munculnya keluhan somatik

c. Dampak sosial seperti hambatan interaksi sosial : pengucilan, merasa tidak pantas.

## 2.3 Konsep *Post Traumatic Stress Disorder* (PTSD)

### 2.3.1 Definisi *Post Traumatic Stress Disorder* (PTSD)

*Post traumatic stress disorder* merupakan suatu stres emosional yang besar yang dapat terjadi pada hampir setiap orang yang mengalami kejadian traumatik *(*Triantoro *et al*, 2012). Kejadian *post traumatic stress disorder* menyebabkan trauma yang dialami atau disaksikan secara langsung oleh seseorang berupa kematian atau ancaman kematian, cidera serius dan ancaman terhadap integritas fisik atas diri seseorang yang dapat menciptakan ketakutan yang ekstrem, horror dan rasa tidak berdaya (Sadock *et al*, 2010).

### 2.3.2 Patofisiologi *Post Traumatic Stress Disorder* (PTSD)

*Post traumatic stress disorder* mengakibatkan terjadinya perubahan hipokampus dan amigdala yang mengatur memori dan emosi, amigdala merupakan *fear center* dari otak yang membantu otak dalam membuat hubungan antara situasi yang menimbulkan ketakutan di masa lalu, kondisi ini dapat berpasangan dengan situasi saat ini yang bisa saja netral, anak dengan gangguan ini akan mempertahankan kondisi waspada yang konstan pada saat situasi yang tidak tepat karena pada saat itu otak memerintahkan individu bahwa dalam situasi yang aman pun individu sedang menghadapi ancaman sehingga penderita PTSD akan mengalami amigdala yang over reaktif dan akan disimpan sebagai ingatan (Guyton *et al*, 2014). Hipokampus merupakan bagian yang menciptakan harapan

terhadap situasi yang akan memberikan situasi traumatis yang kita alami berdasarkan pada memori dan pengalaman belajar dari masa lalu, penderita PTSD dengan kerusakan hipokampus, akan mengalami kesulitan belajar dan menciptakan harapan baru untuk berbagai situasi yang terjadi setelah kejadian traumatik, gejala ini fluktuasi dari waktu ke waktu dan menjadi paling intens selama periode stress, jika tidak tertangani maka hal ini akan bertambah buruk (Sadock *et al*, 2010).

### 2.3.3 Gejala *Post Traumatic Stress Disorder*

Menurut *American Psychiatric Association*, (2013) ada tiga klasifikasi gejala PTSD, yaitu:

a. *Intrusive Re-Experiencing* merupakan selalu kembalinya peristiwa traumatik dalam ingatan penderita dengan gejala perasaan, pikiran dan persepsi mengenai peristiwa muncul berulang-ulang, mimpi-mimpi buruk tentang peristiwa, gangguan psikologis, terjadi reaktifitas fisik, seperti menggigil, jantung berdebar kencang, atau panik ketika bertemu yang mengingatkan peristiwa.
b. *Avoidance* yaitu menghindari sesuatu yang berhubungan dengan trauma, gejalanya adalah berusaha menghindari situasi, pikiran-pikiran atau aktivitas yang berhubungan dengan peristiwa traumatik, kurangnya perhatian atau partisipasi dalam kegiatan sehari-hari, merasa terasing dari orang lain, membatasi perasaan-perasaan termasuk perasaan kasih sayang dan perasaan menyerah dan takut pada masa depan, termasuk tidak mempunyai harapan terhadap karir, pernikahan, anak-anak atau hidup

normal.

c. *Negative aterations in mood and cognition* yaitu suatu penyimpangan secara persisten diantara lain menyalahkan diri sendiri atau orang lain, berkurangnya minat melakukan aktivitas dan ketidakmampuan untuk mengingat aspek- aspek yang menjadi kunci dari kejadian tersebut.

d. *Arousal* merupakan kesadaran secara berlebihan dengan gejala mengalami gangguan tidur, mudah marah, sulit untuk berkonsentrasi, kesadraan berlebih (*hyper-arousal*), penggugup dan mudah terkejut (*American Psychiatric Association*, 2013).

### 2.3.4 Faktor yang Mempengaruhi *Post Traumatic Stress Disorder* (PTSD)

Menurut Figley (2012) faktor yang mempengaruhi *post traumatic stress disorder* pada anak usia 7-12 tahun meliputi :

a. Usia : pada anak-anak cenderung akan menghindari keterbukaan karena kurangnya kemampuan atau kapasitas mereka untuk berbicara ataupun menunjukan emosi yang mereka rasakan, sehingga anak akan memendam sendiri perasaannya, yang berdampak gejala PTSD yang timbul semakin berat

b. Jenis kelamin : anak laki-laki cenderung lebih sering mengalami peristiwa traumatis disbanding anak perempuan, namun anak perempuan lebih memungkinkan mengalami *post traumatic stress disorder* dibanding anak laki-laki

c. Tingkat keparahan trauma : dapat mempengaruhi level gangguan psikologis seorang korban sehingga dapat mempengaruhi hubungan

terapeutik yang terjalin antara korban dan orang lainnya

d. Lingkungan sosial : dukungan sosial yang tidak adekuat dari keluarga dan lingkungan meningkatkan risiko perkembangan PTSD setelah seseorang mengalami kejadian traumatik
e. Riwayat mengalami trauma sebelumnya : anak yang sebelumnya pernah mengalami trauma akan menurunkan resiko terkena PTSD pada peristiwa trauma selanjutnya (Figley, 2012).

### 2.3.5 Jenis *Post Traumatic Stress Disorder* (PTSD)

Menurut Gerald (2010) terjadinya *post traumatic stress disorder* di bedakan menjadi beberapa jenis aspek, yaitu :

a. Kognitif : apabila terjadi trauma lagi pada anak maka akan menimbulkan bangkitan ingatan trauma sebelumnya. Kognitif harus di tingkatkan agar anak mencoba menghindari dari hal yang dialami dan akan menekan ingatan tentang trauma yang dialami di alam bawah sadar.
b. Emosional : anak akan merasa murung, sedih, gelisah, mudah marah, merasa tidak bahagia dan mudah kecewa. Meningkatkan emosional dapat dilakukan dengan cara mengajak anak belajar mengidentfikasi emosi yang mereka rasakan, mengajarkan anak berempati terhadap emosinya, dan membantu anak mengekspresikan emosi dengan cara yang baik.
c. Sosial : ketidakmampuan untuk mengatakan kepada keluarga tentang pengalaman traumatis sehingga anak selalu menarik diri dari lingkugan keluarga dan sosialnya. Kemampuan sosial anak pada kasus ini perlu ditingkatkan, contoh untuk stimulasi sosial dapat dilakukan selalu

mengkomunikasikan kepada anak apa yang di rasakan orang tua dengan bicara yang baik, hal ini akan menjadi contoh bagi anak bahwa pengalaman traumatis dapat dikomunikasikan dengan bicara yang baik bukan menangis atau menarik diri.

d. Akademik : potensi akademik pada anak yang mengalami PTSD akan menurun, karena ia merasa kehilangan rasa percaya diri, takut gagal, sulit berkonsentrasi dan cemas akan masa depan. Dalam hal ini, hindari memberi target akademik yang terlalu tinggi pada anak, namun berikan dorongan atau motivasi terhadap anak untuk meningkatkan rasa percaya dirinya yang berkaitan dengan masa depannya.
e. Motivasi : kecenderungan memiliki emosi yang negatif terhadap sesuatu dan selalu merasa tidak semangat. Motivasi pada diri anak yang mengalami PTSD harus di tingkatkan, agar dapat mengontrol danm mengekspresikan emosinya dengan cara yang baik

### 2.3.6 Kalsifikasi *Post Traumatic Stress Disorder* (PTSD)

Menurut *National Center for PTSD* (2016) *post traumatic stress disorder* (PTSD) terbagi atas tiga jenis, yaitu :

a. *Post traumatic stress disorder* akut, yaitu dimana tanda dan gejalanya terjadi pada rentang waktu 1-3 bulan, namun biasanya berakhir dalam kurun waktu satu bulan. Jika dalam waktu lebih dari satu bulan, individu tersebut harus segera menghubungi pelayanan kesehatan terdekat
b. *Post traumatic stress disorder* kronik, yaitu dimana tanda dan gejalanya berlangsung lebih dari tiga bulan dan jika tidak ada treatment yang

dilakukan maka dapat bertambah berat sehingga akan mengganggu kehidupan sehari-hari

c. *Post traumatic stress disorder with delayed onset*, walaupun sebenarnya tanda dan gejala PTSD muncul pada saat setelah trauma, ada kalanya tanda dan gejalanya baru muncul minimal enam bulan bahkan bertahun- tahun setelah peristiwa traumatic itu terjadi, hal ini timbul pada saat memperingati hari kejadian traumatis tersebut atau bisa juga karena individu mengalami kejadian traumatis lain yang akan mengingatkan terhadap peristiwa traumatasi masa lalunya (*National Center of PTSD/NCPTSD*, 2013).

### 2.3.7 Alat Ukur *Post Traumatic Stress Disorder*

Menurut Elena *et al* (2018) alat ukur yang digunakan untuk *post traumatic stress disorder* pada anak adalah *child ptsd symptom scale* (CPSS) dengan 24 pertanyaan terdiri dari 17 pertanyaan dari skala 0-3 dengan skor 0-51 dan penilaian kedua yaitu 7 item tambahan yang menyatakan tentang fungsi sehari-hari dinilai 0 (tidak ada) dan 1 (ada). Tingkat keparahan gejala :

a. Skor 0-10 (dibawah ambang batas)
b. Skor 11-15 (subklinis)
c. Skor 16-20 (ringan)
d. Skor 1-25 (sedang)
e. Skor 26-30 (cukup parah)
f. Skor 31-40 (parah)
g. Skor 41-51 (sangat parah) (Elena *et al*, 2018)

### 2.3.8 Penanganan *Post Traumatic Stress Disorder*

Menurut Sadock *et al* (2010) agar hasil pengobatan lebih efektif dan tercapai penanganan yang holistik dan komprehensif maka terapi pengobatan yang dapat dilakukan pada anak yang mengalami PTSD yaitu dengan menggunakan farmakologi dan non farmakologi, antara lain :

a. Farmakologi : terapi ini diperlukan untuk menstabilkan zat-zat di otak yang menyebabkan kecemasan, kekhawatiran, dan depresi atau dengan kata lain merupakan terapi simptomatik pada PTSD.

   1. Golongan benzodiazepine : Chlordiazepoxide, Diazepam, Lorazepam.
   2. Golongan non-benzodiazepin : Buspirone, Sulpiride, Hydroxyzine.
   3. Golongan antidepresan : Trisiklik, Amitriptyline, Imipramine.
   4. Golongan Monoamin Oksidase Inhibitor (MAOI) : Moclobemide
   5. Golongan Selective Serotonin Reuptake Inhibitor (SSRI) : Sertraline, Paroxetine, Fluvoxamine, Fluoxetine.

b. Non Farmakologi : perawatan secara umum menggunakan intervensi psikis dengan pendekatan psikologis terhadap pasien yang mengalami gangguan psikis atau hambatan kepribadian yaitu PTSD.

   1. *Eye Movement Desensitization and Reprocessing* (EMDR)

      EMDR dijalankan dengan melakukan kegiatan fisik yang merangsang aktivasi pemrosesan informasi di dalam otak (dalam konteks EMDR disebut sebagai stimulasi bilateral) melalui indra pengelihatan/ pendengaran/ perabaan. Jaringan memori dilihat sebagai landasan yang mendasari patologi sekaligus kesehatan mental, karena jaringan-

jaringan memori adalah dasar dari persepsi, sikap dan perilaku.

2. *Playtherapy*

   *Playtherapy* merupakan cara yang dapat digunakan untuk mengobati PTSD pada anak karena pada terapi ini bertujuan untuk memahami trauma anak dan memberikan kebebasan untuk berekspresi dalam mengurangi tekanan emosional yang dialami.

3. *Cognitive Behavioral Therapy* (CBT)

   Prinsip-prinsip CBT digunakan untuk modifikasi perilaku dan proses *re–learning*. Tujuan terapi ini adalah mengidentifikasi pikiran-pikiran yang tidak rasional, mengumpulkan bukti bahwa pikiran tersebut tidak rasional untuk melawan pikiran tersebut yang kemudian mengadopsi pikiran yang lebih realistik untuk membantu mencapai emosi yang lebih seimbang. Dalam CBT, terapis membantu untuk mengubah kepercayaan yang tidak rasional yang mengganggu emosi dan menganggu kegiatan-kegiatan penderita PTSD misalnya, pada seorang anak korban kejahatan mungkin akan menyalahkan diri sendiri karena ketidakhati-hatiannya.

## 2.4 Konsep *Cognitive Behavioral Therapy* (CBT)

### 2.4.1 Definisi *Cognitive Behavioral Therapy* (CBT)

*Cognitive behavioral therapy* merupakan pendekatan sejumlah prosedur yang secara spesifik menggunakan kognisi sebagai utama terapi, yaitu berfokus kepada persepsi percaya diri dan fikiran sehingga terapi intervensi ini efikatif dan efektif untuk berbagai masalah psikologis pada anak (William *et al*, 2017).

Konsep *cognitive behavioral therapy* ini berfokus untuk mengubah perilaku, menenangkan pikiran dan tubuh sehingga merasa lebih baik, berpikir lebih jelas dan membantu anak membuat keputusan yang tepat (Yahya *et al*, 2016). *Cognitive behavioral therapy* tidak memfokuskan pada kasus yang menyebabkan anak *distress* atau mengalami gejala di masa lampau, namun mengajarkan tentang bagaimana memahami tentang diri sendiri, dunia dan orang lain serta apa yang bisa dilakukan atas pikiran atau perasaan (Sadock *et al*, 2010).

### 2.4.2 Tujuan *Cognitive Behavioral Therapy* (CBT)

*Cognitive behavioral therapy* lebih banyak bekerja pada status kognitif saat ini untuk dirubah dari status kognitif negatif menjadi status kognitif positif yang bertujuan untuk melakukan perubahan pada pola pikir masa kini agar mencapai perubahan di waktu yang akan datang (Yahya *et al*, 2016). Menurut Stepen (2011) tujuan dari CBT antara lain :

a. Memperbaiki dan memecahkan kesulitan atau masalah
b. Membantu anak memperoleh strategi yang konstruktif dalam mengatasi masalah
c. Membantu anak memodifikasi kesalahan fikir atau skema
d. Membantu anak menjadi terapis pribadi untuk dirinya sendiri (Stepen, 2011).

### 2.4.3 Prinsip-Prinsip *Cognitive Behavioral Therapy* (CBT)

Menurut Beck (2011) prinsip dasar dari CBT untuk memahami konsep, strategi dalam merencanakan proses konseling dari setiap sesi, serta penerapan teknik teknik CBT, diantaranya :

a. Pada momen yang strategis, konselor mengkoordinasikan penemuan-penemuan konseptualisasi kognitif anak yang menyimpang dan meluruskannya sehingga dapat membantu anak dalam penyesuaian antara berfikir, merasa dan bertindak
b. Melalui situasi konseling yang penuh dengan kehangatan, empati, peduli, dan orisinilitas respon terhadap permasalahan anak akan membuat pemahaman yang sama terhadap permasalahan yang dihadapi anak, kondisi tersebut akan menunjukan sebuah keberhasilan dari konseling
c. CBT memerlukan kolaborasi dan partisipasi aktif, dengan menempatkan anak sebagai tim dalam konseling maka keputusan konseling merupakan keputusan yang disepakati dengan anak
d. CBT berorientasi pada tujuan dan berfokus pada permasalahan, setiap sesi konseling selalu dilakukan evaluasi untuk mengetahui tingkat pencapaian tujuan.
e. CBT berfokus pada kejadian saat ini. Perhatian konseling beralih pada dua keadaan, pertama, ketika anak mengungkapkan sumber kekuatan dalam melakukan kesalahannya, kedua, ketika anak terjebak pada proses berfikir yang menyimpang dan keyakinan anak dimasa lalunya yang berpotensi merubah kepercayaan dan tingkah laku ke arah yang lebih baik
f. CBT merupakan edukasi, bertujuan mengajarkan konseli untuk menjadi terapis bagi dirinya sendiri, dan menekankan pada pencegahan. CBT mengarahkan anak untuk mempelajari sifat dan permasalahan yang

dihadapinya termasuk proses konseling *cognitive-behavior* serta model kognitifnya karena CBT meyakini bahwa pikiran mempengaruhi emosi dan perilaku.

g. CBT yang terstruktur, tujuannya adalah membuat proses konseling lebih dipahami oleh konseli dan meningkatkan kemungkinan mereka mampu melakukan *self-help* di akhir sesi konseling
h. CBT mengajarkan anak untuk mengidentifikasi, mengevaluasi, dan menanggapi pemikiran disfungsional dan keyakinan mereka. Setiap hari anak memiliki kesempatan dalam pikiran-pikiran otomatisnya yang akan mempengaruhi suasana hati, emosi dan tingkah laku mereka. Anak dilatih untuk menciptakan pengalaman barunya dengan cara menguji pemikiran mereka (misalnya: jika saya melihat gambar laba-laba, maka akan saya merasa sangat cemas, namun saya pasti bisa menghilangkan perasaan cemas tersebut dan dapat melaluinya dengan baik)
i. CBT menggunakan berbagai teknik untuk merubah pemikiran, perasaan, dan tingkah laku (Beck, 2011).

### 2.4.4 Langkah-Langkah *Cognitive Behavioral Therapy* (CBT)

Penerapan sesi *cognitive behavior therapy* yang fleksibel sebanyak 12 sesi, namun penerapannya di Indonesia masih memiliki hambatan, sehingga disesuaikan dengan menerapkan 5 sesi agar lebih efisien. Teknik *cognitive behavioral therapy* menurut Putranto (2016) yaitu :

a. Sesi 1 Assesmen dan Diagnosa awal

   Dalam sesi ini terapis diharapkan mampu melakukan assesmen atas

masalah yang dihadapi, memberikan dukungan dan semangat untuk melakukan perubahan, mendapatkan komitmen kepada klien untuk mengikuti terapi dan pemecahan masalah, serta mendapatkan formulasi masalah dan situasi kondisi yang sedang dihadapi.

b. Mengidentifikasi pikiran negatif, pikiran otomatis, serta asumsi yang berhubungan dengan gangguan

   Pada sesi ini terapis diharapkan mampu memberikan bukti bagaimana sistem keyakinan dan pikiran erat kaitannya dengan emosi dan tingkah laku dengan menolak pikiran negatif dan menawarkan pikiran positif yang dibuktikan bersama, serta terapis diharapkan memperoleh komitmen klien untuk melakukan modifikasi menyeluruh, baik dari segi pikiran, perasaan, dan perilaku yang lebih positif.

c. Menyusun rencana intervensi dengan memberikan konsekuensi positif-konsekuensi negatif kepada pasien

   Pada sesi ini, klien diajak untuk berkomitmen secara personal dengan menerapkan konsekuensi positif-konsekuensi negatif atas kemajuan proses belajar yang diperoleh. Penggunaan konsekuensi positif dan konsekuensi negatif ini dianggap dapat membantu klien untuk mencegah kekambuhan di tahap berikutnya

d. Fokus terapi atau intervensi tingkah laku lanjutan

   Pada sesi ini, terapis diharapkan dapat memberikan *feedback* atas hasil kemajuan dan perkembangan terapi, terapis mampu memberikan semangat dan dukungan atas kemajuan yang dicapai klien, serta

keyakinan untuk tetap fokus kepada masalah utama.

e. Pencegahan *Relapse* (kekambuhan)

Pada sesi ini, diharapkan klien sudah mendapatkan pengalaman dan manfaat tentang *cognitive behavior therapy*. Sesi ini, terapis diharapkan mampu memperleh komitmen klien dalam melakukan metode *Self Help* secara berkesinambungan serta komitmen untuk membentuk pikiran, perasaan, dan perilaku positif dalam setiap masalah yang dihadapi.

### 2.4.5 Teknik *Cognitive Behavioral Therapy* (CBT)

Menurut Corey (2012) beberapa teknik/strategi yang biasanya digunakan selama tahap inti adalah sebagai berikut :

a. *Modeling*
b. *Behavior Rehearsal*
c. *Coaching*
d. *Homework*
e. *Feed back*
f. *Reinforcement*
g. *Cognitive Restructuring*
h. *Problem Solving*
i. *The Buddy System* (Corey, 2012).

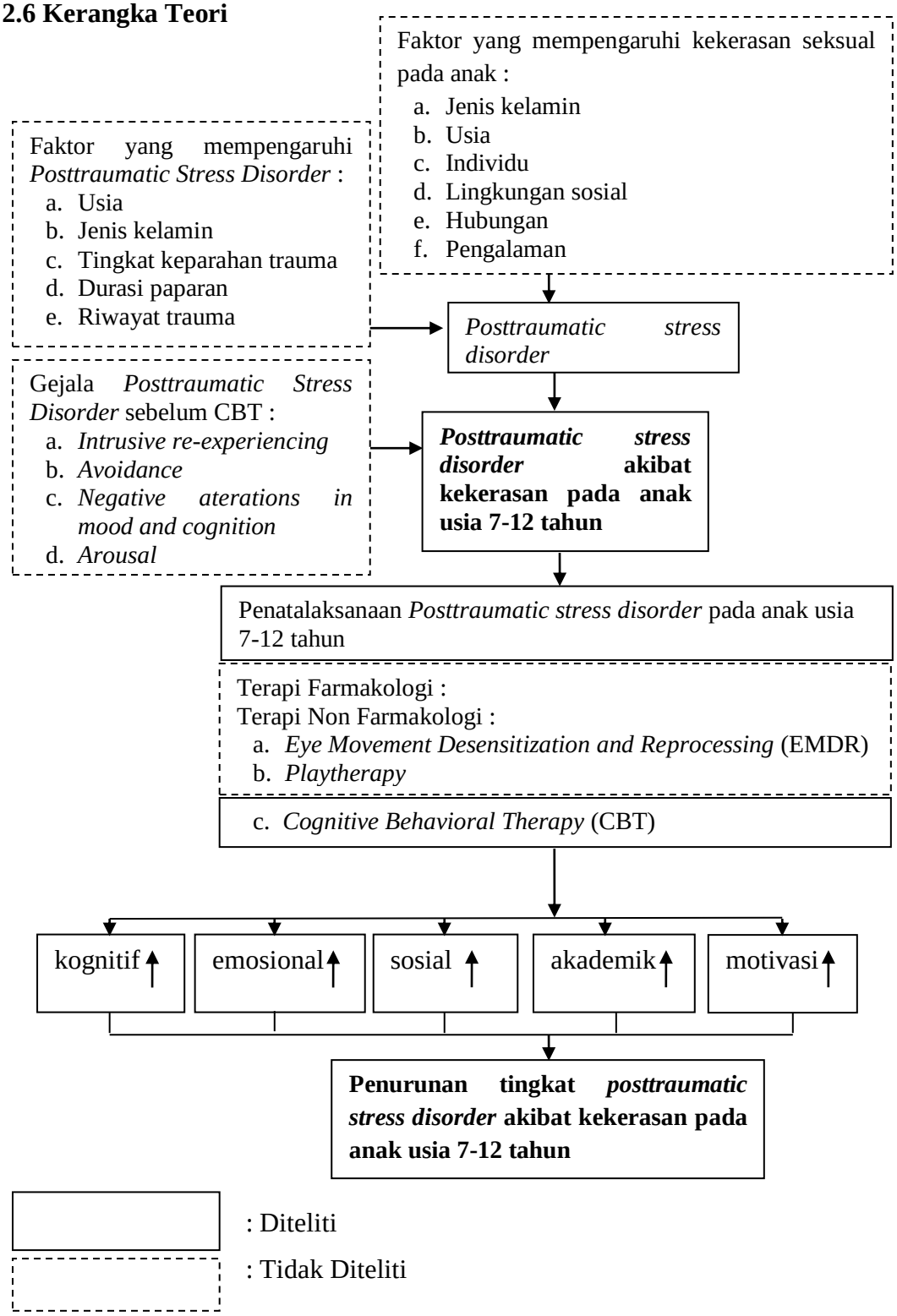
## 2.5 Pengaruh *Cognitive Behavioral Therapy* Terhadap *Posttraumatic Stress Disorder* Akibat Kekerasan Pada Anak

Gangguan *posttraumatic stress disorder* bisa dialami segera setelah peristiwa traumatis terjadi namun bisa juga dialami secara tertunda sampai

beberapa tahun sesudahnya, anak biasanya mengeluh tegang, *insomnia* (sulit tidur), sulit berkonsentrasi dan ia merasa ada yang mengatur hidupnya, bahkan merasa kehilangan makna hidupnya dan hal yang lebih parah terjadi yaitu anak mengalami keadaan stress yang berkepanjangan, yang dapat berakibat munculnya gangguan otak, berkurangnya kemapuan intelektual, gangguan emosional, maupun gangguan kemampuan sosial (Kusumawati, 2016). *Cognitive behavioral therapy* mendasarkan pada model kognitif dimana emosi, perilaku, dan fisiologi seseorang dipengaruhi oleh persepsi atau pikiran terhadap sebuah peristiwa sehingga terapi ini kuat dengan komponen psikoedukasi yang menekankan pada proses mengidentifikasi dan mengubah pemikiran otomatis negatif (*negative automatic thought* atau NAT) yang tidak realistis dan perilaku maladaptif (Beck, 2011).

*Cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan pada anak dilakukan dalam 5 sesi dengan durasi 1 jam sebanyak 2 kali terapi dalam seminggu (Safora *et al*, 2018). Konsep *cognitive behavioral therapy* digunakan untuk perubahan kognitif, emosi, sosial, akademik, meningkatkan motivasi dan mengajarkan anak untuk mengidentifikasi pikiran yang membuat mereka merasa takut atau kesal dan menggantinya dengan pikiran yang positif (*American Psychiatric Association,* 2017).

## 2.6 Kerangka Teori




2.6 Kerangka Teori Pengaruh *Cognitive Behavioral Therapy* Terhadap *Posttraumatic Stress Disorder* Akibat Kekerasan Pada Anak Usia 7-12 tahun

# BAB 3

# METODE PENELITIAN

## 3.1 Strategi Pencarian *Literature*

### 3.1.1 Protokol dan Registrasi

Rangkuman menyeluruh dalam bentuk *literature review* mengenai pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan pada anak. Tujuan dari *literature review* ini adalah untuk menganalisis pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan pada anak. Protokol dan evaluasi dari *literature review* akan menggunakan kerangka kerja PRISMA sebagai upaya menentukan pemilihan studi yang telah ditemukan dan disesuaikan dengan tujuan dari *literature review* ini.

### 3.1.2 *Database* Pencarian

Pencarian sumber data sekunder dilakukan pada bulan Mei 2021 berupa artikel atau jurnal nasional dan jurnal internasional dari tahun 2015-2020 yang menggunakan *database Researcgate* dan Pubmed.

### 3.1.3 Kata Kunci

Pencarian artikel menggunakan kata kunci dan *Boolean operator* (DAN, ATAU TIDAK, atau DAN TIDAK) yang digunakan peneliti untuk memperluas dan menspesifikkan hasil pencarian, sehingga mudah dalam menentukan artikel yang digunakan. Kata kunci dalam *literature review* ini terdiri dari sebagai berikut :

Tabel 3.1 Kata Kunci

| No | Variabel 1 | Variabel 2 | Populasi |
|---|---|---|---|
| 1 | Terapi Perilaku Kognitif | Gangguan Stress Pasca Trauma Akibat Kekerasan | Anak usia 7-12 tahun |
| | *Or* | *Or* | *Or* |
| 2 | *Cognitive Behavioral Therapy* | *Posttraumatic Stress Disorder* Akibat Kekerasan | *School age children* |

## 3.2 Kriteria Inklusi dan Eksklusi

Strategi yang digunakan dalam mencari artikel menggunakan PICOS *framework*, yaitu terdiri dari :

Tabel 3.2 Kriteria Inklusi dan Eksklusi dengan Format PICOS

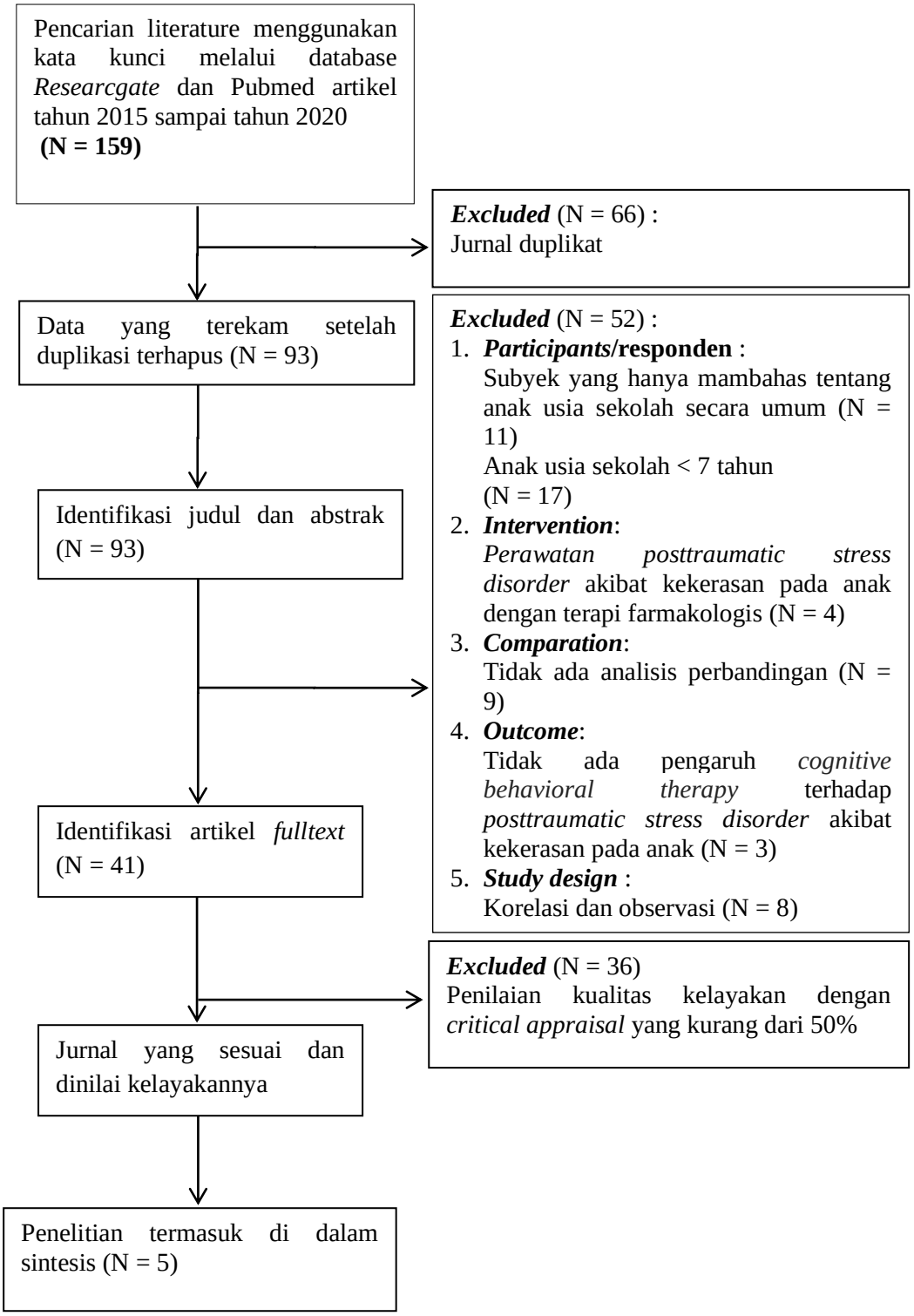
| Kriteria | Inklusi | Eksklusi |
|---|---|---|
| *Population / problem* | Kriteria populasi dalam penelitian ini merupakan anak usia sekolah 7-12 tahun yang mengalami *posttraumatic stress disorder* akibat kekerasan seksual pada anak | Subyek yang hanya mambahas tentang anak usia sekolah < 6 tahun secara umum. |
| *Intervention* | Studi yang meneliti tentang intervensi atau metode mengenai *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan pada anak | Studi yang fokus membahas tentang perawatan *posttraumatic stress disorder* akibat kekerasan pada anak dengan terapi farmakologis. |
| *Comparation* | Ada analisis perbandingan | Tidak ada analisis perbandingan |
| *Outcome* | Ada pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan pada anak | Tidak ada pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan pada anak |
| *Study design* | *Quasi eksperimental pre-test post-test control group design, experiment pre-post design,* eksperimental uji klinis | Korelasi dan observasi |
| *Publication years* | Tahun 2015 dan setelahnya | Sebelum tahun 2015 |

| | | |
|---|---|---|
| *Language* | Bahasa Indonesia dan bahasa Inggris | Bahasa selain Indonesia dan Inggris |

### 3.3 Seleksi Studi dan Penilaian Kualitas

#### 3.3.1 Hasil Pencarian dan Seleksi Studi

Strategi dalam pencarian data yang dilakukan penulis dalam membuat *literature review* ini adalah dengan mengunakan kata kunci : "terapi perilaku kognitif", "gangguan stress pasca trauma", "kekerasan seksual", "*cognitive behavioral therapy", "posttraumatic stress disorder", "abused children"*. Pencarian dalam database dilakukan di *Researcgate* sejumlah 94 artikel dan Pubmed sejumlah 65 artikel. Berdasarkan artikel dalam rentang mulai dari tahun 2015 hingga tahun 2020, dilihat dari seleksi duplikat didapatkan sejumlah 93 artikel, selanjutnya seleksi identifikasi judul dan abstrak didapatkan sebanyak 93 artikel dan seleksi *full text* sebanyak 41 artikel. Artikel akhir yang dianalisa yang sesuai dan bisa digunakan sebanyak 5 artikel yang akan dilakukan *review.*




Gambar 3.1 Kerangka Kerja *Literature Review* berdasarkan PRISMA

# BAB 4

# HASIL DAN ANALISIS

## 4.1 Hasil

### 4.1.1 Karakteristik Studi

Hasil pencarian *literature* akan dilakukan *review* dengan karakteristik studi sebagai berikut :

Tabel 4.1 Karakteristik Studi

| No | Penulis dan Tahun Terbit | Vol. No | Judul | Tujuan | Metode Penelitian (Desain, Sampel, Variabel, Instrument, Analisis) | Hasil Temuan | *Database* |
|---|---|---|---|---|---|---|---|
| 1 | Riyadh *et al* (2015) | Vol. 2 No. 4 | *Trauma Focused Cognitive Behavioral Group Therapy for Abused Children with Post Traumatic Stress: The Case of Institutionalized Children, Addis Ababa, Ethiopia* | Tujuan penelitian ini adalah untuk mengetahui pengaruh terapi *cognitive behavioral therapy* terhhadap | D : *quasi-experimental control group's pretest-posttest* S : *purposive sampling* V : *cognitive* | 1. Hasil penelitian menunjukkan bahwa ada pengaruh terapi *cognitive behavioral therapy* terhadap *post traumatic stress disorder* akibat kekerasan seksual dan fisik dengan nilai *p value* <0,05.<br>2. *Post traumatic stress disorder* akibat kekerasan seksual pada anak sebelum dan setelah terapi CBT :<br>Kelompok Eksperimen — Pre Test — Post Test | *Researchgate* |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | *post traumatic stress disorder* akibat kekerasan seksual dan fisik | *behavioral therapy, post traumatic stress disorder* dan kekerasan anak<br>I : kuesioner<br>A : uji *dependent dan independent t-test* | (%) (%)<br>Ringan 36,7% 53,3%<br>Sedang 56,7% 46,7%<br>Berat 6,7% 0%<br>Kelompok Kontrol<br>Ringan 33,3% 40%<br>Sedang 60% 60%<br>Berat 6,7% 0%<br>3. *Cognitive behavioral therapy* efektif dalam mengurangi *post traumatic stress disorder* dan menata kembali keyakinan disfungsional yang menyertai berbagai gangguan psikologis | |
| 2 | Vahid *et al*<br><br>(2017) | Vol. 5 No. 8 | *Effect of Trauma-Focused Cognitive Behavioral Therapy on Reduction Social and Emotional Maladjustment of Physically Abused Children: A Clinical Trial* | Tujuan penelitian ini adalah untuk mengetahui pengaruh terapi *cognitive behavioral therapy* berfokus *post traumatic stress disorder* terhadap pengurangan | D : eksperimental uji klinis<br>S : *cluster sampling*<br>V : *cognitive behavioral therapy* dan *post traumatic stress disorder*<br>I : kuesioner<br>A : uji *Chi-square* | 1. Hasil penelitian menunjukkan bahwa ada pengaruh terapi *cognitive behavioral therapy* berfokus *post traumatic stress disorder* terhadap pengurangan maladjustment sosial dan emosional pada anak yang mengalami pelecehan dengan nilai *p value* 0,001.<br>2. *Post traumatic stress disorder* (sosial dan emosional) akibat pelecehan pada anak sebelum dan setelah terapi CBT :<br>Kelompok Eksperimen Pre Test (SD) Post Test (SD)<br>Sosial 2.13 2.21 | *Researchgate* |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | *maladjustment* sosial dan emosional akibat kekerasan seksual dan fisik. | | Emosional 1.66 1.76<br>Kelompok Kontrol<br>Sosial 1.81 1.45<br>Emosional 1.44 1.50<br>3. *Cognitive behavioral therapy* dapat meningkatkan keterampilan adaptif anak yang mengalami kekerasan, secara efektif menangani pengalaman trauma dan anak-anak ini didorong untuk mengidentifikasi cara-cara adaptif yang lebih efektif | |
| 3 | Safora *et al*<br><br>(2020) | Vol. 7 | *Trauma-Focused Cognitive Behavioral Therapy A Clinical Trial To Increase Self-Efficacy In Abused The Primary School Children* | Tujuan penelitian ini adalah untuk mengetahui pengaruh terapi *cognitive behavioral therapy* berfokus *post traumatic stress disorder* terhadap *self efficacy* akibat kekerasan seksual dan | D : eksperimental uji klinis<br>S : *cluster sampling*<br>V : terapi perilaku kognitif yang berfokus pada trauma dan kekerasan anak<br>I : kuesioner<br>A : uji *Chi-square* | 1. Hasil penelitian menunjukkan bahwa ada pengaruh terapi perilaku kognitif yang berfokus pada trauma (TF-CBT) terhadap *post traumatic stress disorder* (emosional, *self-efficacy*) anak-anak yang dilecehkan dengan nilai *p value* 0,002.<br>2. *Post traumatic stress disorder* (sosial, emosional dan akademik) akibat kekerasan seksual pada anak sebelum dan setelah terapi CBT :<br>Kelompok Eksperimen — Pre Test (SD) — Post Test (SD)<br>Sosial 3.88 4.08<br>Emosional 4.26 4.69<br>Akademik 3.46 3.48 | Pubmed |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | fisik. | | Kelompok Kontrol<br>Sosial 3.20 2.05<br>Emosional 3.12 2.69<br>Akademik 3.27 2.86<br>3. Terapi CBT yang berfokus pada *post traumatic stress disorder* penekanannya berpartisipasi dalam aktivitas sosial, membangun hubungan interpersonal, dan mengungkapkan pikiran yang jelas dan transparan yang dapat mengarah pada peningkatan efikasi diri sosial anak-anak yang mengalami pelecehan secara fisik | |
| 4 | Naami *et al* (2020) | Vol. 9 No. 81 | *Comparison Of Trauma-Focused Cognitive-Behavioral Therapy and Theory Of Mind On Increasing Social Competence Among Abused Children* | Tujuan penelitian ini adalah untuk mengetahui pengaruh terapi *cognitive behavioral therapy* terhadap anak yang dilecehkan. | D : *quasy experimental pre-post test with control*<br>S : *total sampling*<br>V : *cognitive behavioral therapy* dan *increasing social competence*<br>I : kuesioner<br>A : uji *Chi-Square* | 1. Hasil penelitian menunjukkan bahwa ada pengaruh terapi *cognitive behavioral therapy* terhadap *post traumatic stress disorder* (sosial, kompetensi) dengan nilai *p value* < 0,05.<br>2. *Post traumatic stress disorder* akibat kekerasan seksual pada anak sebelum dan setelah terapi CBT :<br>Kelompok Eksperimen \| Pre Test (SD) \| Post Test (SD)<br>Social 11.49 15.737<br>Cognitive 1.506 1.779<br>Motivational 4.03 5.267<br>Emotional 2.631 3.500 | Pubmed |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | Kelompok Kontrol<br>Social 11.40 11.13<br>Cognitive 6.38 3.302<br>Motivational 16.30 14.53<br>Emotional 3.302 2.221<br><br>3. *Cognitive behavioral therapy* dapat digunakan secara efektif untuk meningkatkan kompetensi sosial anak perempuan yang mengalami pelecehan | |
| 5 | Nurilla *et al*<br><br>(2020) | Vol. 32 No. 2 | *The effectiveness of Cognitive Behavior Therapy on Self-efficacy to Prevent Sexual Abuse among Children in Primary School of Surabaya City* | Tujuan penelitian ini adalah untuk mengetahui pengaruh terapi *cognitive behavioral therapy* terhadap *Self-efficacy* kekerasan seksual | D : *quasy experimental pre-post test with control*<br>S : *random sampling*<br>V : *cognitive behavioral therapy* dan *self eficacy*<br>I : kuesioner<br>A : uji *Chi-square* | 1. Hasil penelitian menunjukkan bahwa ada pengaruh terapi *cognitive behavioral therapy* terhadap *Self-efficacy* kekerasan seksual dengan nilai *p value* 0,000.<br>2. *Self-efficacy* kekerasan seksual seksual pada anak sebelum dan setelah terapi CBT :<br>Kelompok Eksperimen — Pre Test (SD) — Post Test (SD)<br>Informasi kekerasan seksual, dekat dan sharing dengan orang tua, nonton video porno dan sentuhan seksual 35.11 44.23<br>Kelompok Kontrol<br>Informasi kekerasan 36.06 36.49 | Pubmed |

| | | | |
|---|---|---|---|
| | | | seksual, dekat dan sharing dengan orang tua, nonton video porno dan sentuhan seksual |

Tabel 4.1 Karakteristik studi pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun menemukan sejumlah 5 artikel, selanjutnya peneliti mereview karakteristik studi kembali dengan tabel sebagai berikut:

| No Jurnal | Kriteria | F (artikel) | % |
|---|---|---|---|
| 1 | Jurnal :<br>a. Nasional<br>b. Internasional | <br>a. 1<br>b. 4 | <br>a. 20%<br>b. 80% |
| 2 | Desain :<br>a. Eksperimental uji klinis<br>b. *Quasy experimental pre-post test with control* | <br><br><br>a. 1<br>b. 4 | <br><br><br>a. 20%<br>b. 80% |
| 3 | Sampling<br>a. *Purposive*<br>b. *Cluster*<br>c. *Total*<br>d. *Random* | <br>a. 1<br>b. 2<br>c. 1<br>d. 1 | <br>a. 19%<br>b. 39%<br>c. 19%<br>d. 23% |
| 4 | Analisis<br>a. *Independent t-test*<br>b. *Chi-square* | a. 2<br>b. 3 | a. 40%<br>b. 60% |
| 5 | Database :<br>a. Researchgate<br>b. Pubmed | <br>a. 2<br>b. 3 | <br>a. 40%<br>b. 60% |

Hasil karakteristik studi dari 5 artikel ditemukan sejumlah 1 artikel nasional dan 4 artikel internasional, desain yang digunakan pada 1 artikel menggunakan *independent t-test* dan 4 artikel lainnya menggunakan desain *chi-square*. Teknik sampling yang di gunakan dalam 5 artikel tersebut yaitu 1 artikel dengan menggunakan *purposive sampling*, 2 artikel dengan dengan menggunakan teknik *cluster sampling*, 1 artikel dengan menggunakan teknik *total sampling* dan 1 artikel dengan menggunakan teknik *random sampling*. Analisis dalam 5 artikel tersebut menggunakan eksperimental uji klinis sebanyak 2 artikel dan 3 artikel menggunakan *quasy experimental pre-post test*

*with control*. Database pencarian jurnal pada penelitian ini bersumber dari *researchgate* 2 artikel dan pubmed sejumlah 3 artikel.

### 4.1.2 Karakteristik Responden Studi

Karakteristik responden studi dari 5 jurnal yang di review terdiri dari sebagai berikut :

Tabel 4.2 Distribusi frequensi dan persentase karakteristik responden

| No Artikel | Karakteristik | F (jurnal) | % |
|---|---|---|---|
| | Jenis Kelamin : | | |
| 1 | a. Mencantumkan | a. 3 | a. 60% |
| | b. Tidak mencantumkan | b. 2 | b. 40% |
| | Usia : | | |
| 2 | a. Mencantumkan | a. 3 | a. 60% |
| | b. Tidak mencantumkan | b. 2 | b. 40% |
| | Riwayat mengalami kekerasan seksual : | | |
| 3 | a. Mencantumkan | a. 4 | a. 80% |
| | b. Tidak mencantumkan | b. 1 | b. 20% |

Sumber : Data Sekunder

Tabel 4.2 Data umum karakteristik responden studi diketahui bahwa 3 artikel menjelaskan usia dan jenis kelamin. Pada riwayat anak mengalami kekerasan seksual diketahui bahwa 4 artikel mencantumkan dan 1 artikel tidak mencantumkan.

## 4.2 Data Khusus

Data khusus *literature review* didalam mengidentifikasi *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun terdapat 2 kategori yaitu sebagai berikut :

Tabel 4.3 Distribusi frekuensi tingkat dan jenis *posttraumatic stress disorder*

| No | Kategori | F (jurnal) | % |
|---|---|---|---|
| 1 | Tingkat PTSD (ringan, sedang, berat) | 1 | 20% |
| 2 | Jenis PTSD (kognitif, emosional, sosial, akademik, motivasi) | 4 | 80% |

Sumber : Data Sekunder

Tabel 4.3 Distribusi frekuensi data khusus 5 artikel diketahui bahwa 1 artikel (20%) mengidentifikasi *posttraumatic stress disorder* dengan tingkat PTSD dan 4 artikel (80%) dengan jenis PTSD.

### 4.2.1 Identifikasi *Posttraumatic Stress Disorder* Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun Sebelum Dilakukan *Cognitive Behavioral Therapy*

Hasil dari identifikasi 5 artikel *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun sebelum *cognitive behavioral therapy* pada kelompok eksperimen dan kelompok kontrol dapat dilihat pada tabel berikut :

Tabel 4.4 Distribusi frekuensi tingkat *posttraumatic stress disorder*

| No | Kelompok | Tingkat PTSD |
|---|---|---|
| 1 | Eksperimen | Ringan 36,7%<br>Sedang 56,7%<br>Berat 6,7% |
| 2 | Kontrol | Ringan 33,3%<br>Sedang 60% |

| | |
|---|---|
| | Berat 6,7% |

Sumber : Data Sekunder

Tabel 4.4 Tingkat PTSD pada kelompok eksperimen sebagian besar mengalami tingkat sedang sebesar (56,7%) dan kelompok kontrol sebagian besar mengalami tingkat sedang sebesar (60%).

Tabel 4.5 Distribusi frekuensi jenis *posttraumatic stress disorder*

| No Artikel | Keterangan Jenis Aspek | Kelompok Eksperimen (SD) | Kelompok Kontrol (SD) |
|---|---|---|---|
| 1 | Sosial | 2.13 | 1.81 |
| | Emosional | 1.66 | 1.44 |
| 2 | Sosial | 3.88 | 3.20 |
| | Emosional | 4.26 | 3.12 |
| | Akademik | 3.46 | 3.27 |
| 3 | Sosial | 11.49 | 11.40 |
| | Kognitif | 1.506 | 6.38 |
| | Motivasi | 4.03 | 16.30 |
| | Emosional | 2.631 | 3.302 |
| 4 | Kognitif | 35.11 | 36.06 |

Sumber : Data Sekunder

Tabel 4.5 Jenis *posttraumatic stress disorder* pada artikel ke-1 kelompok eksperimen dan kelompok kontrol didapatkan standart deviasi tertinggi pada aspek sosial. Artikel ke-2 kelompok eksperimen standart deviasi tertinggi pada aspek emosional dan kelompok kontrol pada aspek akademik. Artikel ke-3 kelompok eksperimen standart deviasi tertinggi pada aspek sosial dan kelompok kontrol pada aspek motivasi dan artikel ke-4 kelompok eksperimen dan kelompok kontrol didapatkan terjadi pada aspek kognitif. Dapat disimpulkan bahwa pada kelompok eksperimen terdapat 3 artikel yang memiliki standart deviasi tertinggi

pada aspek sosial dan 1 artikel pada aspek kognitif, pada kelompok kontrol didapatkan 1 artikel yang memiliki standart deviasi tertinggi pada aspek sosial, 1 artikel pada aspek akademik, 1 artikel pada aspek motivasi dan 1 artikel pada aspek kognitif.

### 4.2.2 Identifikasi *Posttraumatic Stress Disorder* Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun Setelah Dilakukan *Cognitive Behavioral Therapy*

Hasil dari identifikasi 5 artikel *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun setelah *cognitive behavioral therapy* pada kelompok eksperimen dan kelompok kontrol dapat dilihat pada tabel berikut:

Tabel 4.6 Distribusi frekuensi tingkat *posttraumatic stress disorder*

| No | Kelompok | Tingkat PTSD (Pre test) | Tingkat PTSD (Post test) |
|---|---|---|---|
| 1 | Eksperimen | Ringan 36,7%<br>Sedang 56,7%<br>Berat 6,7% | Ringan 53,3%<br>Sedang 46,7%<br>Berat 0% |
| 2 | Kontrol | Ringan 33,3%<br>Sedang 60%<br>Berat 6,7% | Ringan 40%<br>Sedang 60%<br>Berat 0% |

Sumber : Data Sekunder

Tabel 4.6 Tingkat PTSD pada kelompok eksperimen sebagian besar mengalami tingkat ringan sebesar (53,3%) dan kelompok kontrol sebagian besar mengalami tingkat sedang sebesar (60%).

Tabel 4.7 Distribusi frekuensi jenis *posttraumatic stress disorder*

| No | Kelompok Eksperimen | | | Kelompok Kontrol | | |
|---|---|---|---|---|---|---|
| | Keterangan | Pre test | Post test | Keterangan | Pre test | Post test |
| 1 | Sosial | 2.13 | 2.21 | Sosial | 1.81 | 1.45 |
| | Emosional | 1.66 | 1.76 | Emosional | 1.5 | 1.44 |
| 2 | Sosial | 3.88 | 4.08 | Sosial | 3.2 | 2.05 |
| | Emosional | 4.26 | 4.69 | Emosional | 3.12 | 2.69 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Akademik | 3.46 | 3.48 | Akademik | 3.27 | 2.86 |
| 3 | Sosial | 11.49 | 15.737 | Sosial | 11.4 | 11.13 |
| | Kognitif | 1.506 | 1.779 | Kognitif | 6.38 | 3.302 |
| | Motivasi | 4.03 | 5.267 | Motivasi | 16.3 | 14.53 |
| | Emosional | 2.631 | 3.5 | Emosional | 3.302 | 2.221 |
| 4 | Kognitif | 35.11 | 44.23 | Kognitif | 36.49 | 36.06 |

Sumber : Data Sekunder

Tabel 4.7 Jenis *posttraumatic stress disorder* pada kelompok eksperimen terdapat 2 artikel yang memiliki standart deviasi tertinggi pada aspek sosial dan 1 artikel pada aspek emosional dan 1 artikel pada aspek kognitif. Pada kelompok kontrol didapatkan 2 artikel yang memiliki standart deviasi tertinggi pada aspek sosial, 1 artikel pada aspek akademik dan 1 artikel pada aspek kognitif. Dapat disimpulkan bahwa pada 4 artikel kelompok eksperimen terjadi peningkatan pada aspek sosial, kognitif, emosi, akademik dan emosional, sedangkan pada 4 artikel kelompok kontrol terjadi penurunan pada aspek sosial, kognitif, emosi, akademik dan emosional.

### 4.2.3 Analisis Pengaruh *Cognitive Behavioral Therapy* Terhadap *Posttraumatic Stress Disorder* Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun

Analisis pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun didapatkan hasil sebagai berikut :

Tabel 4.8 Distribusi frequensi pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun

| No | P value | F | % | Keterangan |
|---|---|---|---|---|
| 1 | < 0,05 | 5 | 100% | Ada pengaruh cognitive behavioral therapy terhadap posttraumatic stress disorder akibat kekerasan pada anak usia 7-12 tahun |
| 2 | > 0,05 | 0 | 0% | Tidak ada pengaruh cognitive behavioral therapy terhadap posttraumatic stress disorder akibat kekerasan pada anak usia 7-12 tahun |

Sumber : Data Sekunder

Tabel 4.8 diketahui bahwa dari keseluruhan jurnal didapatkan hasil *p value* <0,05 artinya ada pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan pada anak usia 7-12 tahun.

# BAB 5

# PEMBAHASAN

## 5.1 Identifikasi *Posttraumatic Stress Disorder* Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun Sebelum *Cognitive Behavioral Therapy*

Hasil identifikasi dari 5 artikel menunjukkan bahwa kategori *posttraumatic stress disorder* dibagi menjadi tingkat *posttraumatic stress disorder* dan jenis *posttraumatic stress disorder*. Tingkat *posttraumatic stress disorder* terdiri dari tingkat ringan, sedang, berat. Kategori jenis *posttraumatic stress disorder* terdiri dari aspek kognitif, emosional, sosial, akademik, motivasi.

Hasil identfikasi berdasarkan tingkat PTSD dari kelompok eksperimen sebagian besar mengalami *posttraumatic stress disorder* tingkat sedang sebesar (56,7%) dan kelompok kontrol sebagian besar mengalami *posttraumatic stress disorder* tingkat sedang sebesar (60%). Hasil identfikasi berdasarkan kategori jenis PTSD dari kelompok eksperimen terdapat 3 artikel yang memiliki standart deviasi tertinggi pada aspek sosial dan 1 artikel pada aspek kognitif, dan kelompok kontrol didapatkan 1 artikel yang memiliki standart deviasi tertinggi pada aspek sosial, 1 artikel pada aspek akademik, 1 artikel pada aspek motivasi dan 1 artikel pada aspek kognitif. Hasil nilai dampak aspek sosial tersebut selaras dengan teori WHO (2017) yaitu anak akan mengalami hambatan interaksi sosial seperti pengucilan dan merasa tidak pantas.

Pada hasil penelitian dari masing-masing jurnal faktor penyebab terjadinya *posttraumatic stress disorder* akibat kekerasan pada anak usia 7-12 tahun mempunyai efek yang berbeda, perbedaan ini dapat dilihat dari penelitian yang

dilakukan oleh Riyadh *et al* (2015) yang menjelaskan bahwa disebabkan oleh faktor usia dan tingkat pendidikan. Penelitian yang dilakukan oleh Safora *et al* (2020) menjelaskan bahwa dampak kekerasan seksual akan merusak masalah perkembangan, kognitif, emosional dan perilaku, hal itu terjadi tidak hanya terbatas pada masa kanak-kanak, tetapi kesulitan berlaku hingga tahun-tahun mendatang.

Penelitian tersebut selaras dengan penelitian yang dilakukan oleh Vahid *et al* (2017) bahwa *posttraumatic stress disorder* akibat kekerasan pada anak usia 7-12 tahun disebabkan oleh faktor usia. Perbedaan dengan penelitian sebelumnya adalah dalam penelitian ini juga disebabkan oleh faktor sosial dan tingkat keparahan trauma. Penelitian yang dilakukan oleh Naami *et al* (2020) diketahui bahwa disebabkan oleh faktor usia dan jenis kelamin.

Penelitian ini selaras dengan studi yang dilakukan oleh Nurilla *et al* (2020) yang menjelaskan bahwa seorang anak yang dianiaya tidak dapat bereaksi atau menentang otoritas yang dilakukan oleh pelaku kekerasan seksual, meskipun anak tidak setuju namun ia merasa tidak dapat mencegah kejadian ini, selain itu dalam menghadapi kekerasan seksual anak-anak sering menyimpan fakta bahwa mereka telah dilecehkan.

Hasil pemaparan dari 5 artikel diketahui bahwa faktor *posttraumatic stress disorder* akibat kekerasan pada anak yaitu usia, jenis kelamin, sosial, tingkat keparahan trauma dan kognitif. Pernyataan tersebut selaras dengan teori Figley *et al* (2012) yang menjelaskan bahwa faktor jenis kelamin pada anak perempuan lebih sering mengalami kekerasan seksual sehingga anak perempuan lebih tinggi

mengalami *post traumatic stress disorder* dibanding anak laki-laki. Teori dari Ramos *et al* (2013) juga memperkuat faktor sosial *posttraumatic stress disorder*, yang menjelaskan bahwa dukungan sosial mempengaruhi anak untuk keluar dari pengalaman traumanya, namun pada umumnya anak tidak mengatakan kejadian yang sebenarnya sehingga menyebabkan anak selalu menarik diri, berpotensi untuk menurunkan prestasi akademik anak dan PTSD timbul semakin berat. Menurut teori Markowitz *et al* (2015) faktor tingkat keparahan trauma *post traumatic stress disorder* seperti kekerasan seksual yang dialami oleh anak dapat mempengaruhi level gangguan psikologis anak sehingga hal itu juga dapat berpengaruh pada hubungan terapeutik yang terjalin antara anak dengan orang lain. Menurut Desmita (2015) faktor kognitif pada anak usia 7-12 disebut dengan pemikirian operasional konkret dimana pemikiran yang logis di aplikasikan menjadi contoh-contoh yang spesifik, namun kekurangan pada fase ini adalah ketika anak dihadapkan dengan suatu permasalahan, maka ia akan mengalami kesulitan bahkan tidak mampu menyelesaikan masalahnya.

Menurut penulis, anak usia 7-12 tahun sangat membutuhkan pengawasan dari orang-orang terdekat terutama dari orang tua, karena anak akan merasa aman apabila ia berada dalam lingkungan dan pengawasan yang tepat. Usia anak sangat rentan sekali menjadi objek kekerasan seksual karena sifatnya yang masih berada dalam fase kanak-kanak tengah, maka akan sangat mudah untuk di pengaruhi oleh orang lain yang berniat untuk menyakitinya. Pada saat anak mengalami kekerasan seksual di masa hidupnya, maka ia akan terus mengingat kejadian trauma tersebut dan merasa takut untuk berinteraksi lagi dengan lingkungan sosial. Rasa trauma

atau *posttraumatic stress disorder* yang dialami anak dapat berupa gejala seperti mudah marah, selalu mimpi buruk, persaan menyerah dan tidak berdaya. *Posttraumatic stress disorder* yang terjadi pada anak usia 7-12 tahun akan berdampak lebih besar atau lebih berat dari pada usia dewasa atau lansia karena pada umumnya anak cenderung akan menghindari keterbukaan pada orang terdekat atau orang tuanya karena adanya perasaan takut dan kurangnya kemampuan mereka menunjukkan emosi yang di rasakan, sehingga anak akan lebih memilih memendam perasaannya sendiri atau memilih diam. Dari fenomena tersebut, seorang anak harus selalu berada dalam pengawasan orang tua dalam hal apapun, karena kekerasan seksual bisa saja terjadi bukan dari orang-orang yang tidak di kenal namun juga dapat dilakukan oleh orang-orang terdekat.

## 5.2 Identifikasi *Posttraumatic Stress Disorder* Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun Setelah *Cognitive Behavioral Therapy*

Hasil identifikasi dari 5 artikel berdasarkan tingkat PTSD dari kelompok eksperimen sebagian besar mengalami *posttraumatic stress disorder* tingkat ringan sebesar (53,3%), kelompok kontrol tetap sebagian besar mengalami tingkat sedang sebesar (60%). Hasil identfikasi berdasarkan kategori jenis PTSD dari kelompok eksperimen didapatkan 4 artikel kelompok eksperimen terjadi peningkatan pada aspek sosial, kognitif, emosi, akademik dan emosional, sedangkan pada 4 artikel kelompok kontrol terjadi penurunan pada aspek sosial, kognitif, emosi, akademik dan emosional. *Cognitive behavioral therapy* dilakukan secara bertahap atau beberapa sesi, hal ni dapat dilihat dari penelitian yang dilakukan oleh Riyadh *et al* (2015) yaitu *cognitive behavioral therapy* dilakukan 3

sesi dalam seminggu, dengan total 12 sesi, selanjutnya anak dinilai dalam tiga tahap yang berbeda yaitu sebelum terapi, setelah terapi dan 15 hari setelah terapi *cognitive behavioral therapy*.

Pada penelitian yang dilakukan oleh Vahid *et al* (2017) pemberian *cognitive behavioral therapy* dilakukan 10 sesi dengan durasi waktu satu jam, terapi tersebut diberikan dua kali dalam seminggu. Penelitian tersebut juga di dukung oleh Safora *et al* (2020) dimana *cognitive behavioral therapy* dilakukan 10 sesi terapi dalam dua kali seminggu, selain itu terapi tersebut juga dilakukan oleh psikolog anak yang bergelar doctor.

Penelitian diatas selaras dengan studi yang dilakukan oleh Naami *et al* (2020) *cognitive behavioral therapy* dilakukan secara berkelompok dan juga di lakukan secara individual seminggu dua kali, selain itu terapi tersebut juga dilakukan oleh perawat dan psikolog anak. Pada penelitian Nurilla *et al* (2020) *cognitive behavioral therapy* dilakukan menggunakan media animasi 2D yang diberikan kepada anak dalam upaya pencegahan pelecehan seksual, sehingga hal itu dapat mempengaruhi pengetahuan anak, efikasi diri, dan mempengaruhi perilaku protektif pada anak, selain itu *cognitive behavioral therapy* juga dilengkapi dengan pengetahuan dan keterampilan terhadap sentuhan yang tidak diinginkan atau langkah-langkah apa yang harus dilakukan anak ketika terjadi kekerasan seksual.

Hasil pemaparan dari 5 artikel diketahui bahwa kelompok eksperimen terjadi peningkatan pada aspek sosial, kognitif, emosi, akademik dan emosional, fakta tersebut didukung oleh teori menurut Gerald (2010) yang menyatakan

kognitif harus di tingkatkan agar anak mencoba menghindari dari hal yang dialami dan akan menekan ingatan tentang trauma yang dialami di alam bawah sadar, meningkatkan emosional dapat dilakukan dengan cara mengajak anak belajar mengidentifikasi emosi yang mereka rasakan, mengajarkan anak berempati terhadap emosinya, dan membantu anak mengekspresikan emosi dengan cara yang baik, kemampuan sosial anak pada kasus ini perlu ditingkatkan, contoh untuk stimulasi sosial dapat dilakukan selalu mengkomunikasikan kepada anak apa yang di rasakan orang tua dengan bicara yang baik, hal ini akan menjadi contoh bagi anak bahwa pengalaman traumatis dapat dikomunikasikan dengan bicara yang baik bukan menangis atau menarik diri, hindari memberi target akademik yang terlalu tinggi pada anak, namun berikan dorongan atau motivasi terhadap anak untuk meningkatkan rasa percaya dirinya yang berkaitan dengan masa depannya dan motivasi pada diri anak yang mengalami PTSD harus di tingkatkan, agar dapat mengontrol dan mengekspresikan emosinya dengan cara yang baik. Penerapan sesi *cognitive behavior therapy* yang fleksibel sebanyak 12 sesi, namun penerapannya di Indonesia masih memiliki hambatan, sehingga disesuaikan dengan menerapkan 5 sesi agar lebih efisien, yaitu terdiri dari assesmen dan diagnosa awal, mengidentifikasi pikiran negatif, menyusun rencana intervensi dengan memberikan konsekuensi positif dan konsekuensi negatif kepada pasien, fokus terapi atau intervensi tingkah laku lanjutan dan pencegahan *relapse* (kekambuhan). Menurut teori dari Imas *et al* (2017) tahapan sesi *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* juga terdapat 5 sesi

yaitu assesmen, perilaku aktivasi, mengidentifikasi pikiran, merencanakan intervensi atau altruisme dan harapan atau pencegahan.

Menurut penulis, pada saat anak usia 7-12 tahun mengalami *posttraumatic stress disorder* gejala yang dirasakan awalnya merupakan masalah psikologis namun pada akhirnya juga akan berdampak pada masalah kesehatan dan masa depannya seperti gejala menggigil, jantung berdebar kencang, gangguan tidur, sulit untuk berkonsentrasi dan tidak mempunyai harapan untuk hidup normal seperti sebelumnya. Terapi yang dapat diberikan oleh perawat atau konselor yaitu terapi non farmakologi agar tidak menimbulkan efek samping yang berbahaya apabila di minum dalam jangka panjang. Terapi non farmakologi yang dapat dilakukan untuk mengatasi *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun yaitu dengan *cognitive behavioral therapy* yang berfokus untuk mengubah perilaku seperti semula, menenangkan pikiran dan tubuh sehingga merasa lebih baik dan berfikir secara positif, berpikir lebih jelas dan membantu anak membuat keputusan yang tepat.

### 5.3 Analisis Pengaruh *Cognitive Behavioral Therapy* Terhadap *Posttraumatic Stress Disorder* Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun

Hasil dari analisis 5 jurnal diketahui bahwa keseluruhan jurnal sebelum dan setelah *cognitive behavioral therapy* didapatkan nilai *p value* < α 0,05. Nilai tersebut berarti Ho di tolak dan Ha diterima, artinya ada pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan pada anak usia 7-12 tahun.

Teori yang mendukung pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan pada anak usia 7-12 tahun menjelaskan bahwa, *cognitive behavioral therapy* mendasarkan pada model kognitif dimana emosi, perilaku, dan fisiologi seseorang dipengaruhi oleh persepsi atau pikiran terhadap sebuah peristiwa sehingga terapi ini kuat dengan komponen psikoedukasi yang menekankan pada proses mengidentifikasi dan mengubah pemikiran otomatis negatif (*negative automatic thought* atau NAT) yang tidak realistis dan perilaku maladaptif (Beck, 2011). Konsep *cognitive behavioral therapy* digunakan untuk perubahan kognisi, emosi, tingkah laku, meningkatkan harga diri, konsep diri (gambaran diri), kepercayaan diri, resiliensi diri (perkembangan kesehatan mental) dan mengajarkan anak untuk mengidentifikasi pikiran yang membuat mereka merasa takut atau kesal dan menggantinya dengan pikiran yang positif (*American Psychiatric Association*, 2017).

Menurut penulis, anak usia 7-12 tahun dapat diberikan *cognitive behavioral therapy* untuk mengatasi *posttraumatic stress disorder* akibat kekerasan seksual, karena dengan adanya penelitian langsung tentang *cognitive behavioral therapy* ini tentu saja dapat dikatakan bahwa *cognitive behavioral therapy* efektif untuk menurunkan tingkat *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun. Pada saat anak usia 7-12 tahun mengalami *posttraumatic stress disorder* akibat kekerasan seksual, umumnya tidak ingin mengingat kejadian yang telah membuatnya trauma meskipun ingatan kejadian traumatik tersebut selalu datang dengan sendirinya, maka dari itu *cognitive behavioral therapy* sesuai dengan adanya masalah *posttraumatic stress disorder,* karena

terapi ini tidak memfokuskan pada kejadian traumatik yang menyebabkan anak menjadi *distress* atau mengingat kejadian di masa lampau, melainkan terapi ini berfokus untuk meningatkan persepsi percaya diri dan tingkah laku anak usia 7-12 tahun. Manfaat lain dari *cognitive behavioral therapy* yaitu pada saat konseling terapi, anak usia 7-12 tahun yang mengalami *posttraumatic stress disorder* akibat kekerasan seksual ditempatkan sebagai tim agar setiap keputusan yang diambil pada saat konseling juga merupakan keputusan yang di sepakati dengan anak, selain itu cara tersebut juga melatih anak untuk menjadi terapis bagi dirinya sendiri apabila suatu waktu ia merasakan keluhannya kembali. Dari fenomena tersebut, maka orang tua dapat memahami perubahan tingkah laku pada anaknya dan apabila ditemukan masalah psikologis orang tua dapat segera mencari infomasi kepada perawat atau konselor untuk mengatasinya serta perawat atau konselor dapat menerapkan *cognitive behavioral therapy* untuk menurunkan tingkat *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun.

# BAB 6

# KESIMPULAN DAN SARAN

## 6.1 Kesimpulan

### 6.1.1 *Posttraumatic Stress Disorder* Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun Sebelum *Cognitive Behavioral Therapy*

Hasil identifikasi dari artikel berdasarkan tingkat PTSD diketahui bahwa satu artikel kelompok eksperimen dan kelompok kontrol sebagian besar mengalami *posttraumatic stress disorder* tingkat sedang, sedangkan berdasarkan jenis PTSD diketahui bahwa pada kelompok eksperimen terdapat tiga artikel yang memiliki standart deviasi tertinggi pada aspek sosial dan satu artikel pada aspek kognitif, pada kelompok kontrol didapatkan satu artikel yang memiliki standart deviasi tertinggi pada aspek sosial, satu artikel pada aspek akademik, satu artikel pada aspek motivasi dan satu artikel pada aspek kognitif.

### 6.1.2 *Posttraumatic Stress Disorder* Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun Setelah *Cognitive Behavioral Therapy*

Hasil identifikasi dari artikel berdasarkan tingkat PTSD diketahui bahwa satu artikel kelompok eksperimen sebagian besar mengalami *posttraumatic stress disorder* tingkat ringan dan kelompok kontrol sebagian besar mengalami *posttraumatic stress disorder* tingkat sedang, sedangkan berdasarkan tingkat PTSD diketahui bahwa bahwa pada empat artikel kelompok eksperimen terjadi peningkatan pada aspek sosial, kognitif, emosi, akademik dan emosional, sedangkan pada empat artikel kelompok kontrol terjadi penurunan pada aspek sosial, kognitif, emosi, akademik dan emosional.

### 6.1.3 Pengaruh *Cognitive Behavioral Therapy* Terhadap *Posttraumatic Stress Disorder* Akibat Kekerasan Seksual Pada Anak Usia 7-12 Tahun

Hasil analisis dari lima artikel berdasarkan *literature review* yaitu ada pengaruh *cognitive behavioral therapy* terhadap *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun. Hasil analisis dari lima artikel *cognitive behavioral therapy* memberikan dampak terhadap penurunan *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun.

## 6.2 Saran

### 6.2.1 Bagi Masyarakat

Masyarakat khususnya para orang tua yang memiliki anak dengan *posttraumatic stress disorder* akibat kekerasan seksual apabila timbul kambuh dapat melakukan sebuah komunikasi seperti konseling yang penuh rasa empati, memberikan support dan tekankan tentang konsep *self help*.

### 6.2.2 Bagi Instansi Keperawatan

Penelitian ini perlu dijadikan sebagai sumber bacaan bagi tenaga kesehatan khususnya perawat untuk menerapkan *cognitive behavioral therapy* sebagai upaya menurunkan *posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun. Perawat yang belum memiliki pelatihan *cognitive behavioral therapy* tidak disarankan dalam melakukan terapi tersebut.

### 6.2.3 Bagi Peneliti Selanjutnya

Bagi peneliti selanjutnya perlu melakukan penelitian langsung *(original research)* terkait pengaruh *cognitive behavioral therapy* terhadap

*posttraumatic stress disorder* akibat kekerasan seksual pada anak usia 7-12 tahun.

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Lampiran 1

## PENYUSUNAN SKRIPSI

| Kegiatan | November | | | | | Desember | | | | Januari | | | | Februari | | | | Maret | | | | April | | | | Mei | | | | Juni | | | | Juli | | | | Agustus | | | |
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| Pengajuan Judul dan Pembimbing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Penyusunan Proposal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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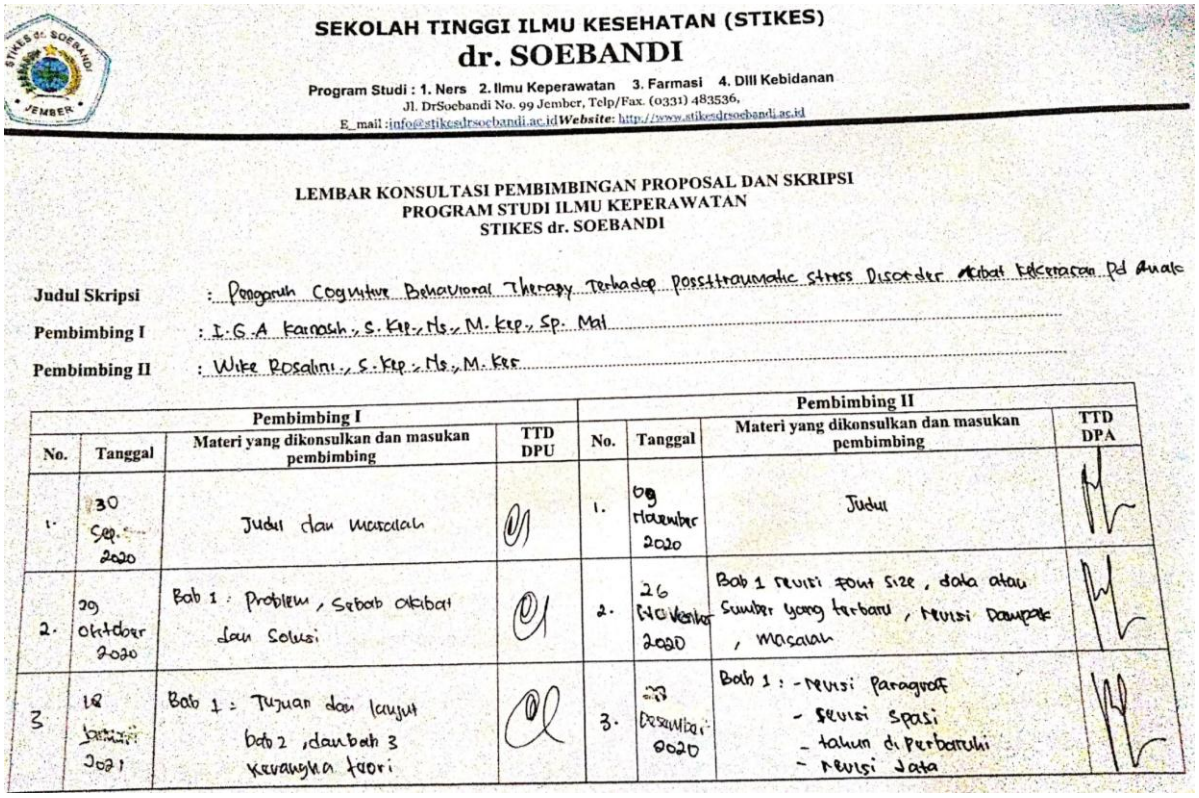
Lampiran 2

# LEMBAR KONSULTASI



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LEMBAR KONSULTASI PEMBIMBINGAN PROPOSAL DAN SKRIPSI
PROGRAM STUDI ILMU KEPERAWATAN
STIKES dr. SOEBANDI

**Judul Skripsi** : Pengaruh Cognitive Behavioral Therapy Terhadap Posttraumatic Stress Disorder Akibat Kekerasan Pd Anak
**Pembimbing I** : I.G.A Karnasih., S.Kep., Ns., M.Kep., Sp. Mat
**Pembimbing II** : Wike Rosalini., S.Kep., Ns., M.Kes

| Pembimbing I | | | | Pembimbing II | | | |
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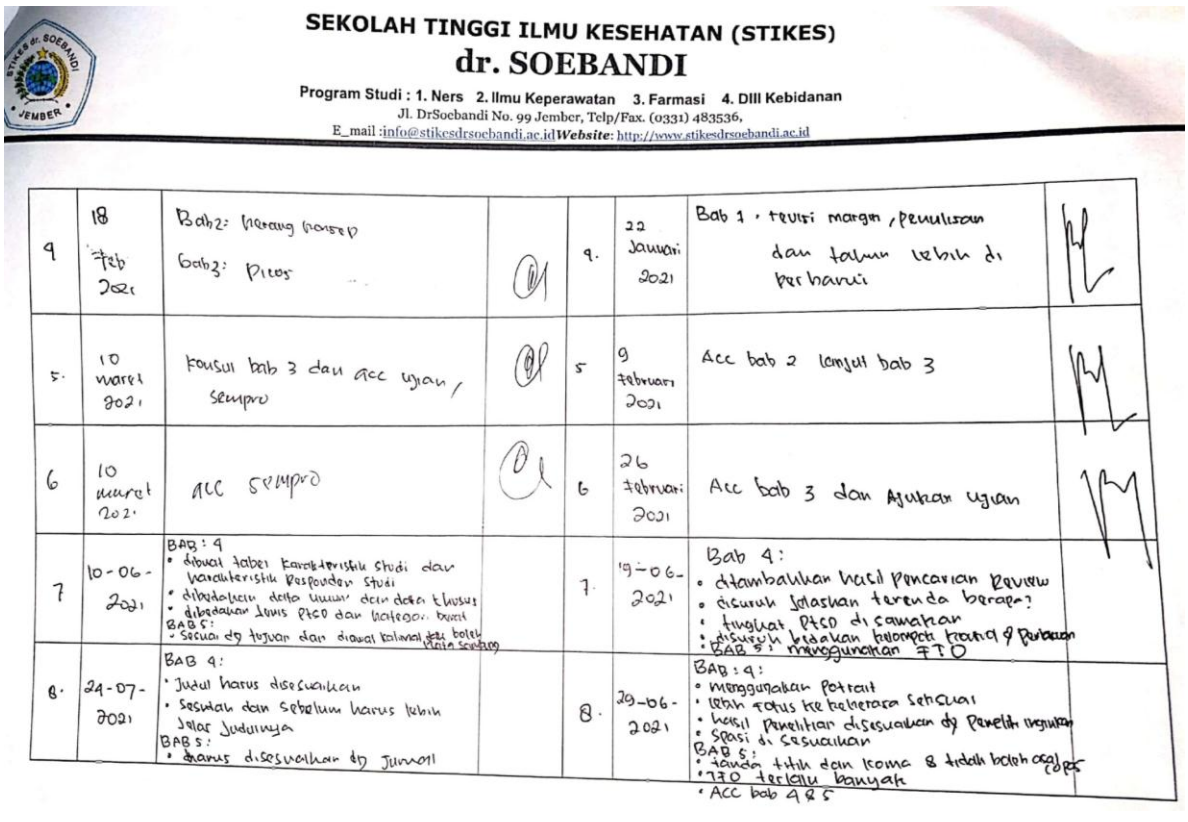
| No. | Tanggal | Materi yang dikonsulkan dan masukan pembimbing | TTD DPU | No. | Tanggal | Materi yang dikonsulkan dan masukan pembimbing | TTD DPA |
| 1. | 30 Sep. 2020 | Judul dan masalah | | 1. | 09 November 2020 | Judul | |
| 2. | 20 Oktober 2020 | Bab 1 : Problem, Sebab akibat dan Solusi | | 2. | 26 November 2020 | Bab 1 revisi font size, data atau sumber yang terbaru, revisi Dampak, masalah | |
| 3. | 18 Januari 2021 | Bab 1 : Tujuan dan lanjut bab 2, dan bab 3 kerangka teori | | 3. | 23 Desember 2020 | Bab 1 : - revisi paragraf<br>- revisi spasi<br>- tahun di perbaharui<br>- revisi data | |



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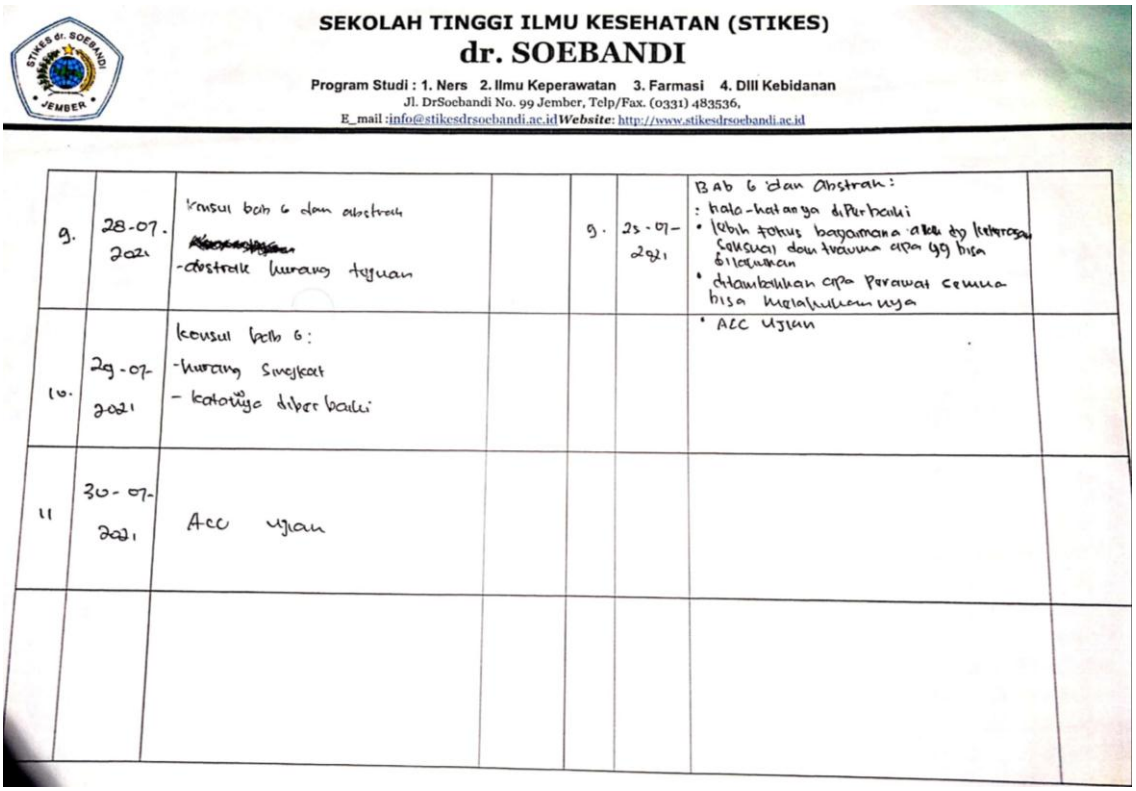
| 4 | 18 Feb 2021 | Bab 2: kerangka konsep<br>Bab 3: Pico | | 4. | 22 Januari 2021 | Bab 1 • revisi margin, penulisan dan tahun lebih di perbaharui | |
| 5. | 10 maret 2021 | konsul bab 3 dan acc ujian / sempro | | 5 | 9 februari 2021 | Acc bab 2 lanjut bab 3 | |
| 6 | 10 maret 2021 | ACC SEMPRO | | 6 | 26 februari 2021 | Acc bab 3 dan Ajukan ujian | |
| 7 | 10-06-2021 | BAB : 4<br>• dibuat tabel karakteristik studi dan karakteristik Responden studi<br>• dibedakan data umum dan data khusus<br>• dibedakan lewis PICO dan kategori kuasi<br>BAB 5:<br>• sesuai dg tujuan dan diawal kalimat jgn boleh Mulai Sendiri | | 7. | 19-06-2021 | Bab 4:<br>• ditambahkan hasil pencarian Review<br>• disusun susunan berapa?<br>• tinjauan PICO di samakan<br>• disusun kedalam kelompok kuasi & percobaan<br>BAB 5: menggunakan PICO | |
| 8. | 24-07-2021 | BAB 4:<br>• Judul harus disesuaikan<br>• sesudah dan sebelum harus lebih jelas judulnya<br>BAB 5:<br>• harus disesuaikan dg Jurnal | | 8. | 29-06-2021 | BAB : 4:<br>• menggunakan Potrait<br>• lebih fokus ke beberapa sehingga<br>• hasil penelitian disesuaikan dg Peneliti ingunkan<br>• Spasi di sesuaikan<br>BAB 5:<br>• tanda titik dan koma & tidak boleh ada<br>• PICO terlalu banyak<br>• ACC bab 4 & 5 | |



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| 9. | 28-07-2021 | konsul bab 6 dan abstrak<br>[redacted]<br>-abstrak kurang tepat | | 9. | 28-07-2021 | Bab 6 dan Abstrak:<br>: hala-hal nya diperbaiki<br>• lebih fokus bagaimana akal dg ketercapaian sensori dan trauma apa yg bisa ditangani<br>• ditambahkan apa perawat semua bisa melaksanakannya | |
| 10. | 29-07-2021 | konsul bab 6:<br>-kurang singkat<br>- katanya diperbaiki | | | | • ACC ujian | |
| 11 | 30-07-2021 | Acc ujian | | | | | |
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Lampiran 3

# JURNAL

Jurnal 1

MedCrave
Step into the World of Research
Journal of Psychology and Clinical Psychiatry

## Trauma Focused Cognitive Behavioral Group Therapy for Abused Children with Post Traumatic Stress: The Case of Institutionalized Children, Addis Ababa, Ethiopia

**Abstract**

**Introduction:** Sexual and physical abuse against children and adolescents are major public health and social problems around the world. Child physical and sexual abuses occur in all cultural, socio economic, educational, racial and ethnic groups. The high prevalence and the devastating negative consequences of sexual and physical abuse initiate research inquiry in the intervention and treatment aspects of the problem.

**Objective:** This study examined whether Trauma Focused Cognitive Behavioral Group Therapy (TF-CBGT) is effective in treating both sexually and physically abused children among Kechene and OPRIFS (Organization for Prevention, Rehabilitation and Integration of Female Street Children) Children's home.

**Methods:** It is a control group's pretest-posttest quasi-experimental design. Sixty female participants aged 8 to 18 were selected purposefully. So as to make equivalent in terms of their score of child post traumatic stress symptoms scale and types of abuse they experienced, participants were divided in to treatment and control group. The treatment group received TF-CBGT for 3 sessions a week for a total of 12 contacts. Child posttraumatic stress disorder symptoms scale (CPSS) used to measure post traumatic stress symptoms of participants. Test was conducted before the treatment, just after the treatment and 15 days after the treatment.

**Results:** TF-CBGT is potentially effective in reducing symptoms of posttraumatic stress disorder from pretest to posttest measures. However, it is recommended to conduct a large scale study with more sample size and diversity to expand the findings of this study.

**Keywords:** Posttraumatic stress; TF-CBGT; Sexual abuse; Physical abuse

Research Article

Volume 2 Issue 4 - 2015

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**Abbreviations:** TF-CBGT: Trauma Focused Cognitive Behavioral Group Therapy; OPRIFS: Organization for Prevention, Rehabilitation and Integration of Female Street Children; CPSS: Child Posttraumatic Stress Disorder Symptoms Scale; UN: United Nations; PTSD: Post Traumatic Stress Disorder; CPTSS: Child Post Traumatic Symptoms Scale

### Introduction

Sexual and physical abuse against children and adolescents are major public health and social problems around the world. According to world health organization estimates, 20% of females and 5 to10% of males in the general population reported child sexual abuse [1]. The overall prevalence of physical abuse is estimated to be 10 to 25% in the general population. Child physical and sexual abuses occur in all cultural, socio economic, educational, racial and ethnic groups. This kind of violence may cause a number of adverse effects in the victim's physical, cognitive, emotional and social development. The problems and symptoms that have been associated repeatedly with childhood sexual abuse and physical abuse history are often over lapping. Among these overlapping symptoms the most common are symptoms of posttraumatic stress disorder, low self-esteem and guilt, anxiety, depression and interpersonal dysfunction [2].

Child abuse or child maltreatment includes all forms of physical and emotional ill treatment that results in actual or potential harm to the child's health, development or dignity [3]. This broad definition includes sexual abuse, physical abuse, emotional abuse, neglect and negligent treatment and child exploitation. Among these sexual abuse and physical abuse are the most disastrous and well studied [4]. Sexual abuse is defined as sexual activity with a child or adolescent that he/she does not fully understand, to which he/she is incapable of consenting, or that violets social taboos [5]. Child physical abuse refers to deliberately causing physical damage or pain on a child. The physical injury may result from many different acts including hitting, kicking, slapping, burning choking, throwing, whipping and/or padding [2].

As mentioned above both sexual abuse and physical abuse are frequently associated with various types of psychological or mental disorders. However, PTSD is assumed as the best conceptualization of disturbance that occurs after child abuse in many researches. Studies have shown that almost half of sexual abuse survivors will develop PTSD symptoms [6]. It has been suggested that, this is due to the frequent presence of various traumatizing factors during or after sexual abuse like interpersonal violence, physical injury and fear of dying. Many studies also indicate that physical abuse frequently leads to post traumatic stress disorder since it involves both physical and

psychological trauma as a result of sudden and brutal attack on a child who cannot defend him/her self [7].

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

As far as intervention is concerned understanding the nature and extent of abuse and neglect and their consequences is important to the design of treatment programs. Many treatment programs and models have been developed to specifically deal with the psychological problems of children who have experienced sexual as well as physical abuse. Some of them include abuse focused cognitive behavioral therapy, play therapy, music therapy, art therapy, non directive supportive therapy, developmental touch therapy and trauma focused cognitive behavioral therapy. However, the effectiveness of these therapy modalities is yet to be investigated.

The high prevalence of sexual and physical abuse and the negative psychological consequences initiate researchers to investigate the effectiveness of psychotherapy in treating victims. One Meta analysis has summarized various research findings on psychotherapy of abused children [8]. This study has concluded that cognitive behavioral therapy was relatively more effective than other treatment modalities, and recommended more researches and replications with more rigorous research designs. In addition, it indicated that trauma focused cognitive behavioral therapy (TF-CBT) was more effective in reducing symptoms of post traumatic stress disorder (PTSD) and restructuring dysfunctional beliefs which accompany various psychological disorders.

The field of empirical research into the psychological treatment of children who have been sexually and/or physically abused is relatively new, only few studies can be mentioned before1980. In Ethiopia few research works have been carried out about child sexual and/or physical abuse in general not to mention the treatment aspect in particular. More recent research worldwide has tended to focus on cognitive behavioral therapy [9]. Important questions remain about the efficacy and effectiveness of different psychological treatments in Ethiopian context. The aim of this study is to assess the effectiveness of cognitive behavioral group therapy in the treatment of post traumatic stress symptom of sexually or physically abused children.

Studies conducted in Ethiopia indicate that there is high prevalence of child abuse. For instance, in one study 38.5% of the sample who are students reported that they have experienced sexual abuse at least once [10]. Physical punishment (corporal punishment) of children is culturally accepted which increase the incidence of physical abuse in our culture. The negative consequences of child physical and sexual abuse can get even worse (exacerbated) by wide spread poverty and HIV Aids. Ethiopia has ratified the convention on the rights of the child which entitles children protection from all forms of abuse until age 18. The criminal code of Ethiopia has a number of protective provisions against child abuse. In addition to the legal provision, various efforts have also been made to raise public awareness on the issue of child abuse.

However, little or no efforts have been made to address the psychological needs of the victims of child abuse. More importantly, it is not known to what extent the treatment approaches developed in western countries work to Ethiopian cultural context. Research in USA, Europe and other parts of the world indicate that cognitive behavioral therapy is one of the most empirically supported therapy technique among the many therapy techniques that are developed to deal with the needs of abused children [11]. However, adequate efforts have not been made to adopt or investigate the effectiveness of cognitive behavioral therapy in Ethiopian context.

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

i. Is there statistically significant difference in posttraumatic stress symptoms from pre-to-post treatment as well as from post treatment to follow up measures in the treatment group (abused children who were treated with trauma focused cognitive behavioral therapy)?

ii. Is there a statistically significant mean difference in posttraumatic stress symptoms from pre-to-post treatment measures between treatment group and control group?

iii. Is there statistically significant difference between the post traumatic stress symptoms score of the children who experienced physical abuse and those who experienced sexual abuse and younger children (9 to 12 years of age) and the teenagers (13 to 16 years of age)at pre test and post test one?

## Materials and Methods

### Study design

The study was a quasi experimental control group pre-post design with intra and inter-group comparisons (Table 1). The intervention was carried out within treatment groups whereas the outcome compared within the same groups as well as between the treatment and control/comparison groups. Participants were assessed in three different stages: before group therapy, just after the group therapy and 15 days after therapy.

**Table 1:** Quasi experimental design

| Study Groups | First Observation | Treatment | Second Observation |
|---|---|---|---|
| Treatment Group | O1 | √ | O2 |
| Control Group | O1 | X | O2 |

### Research site

The study was conducted in Kechene and OPRIFS children's home. These are nongovernmental charity organizations, where; Kechene children's home was established in 1945 while OPRIFS was established in 2008. Kechene children's home currently

accommodates 233 girls up to 18 years of age while OPRIFS accommodate 190 children enrolling for rehabilitation services. Most children in Kechene children's home stay up to 18 years of age some of them integrated with their family while OPRIFS usually provides temporary shelter for children until they integrate with their families.

### Population and sample

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

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

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

### Demographic characteristics of treatment and control groups

The majority of participants age range was 13-16 (63.3%) for treatment group's whereas 53.3% were control groups. Likewise, 73% of treatment groups and 83% of control groups were elementary school students. There were equal number of physically and sexually abused children in both treatment and control groups. Out of the total participants, 86.3% of treatment groups and 92.6% of control group stayed less than a month in the institutions. All participants in both groups and institution have never been received psychotherapeutic service prior to the study.

### Allocation of participants to treatment and control group

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

### Instrument

Two sets of questionnaires (demographic data sheet and Standardized test) were used to gather the required information from the participants before and after the intervention. Demographic data sheet was used to gather demographic information whereas standardized test i.e. child posttraumatic stress symptoms scale was used to measure post traumatic stress symptoms.

### The child post traumatic stress symptoms scale (CPSS)

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

The child post traumatic stress symptoms scale (CPSS), which is used for children aged 8 to 18, is based on diagnostic statistical manual version four (DSM-IV) criteria of post traumatic stress disorder [12]. It has two parts. Part one is consisted of 17 items, each item representing PTSD symptom as described by DSM-IV. These items are rated based on likert scale ranging from 0 (no symptom in two weeks) to 3(five or more times in two weeks) yielding a total score which ranges from 0-51. The second part is consisted of 7 items which measures levels of functional impairment as a result of the symptoms of PTSD. The second part is rated dichotomously as absent (0) or present (1) yielding a total score range from 0-7. Higher score indicating greater functional impairment. Hence, a total score for both parts ranges from 0 to 58.

Psychometrically, the test is characterized as .84 internal consistencies and its convergent validity was also high that its correlation with child post traumatic stress index is 0.80 [12]. The total score of CPSS ranges from 0 to 58. Taking 15 as a cutoff score, the following ranges were adapted for the purpose of this study [12]:

Scores between 0 and 15 are indicative of minimum levels of posttraumatic stress symptoms.

a. Scores between 16 and 24 are indicative of mild levels of posttraumatic stress symptoms.
b. Scores between 25 and 39 are indicative of moderate levels of posttraumatic stress symptoms.
c. Scores between 40 and 58 are indicative of severe levels of posttraumatic stress symptoms.

### Translation and pilot testing

The standardized child post traumatic stress scale (CPTSS) was translated earlier by other researchers and adopted for this study. It was pilot tested on 20 samples to test its reliability. The Cronbach alpha's inter item correlation coefficient was 0.73. However, due to the fact that younger children needed some support to understand the items, it was administered in the form of interview by the researcher.

### Ethical considerations

Throughout the research process, all ethical guidelines and principles were considered. Participants' informed consent (willingness) was the basis to participate in testing and the treatment program. The participants were assured that whatever they share in the process of the study (in counseling and in testing results) would be strictly confidential.

### Data analysis

SPSS version 16 (the statistical package for social science) were used to analyze the quantitative data. Moreover, descriptive statistics, frequency distributions and percentage were used to describe participants' demographic characteristics. Dependent and independent t-test is used to compare the mean difference between the pre-test and post-test as well as follow up measures of CPSS.

**Citation:** Abdella R, Sewasew D, Abate G, Bitew M (2015) Trauma Focused Cognitive Behavioral Group Therapy for Abused Children with Post Traumatic Stress: The Case of Institutionalized Children, Addis Ababa, Ethiopia. J Psychol Clin Psychiatry 2(4): 00082. DOI: 10.15406/jpcpy.2015.02.00082



## Results

### Post traumatic stress symptoms (PTSS)

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

Table 2 also show that, 60% of participants in the control group have shown moderate level of post traumatic stress symptom, 26.7% mild and the rest 3.3% showed sever level of PTSD symptoms. At post treatment level of measurement 60%

It is shown on the Table 3 above that, the mean post traumatic stress symptoms measure for the control group at the first point of measurement (pre test) was 28 with standard deviation of 4.92. At the second point of measurement (post test) it was reduced to 27.56 with standard deviation of 4.76.The difference of the two measures was 0.4333 which indicates a reduction in the level of symptoms. However, the difference was not statistically significant.

As Table 4 indicates the mean post traumatic stress symptoms score just after the treatment was 24.70 with a SD of 5.91 while it was 25.13 with SD of 6.27 at the follow up measure (post test two). The difference between the two means was 0.4333 which is not statistically significant.

**Table 4:** Paired t-test of the mean post traumatic stress scores of the treatment group at post test one and post test two (n=30).

| Treatment Group | Post traumatic Stress Symptoms Scores | | | |
|---|---|---|---|---|
| | Mean | SD | t | Sig |
| Post test 1 (just After Treatment) | 24.70 | 5.91 | -.445 | .660 |
| Post test 2 (Follow up) | 25.13 | 6.27 | | |
| Paired Difference | 0.43 | | | |

*Statistically significant at P<.05

## Comparison between treatment group and control group

As shown on the Table 5 before treatment the mean of post traumatic stress symptoms score of the treatment group was 27.13 while the mean of post traumatic stress score of the control group was 28 the difference of the means of the two groups being 0.86. An independent t test of the equality of the two means indicates that the difference of the two means of PTSD score was not significant at 0.05.

**Table 5:** Independent t-test of the mean post traumatic stress scores of the treatment group and control group.

| PTSD Score | Groups | | Mean Difference | t | Sig. |
|---|---|---|---|---|---|
| | Treatment | Control | | | |
| Pre-test | 27.13 | 28.00 | | | |
| Post-test | 24.7 | 27.56 | 0.86 | -577 | .566 |
| Mean Difference | 2.43 | 0.43 | 2.3 | 2.068 | .043 |

*Statistically significant at P<.05

After the treatment the mean post traumatic stress symptoms score of the treatment group was 24.7 and the mean of post traumatic stress score for the control group was 27.56. the difference of the mean for the treatment group and for the control group was 2.3.When a two tailed t test was used to test the mean difference between the control group and the treatment group, there was statistically significant difference between the two means at 0.05 (df=58, t=2.068). That is the treatment group showed statistically significant reduction in the mean score of post traumatic stress symptoms at post test compared to the control group.

## Comparison of post traumatic stress across type of abuse and age

As Table 6 shows the mean score of post traumatic stress symptom scale at pre test was 28.07 for sexually abused children and 26.41 for physically abused children. The difference of the mean post traumatic stress symptoms for sexually abused children and for physically abused children was 1.66. The difference between the two means (sexually abused and physically abused) before treatment is not statistically significant at 0.05.The mean score of PTSD symptoms for sexually abused children was slightly more than that for physically abused even though it was not statistically significant.

**Table 6:** Independent t-test of the mean post traumatic stress scores of the sexually abused and physically abused children.

| PTSD Score | Groups | | Mean Difference | t | Sig. |
|---|---|---|---|---|---|
| | Sexually Abused | Physically Abused | | | |
| Pre-test | 28.07 | 26.41 | 1.66 | .680 | .502 |
| Post-test | 24.88 | 24.46 | 0.42 | -190 | .149 |
| Mean Difference | 3.19 | 2.88 | | | |

*Statistically significant at P<.05

**Citation:** Abdella R, Sewasew D, Abate G, Bitew M (2015) Trauma Focused Cognitive Behavioral Group Therapy for Abused Children with Post Traumatic Stress: The Case of Institutionalized Children, Addis Ababa, Ethiopia. J Psychol Clin Psychiatry 2(4): 00082. DOI: 10.15406/jpcpy.2015.02.00082



It is also indicated on the table that the mean score of PTSD symptoms after the treatment (post test 1) was 24.88 for sexually abused children and 24.46 for physically abused children. The difference between the two means was 0.429 which is not statistically significant when tested with independent t test at 0.05. However the difference was still maintained that sexually abused children scored higher on PTSD symptoms scale once

As can be seen on Table 7 the mean post traumatic stress symptoms score before treatment for younger children(children aged 9-12) was 26.18 while it was 27.68 for the teenagers (13-16 years of age), the teenagers scoring slightly more than the younger children. The difference between the mean post traumatic stress score of the two groups was 1.50 which is not statistically significant tested with independent two tailed t test at 0.05.

PTSD experienced by the two groups.

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

### Follow up

Follow up measure of post traumatic stress symptoms was performed after 15 days of the first treatment outcome test. This was in order to test whether the treatment outcome will be maintained through time. The test revealed that post traumatic stress symptoms show slight increase compared to post test one. However, the difference was too small to be statistically significant which indicates that the treatment outcome was maintained at post test 2.

There are contrasting findings regarding the consistency of treatment outcome at follow up studies. A study by Deblinger et al. [16] fallowed children with PTSD who receive cognitive behavioral therapy for two years measuring PTSD symptoms, child depression inventory and child behavior checklist. The measures were taken 1month, 6 month, 12 month and 2 years after the treatment program. The result shows that the treatment gain was maintained in all the tests and in all follow up times.

In another study, Marit et al. [18] have shown that the participants in short term TF-CBT treatment program recovered from PTSD symptoms one week after the intervention. It was conducted on a sample of 143 which is divided in to treatment group (79) and control group (64). Four months after intervention the difference between the control group and the treatment group in symptoms of PTSD, depression and anxiety was insignificant.

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

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

## Conclusion

In this study majority of the participant's experienced moderate levels of post traumatic stress disorder symptoms before the treatment. TF-CBGT is shown to reduce post traumatic stress symptoms among treatment group and the treatment gains were maintained in follow up measure. The treatment is effective for both sexually abused and physically abused children. It is also shown that both younger children and adolescents are equally responsive to the treatment.

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

## Author's Contribution

Riyadh Mohammed, contributed in problem identification, first proposal preparation and presentation, conducting intervention, data collection, preformed statistical analysis and final report writing and presentation. Daniel Sewasew advised in intervention planning, method section; study design and analysis part, and drafting and editing the manuscript. Gebeyehu Abate consulted in proposal part, method section; study design and analysis part and edit the final written report. Mastewal Bitew contributed in reading and editing the manuscript, data collection and analysis part.

## Acknowledgement

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Jurnal 2

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# Effect of Trauma-Focused Cognitive Behavioral Therapy on Reduction Social and Emotional Maladjustment of Physically Abused Children: A Clinical Trial

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***Abstract***

***Background***
One of the most important and destructive forms of child abuse is the physical abuse which can lead to the maladjustment among abused children; the aim of this study was to determine the effectiveness of trauma focused cognitive-behavioral therapy on reduction social and emotional maladjustment of physically abused children.

***Materials and Methods***
This study was a randomized controlled clinical trial. A number of 40 abused boys, who study in the elementary schools in Kermanshah- Iran, were selected by random cluster method, and randomly divided in intervention and control groups. Before and after Trauma-focused cognitive behavioral therapy (TF.CBT), the Sinha and Singh adjustment questionnaire were used to assess the level of social and emotional maladjustment. In the intervention group, trauma-focused cognitive behavioral therapy was held in ten one-hour sessions.

***Results***
The results showed that after the intervention, the mean of social and emotional maladjustment was decreased significantly in the intervention group ($P < 0.001$), while in the control group the mean of social and emotional maladjustment were not significantly different between pre-test and post-test.

***Conclusion***
At current study, results showed that TF.CBT reduced the social and emotional maladjustment among physically abused children.

***Key Words:*** Child Abuse, Cognition, Emotional maladjustment, Social maladjustment.

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## 1- INTRODUCTION

Children have historically been the most vulnerable stratum of society and it appear that this trend continues yet (1). Each year many children are abused by their caregivers. Child abuse includes any behavior that entails deliberate physical, emotional, sexual abuse / or negligence and neglecting the child (2). The results of studies show that child abuse is very prevalent in the world (3). For example, Finkelhor et al., in a study investigated the prevalence of child abuse among 4,000 children, of which 37.3% were physically abused (4). Child abuse in Iran also had a rising trend. Reports from 1386 indicate the 3.5% growth of the during a year (5). According to the "Society for the protection of Children's Rights in Iran" , the highest type of child abuse in Iran (67.6%) is physically (6).

Abused children are deprived from the educational, psychological and effective support of parents and also the benefits of peaceful living in a family. Childcare, empathic understanding, participation, the power of transparent power and problem-solving are the essential functions of a family, which play a vital role in providing mental health of children. Deprivation from essential functions of a family may cause the abused children to be subject to numerous problems including low social adjustment, drug abuse, emotional problems and running away from home (7-9). Among the adverse effects of child abuse, discussing the problems of these children in the adjustment area is of a great importance (10-12).

Adjustment is a general concept and it is said to be the all strategies that the person uses to handle the stressful life situations (real or unreal threats). In other words, dealing successfully with peers in the community, is called adjustment (13). Adjustment dimensions include the physical, social, emotional and moral adjustment that on top of all is the social and emotional adjustment and it is an introduction to achieve the other dimensions of adjustment (14, 15). Abused children are weak in terms of social and emotional development (16-18), and lack the necessary skills to meet the social expectations, they are involved in communication problems with others and their surroundings and often have difficulty in relationships with peers and show maladaptive behaviors (19-22).

In recent years the dominant treatment to reduce the problems caused by child abuse was the cognitive-behavioral approach. However, using this method in various studies and on patients experienced different traumas has shown various effect sizes and the effect of this method in the treatment of psychological symptoms associated with child abuse has been reported to be varying and low (23), this indicate the low efficacy of this treatment in reducing the problems of abused children, which has caused the researchers to look for trauma-focused psychotherapies to treat the abused children (24), that that one of them is trauma-focused cognitive-behavioral therapy.

Trauma-focused cognitive-behavioral therapy is a well-known and very effective treatment for children who have been abused; this treatment has been suggested by Cohen and Deblinger, specifically to help the abused children and its main focus is on reducing the emotional and behavioral problems caused by trauma (25). In this treatment we focus on the psychological education for children about false believes and mental errors and correcting them and help children to be able to regain their overcome and control feeling over the situations (26). In various studies, this treatment has been used to reduce the problems of abused children (27, 28). Child abuse and physical abuse of children and adolescents is an issue that apart from causing the present and future

life of children to be painful, will have negative and problematic effects for children and also would impose very high costs for the treatment of signs and symptoms of child abuse on society (11-12). On the other hand, studies on trauma-focused cognitive-behavioral therapy have been started in recent years and various studies were conducted in this area and there is no sign of reduction in these researches. While researches done in this area in our country are very few, also researches done in the area of child abuse in terms of method are often descriptive and reducing the problems of these children are rarely considered. In general it can be said that given to the increasing number of abused children in Iran more than before and the lack of researches done, this research aimed to investigate the effect trauma-focused cognitive-behavioral therapy on social and emotional adjustment of abused children.

## 2- MATERIALS AND METHODS

### 2-1. Study design and Population

This randomized controlled clinical, registered in the clinical trial registry center of Iran with IRCT.2016011923705N3. This study has been approved by ethics committees of Kermanshah University of Medical Sciences. The research population is comprised of all abused children studying in the boy's primary schools in Kermanshah city in 2016-2017. Sampling was performed in two stages.

**1)** Identification phase: At this stage, 263 boy's students were randomly selected using multi-stage cluster sampling. For this goal, out of the three educational districts in Kermanshah city, District II was randomly selected. Furthermore, among 10 boy's primary schools, one was randomly selected, and all of the students in the school were evaluated, and finally 40 physical abused children were identified by making reference to the paper published by Dalgleish et al. (29), and using Child Abuse Inventory and also interview with parents and children.

**2)** Random selection: the identified children were randomly assigned to the intervention and control groups (per group=20 students). To perform assimilation among the two groups, the subjects of the control were comprised of the boys who had experienced abuse, and due to moral considerations, the control group received cognitive trauma-focused behavioral therapy after completing the study. After coordination, obtain consent of the subjects, and also identification, recognition and interview with the physically abused children, the research's objective was explained to them, the questionnaires were distributed in the pre-intervention stage, and finally the subjects were asked to carefully read the questions, to choose the answers consistent with their own characteristics and attempt to respond to the entire questions.

The inclusion criteria were the physical type of child abuse, 9-12 years old, not receiving the psychological treatment and drug therapy along with the research. Exclusion criteria included the obvious symptoms of psychosis in the child, suffering from chronic diseases and mental disorders in the child. Written consent form was obtained from one parent of all the participants. These children were allocated in the intervention and control groups randomly. The level of social and emotional maladjustment were assessed with Sinha and Singh adjustment questionnaire in the two groups.

In the intervention stage, trauma-focused cognitive-behavioral therapy based on Cohen's protocol (30), was performed in the intervention group in 10 one- hour sessions, twice a week, as explained bellow. The control group also was on the waiting list, and in order to observe the ethical morals they received the trauma-focused cognitive-behavioral therapy after

the research. In the post-test, again the maladjustment questionnaire was performed and scored.

### 2-2. Interventions

#### 2-2-1. Trauma-focused cognitive-behavioral therapy

In the first session that was for "understanding the goals and determining the expectations", the participants were introduced and the trauma-focused cognitive-behavioral therapy and rules of group were explained briefly. In the second, third and fourth sessions, informing about trauma and reaction to it, focusing on the positive aspects of oneself, managing the emotional responses to the trauma, and identifying various types of emotions on the face were discussed. In the fifth and sixth sessions, communicating the thought, emotions and behavior, examining the daily thoughts, learning to stop thinking through writing or painting, were trained. In the seventh and eighth sessions we concentrated on the cognitive coping, introduction to cognitive distortions and discovering the negative thoughts and challenging them. Also, the trauma was narrated. In the ninth and tenth sessions, overcoming the fears associated with trauma, discussing the trauma reminders, and increasing the environmental supports, was addressed.

### 2-3. Instruments

#### 2-3-1. Social adjustment questionnaire

This questionnaire was made by Sinha and Singh (1993) to determine the social, emotional and academic adjustment (31). In Iran, Aghdasi Ahghar has examined the 55-questions form of this scale in a sample of 3,000 students from different levels of education. The scoring of this test is by zero and one, that a high score and low score indicate the high and low adjustment, respectively. Developers achieved the reliability of the test by dividing, re-test and Kuder-Richardson equal to 95%, 94% and 92%, respectively (32). In Iran, the reliability of subscales of social, emotional, educational and total were achieved 0.92%, 0.92%, 0.96% and 0.94%, respectively. Also, the content validity of the test was confirmed by Khanizadeh and Bagheri (2012) (32).

#### 2-3-2. Child abuse questionnaire

In order to assess child abuse, Hosseinkhani et al. child abuse questionnaire was used. Hosseinkhani et al., to assess child abuse in Iran, provided a Questionnaire based on the ISPCAN Child Abuse Screening Tool according to Iranian culture.

ICAST was prepared by Zolotor and colleagues in USA firstly and Cronbach's alpha was evaluated 0.68 to 0.85 (33). The questionnaire is comprised of 26 items, and the metrics to measure each item is multiple-choice Likert scale (never=0, rarely=1, often=2, always= 3) including three subscales namely neglect, emotional abuse, and physical abuse. The items 1-10 measures emotional child abuse, 11-20: physical abuse, and 21-26: child abuse in terms of neglect.

In the area of subscale namely 'neglect' the minimum score is (0), and the maximum score is (18). In terms of 'emotional and physical abuse', the minimum score is (0), and the maximum score is (30). Hosseinkhani et al. reported the reliability of subscales by two methods of retest and Cronbach's Alpha between 0.92% to 0.95 (34).

### 2-4. Data analyses

Data were analyzed using SPSS software version 17.0. For descriptive data analysis Chi-square test, to inferential data analysis and to comparison of intra-group and inter-group means independent and paired t-test were used. P-value less than 0.05 were significant.

**Table-3**: The comparison of the mean of the social maladjustment and emotional maladjustment in intervention and control group

| Groups | Variables | Mean (SD) | Statistical results | |
|---|---|---|---|---|
| | | | Paired t-test | P- value |
| Intervention | Social maladjustment | 3.80(2.21) | 7.67 | 0.001 |
| | Emotional maladjustment | 0.85(1.46) | 9.16 | 0.001 |
| Control | Social maladjustment | 3.25(1.58) | 2.60 | 0.18 |
| | Emotional maladjustment | 0.65(1.53) | 1.89 | 0.73 |

## 4- DISCUSSION

At current study, the analyzing the findings indicated that trauma-focused cognitive behavioral therapy is effective on social adjustment of the abused children. This finding is consistent with Konanur et al., (27), Koglin and Petermann (26), Deblinger et al., (28) that showed that children who received the trauma-focused cognitive behavioral therapy had a significant improvement in interpersonal skills and social relationships. In explaining this finding it can be said that, in the therapy sessions it was attempted to increase the adaptive skills of abused children and be able to effectively deal with the trauma experience and these children were encouraged to identify the adaptive ways which are more effective for them; for example, they are taught to prepare a list of strategies that are useful in stressful situations, also they were asked to prepare a card and name it the happiness and vitality and write on it the ways that can be helpful during stress and tension and use these methods when the stress symptoms occur.

Also, they were asked to avoid the strategies with high risk of negative consequences (such as long and repeated isolation and/or negative emphasis sentences caused by cognitive distortions), because the more appropriate strategies are used by the abused children to reduce the stress, the more successful they are in social interactions and will have more social adjustment (13). On the other hand, in trauma-focused cognitive-behavioral therapy they were helped, and in an empathic process it was tried to reduce the emotions associated with abuse. Also, using this therapy we tried to reduce the social problems of these children which have continued as a result of irrational thinking, using a variety of behavioral, emotional and cognitive techniques. Another finding of this study was that trauma-focused cognitive-behavioral therapy is effective on the emotional adjustment of abused children. This finding is consistent with the findings of Cisler et al., (35), GoldbeckL et al., (36), and Cohen, and Knudsen (37).

In explain this finding, it can be said that considering that in trauma-focused cognitive-behavioral therapy various techniques such as identifying emotions and thoughts, to stop the negative thoughts and improving the sense of safety and relaxation are used. The same techniques because of affecting the emotions of abused children, can have a good impact on their emotional adjustment.

Also, during the therapy sessions a special attention was paid to the children's emotions, and the emotional experience and proper responses to them were emphasized, and the children were helped to learn how to face their bad emotions and thus helped to their emotional adjustment. Also, trauma-focused cognitive-behavioral therapy try to training the children to logically think about things happen in their live and they are encouraged to face

inefficient feelings and thoughts properly and try to have new thoughts and behaviors (29, 31). On the other hand, using methods such as trauma narrative in this treatment, which has done by literary writing, painting and analyzes of trauma and expressing the feelings about it; it can help the abused children against negative cognitions and dealing better with the traumatic event that all of these could underlie the improvement of emotional adjustment in these children. However, this study showed that, trauma-focused cognitive-behavioral therapy can be effective on the social and emotional adjustment of physically abused children, but it is necessary to repeat the study to clarify the amount of effectiveness and mechanism of this method.

### 4-1. Limitations of the study

Among the limitations of this study, we could mention the small sample size, semi-intervention method of study, limiting the group to physically abused children. It is recommended for future research to perform this treatment for other types of child abuse such as mental, neglecting and sexual abuse with expanded sample number.

## 5- CONCLUSION

In general it can be said, since abused children have grown in the tense family, and one parent or both of them usually deal with their children violently, abused children have several problems in communication, social adjustment and emotional control. For this reason, the current article examines the effect of trauma-focused cognitive-behavioral therapy in reducing social and emotional maladjustment among the abused children. The results showed that, there was a significant difference in means of emotional and social maladjustment between the abused children in the intervention group compared to the control. In general terms, it could be said that trauma focused cognitive-behavioral therapy help abused children to avoid from negative and maladaptive thoughts, and by learning different techniques to control their emotions, can increase the social and emotional adjustment of physically abused children.

## 6- CONFLICT OF INTEREST: None.

## 7-ACKNOWLEDGMENTS

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Jurnal 3



Original Article

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# Trauma-focused cognitive behavioral therapy a clinical trial to increase self-efficacy in abused the primary school children

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**Abstract:**

**BACKGROUND:** Child abuse and violence toward children has become a complex phenomenon in nowadays societies leaving hurt children with numerous complications such as lowered self-efficacy. Hence, this study was conducted to assess the effect of trauma-focused cognitive behavioral therapy (TF-CBT) in physically abused children self-efficacy.

**MATERIALS AND METHODS:** This study was a randomized clinical trial. From this statistical population of all abused children aged 9–12 in Kermanshah in 2016–2017, 40 were divided into intervention and control groups randomly. Tools used in this study were Maurice self-efficacy questionnaire and child abuse questionnaire. Data analysis was done using Chi-square test, paired *t*-test, and independent *t*-test.

**RESULTS:** It was revealed that the mean difference between two groups was not meaningful before intervention. After TF-CBT in intervention group, self-efficacy mean scores of social (17.95 vs. 24.20) and emotional (15.05 vs. 19.05) domains showed meaningful differences, whereas academic self-efficacy mean score did not change significantly (14.10 vs. 14.65) ($P < 0.086$). In control group, social (16.20 vs. 15.55), emotional (13.90 vs. 14.35), and academic (13.40 vs. 13.90) mean self-efficacy scores were not of significant difference ($P > 0.001$).

**CONCLUSIONS:** TF-CBT can be used as an appropriate therapy intervention to improve social and emotional self-efficacy in abused children.

**Keywords:**

Child abuse, self-efficacy, trauma-focused cognitive behavioral therapy

## Introduction

Child abuse and violence toward children has become a complex phenomenon in human societies at the present time as well as a subject of studies in various cultures and social backgrounds.[1] The malicious effect of child abuse on developmental, cognitive, emotional and behavioral eras do not remain limited to childhood but the adversities prevail to upcoming years of adulthood.[2]

Although interactions with others, especially family members, children gain the skills of communication as well as interpreting others behaviors and experiencing their own emotions.[3] Loss of parental flectional support experience among abused children would make them vulnerable to a wide range series of problems, namely, low self-esteem and increased risk of physical and mental complications.[4]

Sense of self-efficacy defined as the personal perception of ones abilities to change behavior, level of motivation, and through



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patterns and emotional reactions[5] is one of the psychological aspects of mental health mostly gained through familial support which can play a prominent role in personal social and affective health.[6] As Bandora believed, self-efficacy is among the factors of highest importance related to social, communicational wellness which results in one's contentment of life.[7] The main source of self-efficacy formation is assumed to be social and familial support. For lack of educational, psychological, and supportive attendance of parents in abused children, the level of sense of self-efficacy is lower in them compared to other children.[8-12] The importance of positive parental behavior in self-efficacy formation, also the prominent role of secure relationship with parents in preventing childhood mental problems as well as better educational functionality and higher sense of self-efficacy has been revealed in numerous studies.[13-17]

Regarding the at-risk population, the prevalence of child abuse was 0.60 among girls and 0.53 in boys (for most of the cases abusive encounters possibly began from early years of primary school) reported through a meta-analysis of 38 studies in 21 countries worldwide;[18] so, dealing with effective therapy modalities to diminish abused children's suffering is noteworthy. A wide variety of therapeutic approaches to alleviate affective and behavioral problems of child-adolescent abuse cases have been recently introduced by researchers among them and as a new option is trauma-focused cognitive behavioral therapy (TF-CBT) in abused children. TF-CBT was first introduced by Deblinger *et al*. and was basically designed to lessen the sexually abused children problems. The method was then utilized for other hurtful experiences such as physical and mental abuse.[19]

Many studies have made comparisons between TF-CBT and other therapy methods such as supportive therapy, child-centered play therapy, and community-based therapy which reported remarkable recoveries for abused children after TF-CBT.[20,21] In this modality, the child is managed in a controlled environment to re-expose to signs which recall him/her the unpleasant experiences. The goal of such a remaking is to help the child to internalize his/her thoughts and emotions and get verbally or nonverbally emotionally relieved.[22]

Regarding the two facts that child abuse has been of high prevalence in Iran in recent years,[23,24] and TF-CBT is a new and rarely utilized therapy option for treatment of abused children, especially to improve the sense of self-efficacy in them, we designed to assess the effect of TF-CBT on increasing social sense of self-efficacy in physically and abused boys in this study.

## Materials and Methods

This study with the code IR2016011923705N3 registered at Iranian clinical trial registration center is a quasi-experimental (preintervention, postintervention with the control group) research the statistical population of this research consisted of all abused boy primary schoolers studying in primary schools of Kermanshah in 2016–2017.

Identification stage: In this, stage 263 students were selected through multistage cluster sampling. for this, among 3 education district 2 and from 10 boy primary schools of this district 1 school were selected randomly who's all the students were assessed and 40 physically abused children were identified through child abuse questionnaire and separate interviews with parents and children themselves.

The questionnaires were first completed by children and after that interviews were held with parents whose children had highest scores. Finally, children with highest scores regarding the questionnaire completion results with a history of abuse confirmed by parents were enrolled in a study as samples.

Random selection (distribution) stage: In this stage identify children were divided randomly into intervention and control groups (20 for each group).

Inclusion criteria for this study where physical child abuse 9–12 years of age no concurrent other psychological treatments during a study and exclusion criteria for prominence psychotic symptoms in child and chronic diseases.

In the pretest stage, after identification of abuse children the first objective of a study was explained to them and after receiving questionnaires as they were asked to read the questions with precision and choose answers regarding their own specific is with no answers left blank.

In the intervention stage, TF-CBT based on Cohen's[25] protocol was performed in 10 therapy sessions twice weekly as explained separately hourly afterward. Intervention therapy was held by a child psychologist of doctorate degree.

During the first session noted as therapy goals and expectations determination, primary questionnaires was achieved and TF-CBT, as well as therapy group rules, were briefly identified explained.

In 2nd, 3rd, and 4th sessions concentrating on positive self-aspect, awareness toward trauma and reactions to trauma, management of affective responses to trauma,

**Table 2: Independent *t*-test results to compare mean of scores between groups before and after intervention**

| Variables | Mean±SD | |
|---|---|---|
| | Before intervention | After intervention |
| Social self-efficacy | | |
| Intervention | 17.95±3.88 | 24.20±4.08 |
| Control | 16.20±3.20 | 15.55±3.26 |
| Significance level of *t*-test | 0.12 | 0.001 |
| Emotional self-efficacy | | |
| Intervention | 15.05±4.26 | 19.05±4.69 |
| Control | 13.90±3.12 | 14.35±4.02 |
| Significance level of *t*-test | 0.33 | 0.002 |
| Academic self-efficacy | | |
| Intervention | 14.10±3.46 | 14.65±3.48 |
| Control | 13.10±2.86 | 13.90±3.27 |
| Significance level of *t*-test | 0.32 | 0.487 |

SD=Standard deviation

**Table 3: Results of dependent *t*-test for in-group compression of pretest and posttest mean scores of experiment group**

| Groups | Variable | Mean±SD | Statistical results | |
|---|---|---|---|---|
| | | | Paired *t*-test | *P* |
| Intervention | Social self-efficacy | 6.25±4.08 | 6.83 | 0.001 |
| | Emotional self-efficacy | 4.0±2.10 | 8.50 | 0.001 |
| | Academic self-efficacy | 0.55±1.35 | 1.81 | 0.086 |
| Control | Social self-efficacy | 0.65±2.05 | 1.41 | 0.174 |
| | Emotional self-efficacy | 0.45±2.69 | 0.67 | 0.505 |
| | Academic self-efficacy | 0.80±3.96 | 0.96 | 0.345 |

SD=Standard deviation

scores for social ($P > 0.174$), emotional ($P > 0.505$), and academic ($P > 0.345$) self-efficacy were not significant.

## Discussion

Data analysis revealed that TF-CBT meaningfully increased social self-efficacy in the intervention group compared to control group. Since we could not track research reporting the use of TF-CBT to enhance social self-efficacy in our literature review, similar studies are noted here.[30-32] Khaneh Ke and Ajappa reported an increase in high school student's self-efficacy after cognitive behavioral therapy.[33] Latifi showed the effects of CBT on improving social and interposed relations as well as self-efficacy among students[34] in Kumar and Sebastian study, academic achievement and self-efficacy were reported to increase after CBT in adolescent students.[35]

As an explanation for the finding, it could be noted that during TF-CBT sessions emphasis is on issues such as participating in social activity, building interpersonal relationships, and clear and transparent expressing of thoughts which can lead to improved physically abused children's social self-efficacy.[36] In addition, in TF-CBT there are techniques which affect on emotions and behaviors of children including though and emotion detection, thought stopping and security feeling enhancement which can bring about an increase in social self-efficacy. Another hand, group session provided the abused children for better interactions toward each other building a background for achieving trustful relationships. This trust and the confidence to express abilities of social communication may lead to improved sense of self-efficacy in physical abused children which is also a result of sharing the common experience of failure and achievement among children.[37]

The other finding of this research was a meaningful increase of emotional self-efficacy in physically abused children after TF-CBT. Since we could not find studies assessing TF-CBT effects on social self-efficacy in our data search, similar studies are mentioned afterward. Jafari *et al.* performed CBT on substance dependents to improve their social and emotional self-efficacy, and they reported a significantly enhanced emotional self-efficacy after treatment.[38] The fact that TF-CBT is in part educating children to think logically about the events happening in their lives and encounter property with unfunctional feelings and thoughts to take new attitudes, this new opportunity to implement introduced new ways of feeling and thinking for them empowers the assumption, and also, the result of this study that after such a therapy their emotional self-efficacy increase. Furthermore, utilizing skills such as trauma narrating skill through literary writings, painting, and trauma analysis can help the child to cope with negative cognitions of the traumatic events which all can result in improvement of emotional self-efficacy.[39,40]

Another finding of this study was that the mean difference of academic self-efficacy variable between the intervention and control groups was not statically meaningful. This finding was incongruent with Nayebaghayee *et al.* which concluded that CBT could raise the academic self-efficacy in a group of high school students.[41]

The result is also not congruent with the Bardideh *et al.* study which reported enhanced self-efficacy in all three aspects after they assessed the effect of CBT on 9–11-year aged students in improving emotional, social, and academic self-efficacy.[42] To give a reason for why TF-CBT did not end in increased academic self-efficacy, it could be said that because TF-CBT protocol does not include a directed focus on academic promoting abilities which demands forming specific abilities around the educatory assignment fulfilling in specified subjects and the main focus of TF-CBT is on cognitive reconstruction, gradual relief of stress, role-playing, and emotional regulation related to the trauma so the obtained result is justifiable.

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# Comparison of trauma-focused cognitive-behavioral therapy and theory of mind on increasing social competence among abused children

**Abdulzahra Naami, Yadollah Zargar, Iran Davoodi, Vahid Farnia[1], Safora Salemi[1], Faeze Tatari[1], Maryam Khanegi[1]**

**Abstract:**

**BACKGROUND:** In recent decades, the use of psychological methods has been considered to improve the barriers and challenges of abuse adolescent females. This study focuses on comparing the efficacy of trauma-focused cognitive-behavioral therapy (TF-CBT) and theory of mind (ToM) on social competence among abused children.

**MATERIALS AND METHODS:** A clinical trial was performed with 39 abused children as the subjects of the study. Participants are residents in Ahvaz (Iran) host-family centers and were randomly divided into two groups of experimental subjects and control subjects. The data collection method utilized the Social Competence Questionnaire. Descriptive statistics, covariance analysis, and Tukey's *post hoc* test were used for the data analysis.

**RESULTS:** Comparison of the groups showed that the average behavioral and cognitive competence increased in both TF-CBT and ToM groups, but the average emotional, social competence is significantly higher in the ToM group. It is also found that the average social motivational competence is significantly higher in the TF-CBT group than in the ToM group.

**CONCLUSION:** TF-CBT and ToM can be effectively used to improve the social competence of abused adolescent females.

**Keywords:**

Abused children, social competence, theory of mind, trauma-focused cognitive-behavioral therapy

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## Introduction

Many children are abused by their caretakers every year. The World Health Organization (2006) considers child abuse as behavior that involves any intentional means of physical, emotional, and sexual harassment of children or negligence and carelessness toward children. Abuse of children and teenagers has a severely negative impact on children and aggravates the future outlook of children. Substance abuse in the form of narcotics, alcohol, and prescription drugs, as well as abandoning and running away from home are more frequent in abused children.[1-3]

One of the problems often affecting abused children is lower social competence. Social competence includes a set of skills whose mastery would promote social awareness.[4-6] Social awareness focuses on the ability to understand others and establish effective communication and social responsibility. It enables maintaining a personal independence and managing relationships.[7] Damage to social competence can lead to vulnerabilities to interpersonal relationships in abused



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children. Accordingly, these children fall victim to psychological, social, and behavioral problems.[8] Recent research findings have established that children and teenagers with low social competence suffer more heavily from depression,[9] criminal tendencies,[10] aggression,[11] and other behavioral problems. Educational programs that enhance individual and social abilities can effectively prevent these behaviors and increase the social competence of these children.[12]

Of the existing and new therapies in helping abused children, considerable evidence suggests that trauma-focused cognitive-behavioral therapy (TF-CBT) to be a novel and effective approach. TF-CBT is derived from the cognitive-behavioral approach. TF-CBT is used to reduce the symptoms of posttraumatic stress disorder, depression, and anxiety, as well as trauma-related features.[13] This treatment is a combination of standard cognitive-behavioral techniques and supportive individual interventions.[14] In many studies, this treatment is compared with other commonly used treatments, such as supportive care, child-centered therapy, game therapy, or community-based treatment. It is shown that children who receive TF-CBT improve significantly.[15]

The issue of child abuse has been widely studied; however, due to many varying and complex challenges in this area, one standard cannot be utilized for the method for all children in this study. Therefore, another method is paired up in this study that is the theory of mind (ToM). The ToM is derived from social cognition theory. ToM is the ability to have mental states being different from reality or one's mental state and to motivate human actions by the internal mental state such as beliefs, desires, and intentions.[16,17] Teaching ToM may facilitate the creation of empathy and thus provides a broader insight into beliefs and emotions. Therefore, it is feasible that abused children could effectively benefit from ToM education that otherwise would have been further aggravating.[18,19]

In addition, given that the child abuse has become increasingly widespread in Iran in recent years, several researchers in Iran have focused on this critical issue. For example, Mikaeili in a study assessed 2000 students aged 11–14 years demonstrating that at least one type of child abuse was reported by 15% of students.[20] Regarding the at-risk population, the prevalence of childhood sexual abuse was 0.60 among male and 0.53 in women (for most of the cases abusive encounters possibly began from early years of primary school), which reported through a meta-analysis of 38 studies in 21 countries worldwide;[21] hence, dealing with effective therapy modalities to diminish abused children's suffering is noteworthy.

Concurrent with the recognition of the psychological problems and symptoms among the abused children, the issue of their treatment was raised. The dominant approach among the psychotherapy ones in the area of the treatment of behavioral and emotional problems caused by child abuse was CBT approach in recent years. However, the application of this method in different studies resulted in different effects, and it was reported that the method contributes to varying effects in the treatment of psychological symptoms relevant to the child. This inconsistency and limitation led researchers to seek other approaches in the field.

Furthermore, TF-CBT and ToM have not yet been compared in terms of analyzing the social competence escalation among the abused children. Therefore, it has not been feasible to determine which one is more effective in this area. For these reasons, the present study aimed to compare the effectiveness of trauma-based CBT and ToM on enhancing the social competence of abused children.

## Materials and Methods

### Study design

This was a randomized controlled clinical trial. The statistical population includes all participants referred to the Ahvaz Welfare Organization. The first sampling includes 49 abused girls who were admitted to the family-like (foster home placement centers) centers of the Ahvaz Welfare Organization. Of them, 43 participants have entry criteria. Of 43 admitted people, one of the participants refused to cooperate with us, and three participants were discharged (two girls were admitted by parents and one of them was admitted by grandfather). Finally, 39 participants were chosen. Of those, 26 participants were randomly put in two experimental groups (TF-CBT and ToM) and 13 participants were randomly put in the control group [Figure 1].

### Selection criteria

The entry criteria of the study include (a) gender (girls), (b) referral and admission to pseudo-family centers due to physical and psychological abuses and ignorance, (c) ages range of 9–12 years, and (d) failure to receive psychological treatments at the time of conducting research. The exit criteria of the study are obvious symptoms of psychosis in the child, chronic illness or other simultaneous psychical disorders, and mental retardation observed in children. It should be noted that criteria to recognize child abuse are referral and admission of children to the Ahvaz Welfare Organization due to the report of child abuse. This study was conducted and overseen by the Research Committee of Shahid Chamran University of Ahvaz, Iran.

### Procedure

The general procedure was that after the approval of

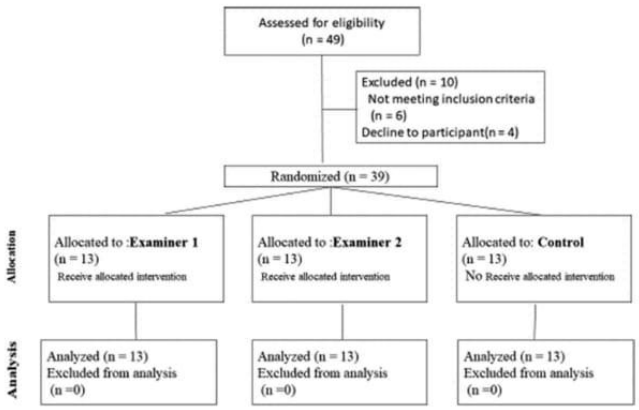


**Figure 1:** Consort flow diagram of the participants

the Research Committee in Shahid Chamran University, Ahvaz, the necessary coordination was carried out with the social affairs deputy and the expert responsible for the foster-family affairs in the Welfare Organization, and the researcher referred to foster-family centers after obtaining the consent and performing the above steps. Then, the objective underlying the present study was explained to the experts based in these centers, and the children were selected according to the inclusion and exclusion criteria.

After identifying the children and before any intervention, the children completed a self-report social competency questionnaire. Data obtained from this stage were considered as pretest scores. Then, the training was conducted in groups, twice a week, and individually for each group. Due to the use of two different methods, the first and second experimental groups were selected from two different dormitories to avoid the effects of the intervention. Interventions were conducted by psychologists at the centers where these children were kept, and the interventions were performed in Persian.

## Selective protocol

### *Trauma-focused cognitive-behavioral therapy protocol*

In the first session, the goal of treatment along with expectations was explained. A brief summary of TF-CBT and the rules of the group were presented. Managing emotional responses to trauma, identifying types of emotions through games and images, managing the physiological responses to trauma, deep muscle relaxation, and diaphragmatic breathing are taught from the second session to the fourth session. Stopping thought technique, communication between thought, emotion, and behavior, and investigation of the daily thoughts through writing or painting are taught in the 5th and 6th sessions. We focused on the identification of negative thoughts, cognitive coping, familiarity with and cognitive distortions, and their challenges in 7th and 8th sessions. Furthermore, the trauma narrative was performed by storytelling techniques. In the 9th and 10th sessions, we discuss the trauma reminders, and then, overcoming the fear associated with the trauma and increasing environmental protection were considered.[22]

### *Theory of mind protocol*

The first session consists of familiarization and general explanation of the educational plan. We teach the identification of emotional states by means of images while teaching situational emotion by a combination of images and stories from the 2nd session to the 4th session. Images depicting different situational emotions are offered to children, and the emotion of the character in the image and story is taught in the 5th and 6th sessions. A set of images is presented to the child and the desire and thought of the character in the story are taught to them in the 7th and 8th sessions. Finally, in the final sessions, (9th and 10th), a set of cartoon images is presented to children so that the thoughts and beliefs of characters in the story can be taught.[23]

## Measurements

Social Competence Questionnaire was used to collect the data. The questionnaire is constructed and normalized by Parandine (2006) based on Felener's four-dimensional social competence model (1990). This questionnaire is composed of 47 questions with Likert scale. The scores of overall social competence range from 47 to 329.

and control groups, it is 141.384 and and 163.923 and 140, respectively.

According to the present research design which was of a pretest and posttest type, covariance analysis was used to analyze the data and to control the effect of pretest. In addition, prior to using this method, the prerequirements to perform covariance test including variance–covariance matrix homogeneity, variance homogeneity, and regression coefficients homogeneity were evaluated, and then, this method was used.

Based on the analysis summarized in Table 3, the value of $F$ relevant to the social–behavioral competence is $F = 1625.154$ ($P < 0.005$), and the value of $F$ relevant to the cognitive and total social competence are $F = 4.280$ ($P < 0.022$) and $F = 8.313$ ($P < 0.001$), respectively. This indicates that there is a significant difference between the posttest scores of social–behavioral, cognitive, and general social competences in the two groups of the experiment and control. However, there is little to no difference between the posttest scores of motivational and emotional social competence in the experimental and control groups based on the value of $F$ when comparing the social–motivational competence ($F = 2.957, 0.065$) and social–emotional competence ($F = 4.806, 0.014$).

To determine the exact difference between the test and control groups, Tukey's *post hoc* test was used, and the results are summarized in Table 4.

The results of Table 4 suggest that the average score of overall social, behavioral, cognitive, and motivational competence in TF-CBT group has a more significant difference as compared to the control group ($P < 0.005$). In contrast, this difference in the emotional–social competence is not significant ($P < 0.998$). Furthermore, it is clear that ToM has a significant effect on the overall social, behavioral, cognitive, and emotional competence ($P < 0.005$). This, however, does not translate to a significant effect on the motivational competence ($P < 0.334$).

The other findings suggest that there would be no significant differences between TF-CBT and ToM in the overall social competence ($P < 0.818$). In short, both methods have a significant effect in increasing the overall social competence.

## Discussion

Data analysis shows that there is a measurably significant difference in favor of TF-CBT group between average posttest score of social competence in TF-CBT and control groups.

This study further supports the findings of Deblinger *et al*., based on the effectiveness of CBT on the improvements in the personal resiliency among youth.[25] Furthermore, the results of this study are in agreement with the findings of de Arellano *et al*., showing that TF-CBT leads to reducing behavior problems or symptoms of depression.[13] To explain this finding further, in the TF-CBT sessions, we helped the participants restructure the abused children's cognitive properties including belief and mental imagery, and then, we attempted to alleviate the emotions associated with their harassment during the sympathy process. Furthermore, attempts were made to reduce the social problems of these children, which continues due to irrational thoughts, using diverse behavioral, emotional, and cognitive techniques through carrying out assignments.[26,27]

There is also a significant social competence difference in favor of ToM group when ToM and control groups with pretest control are compared. This finding is consistent with the results of Le based on the effect of ToM on the

**Table 2: Mean and standard deviation of social competence before and after intervention**

| Variables | Mean (SD) | |
|---|---|---|
| | Before intervention | After intervention |
| Social competence | | |
| Behavioral | | |
| TF-CBT | 114.92 (18.98) | 133 (15.737) |
| Theory of mind | 112 (18.533) | 127.15 (17.367) |
| Control | 114.07 (13.972) | 111.38 (15.840) |
| Cognitive | | |
| TF-CBT | 5.46 (1.506) | 9 (1.779) |
| Theory of mind | 6.76 (2.087) | 8.84 (1.675) |
| Control | 6.38 (2.785) | 6.61 (3.302) |
| Motivational | | |
| TF-CBT | 16.38 (4.03) | 19.07 (5.267) |
| Theory of mind | 15.15 (4.450) | 17.23 (3.833) |
| Control | 16.30 (4.479) | 14.53 (5.125) |
| Emotional | | |
| TF-CBT | 6.61 (2.631) | 7.38 (3.500) |
| Theory of mind | 7.46 (2.933) | 10.69 (3.425) |
| Control | 7.61 (3.302) | 7.46 (2.221) |
| Total | | |
| TF-CBT | 143.38 (17.91) | 168.46 (18.581) |
| Theory of mind | 141.38 (17.918) | 163.92 (18.607) |
| Control | 144.38 (18.305) | 140 (20.337) |

TF-CBT=Trauma-focused cognitive-behavioral therapy, SD=Standard deviation

**Table 3: The results of the multivariate covariance analysis on the mean posttest scores in the experimental and control groups**

| Variables | Sum of square | DF | Mean square | F | P |
|---|---|---|---|---|---|
| Social competence | | | | | |
| Behavioral | 3250.308 | 2 | 1625.154 | 6.093 | 0.005 |
| Cognitive | 46.308 | 2 | 23.154 | 4.280 | 0.022 |
| Motivational | 135.436 | 2 | 67.718 | 2.957 | 0.065 |
| Emotional | 92.667 | 2 | 46.33 | 4.806 | 0.014 |
| Total | 6079.538 | 2 | 3039.769 | 8.313 | 0.001 |

**Table 4: The results of Tukey's *post hoc* test to compare the averages of groups in posttest step**

| Variables | Comparison | Mean difference | Standard error | P |
|---|---|---|---|---|
| Social competence | | | | |
| Behavioral | 1st and 2nd groups | 5.846 | 6.406 | 0.636 |
| | 1st and 3rd groups | 21.615 | 6.406 | 0.005 |
| | 2nd and 3rd groups | 15.769 | 6.406 | 0.048 |
| Cognitive | 1st and 2nd groups | 0.153 | 0.912 | 0.984 |
| | 1st and 3rd groups | 2.384 | 0.912 | 0.034 |
| | 2nd and 3rd groups | 2.230 | 0.912 | 0.050 |
| Motivational | 1st and 2nd groups | 1.846 | 1.877 | 0.592 |
| | 1st and 3rd groups | 4.538 | 1.877 | 0.053 |
| | 2nd and 3rd groups | 2.69 | 1.877 | 0.334 |
| Emotional | 1st and 2nd groups | 3.307 | 1.217 | 0.027 |
| | 1st and 3rd groups | 0.076 | 1.217 | 0.998 |
| | 2nd and 3rd groups | 3.230 | 1.217 | 0.031 |
| Total | 1st and 2nd groups | 4.538 | 7.500 | 0.818 |
| | 1st and 3rd groups | 28.461 | 7.500 | 0.002 |
| | 2nd and 3rd groups | 23.923 | 7.500 | 0.008 |

social competence of schizophrenia.[28] Further, this study supports the findings of Washburn *et al*. which show the effect of ToM on social anxiety disorder.[29]

Expanding on our findings, it can be said that the abused children are helped to find the ability to understand and predict the social behavior of others during the sessions of the ToM. By emphasizing the application of the ToM, abused children's awareness of their and other's emotions improves their relationships with others and helps them cope with their emotion.[30,31] Coping with their and other's emotion and improvement of interpersonal relationship usually positively results in the increase of social competence and enables proper confrontation in interpersonal interactions. Social competence allows abused children to behave efficiently in social settings. This is because children should have an awareness of their and other's traits, and this awareness is the requirement of the ToM. Therefore, the social competence is improved for abused children applying the method of ToM.[32,33]

The findings of the current study indicate that there is no significant difference between the total score of social competence in the group, in which TF-CBT method is used and the group in which ToM is used. Given that there is no study conducted to compare both methods and their effect on the social competence, it was not possible to compare them with other studies.

There are no significant differences between the two methods with regard to the increase in social competence. In both the methods, the outcomes are contributed to the children modifying their inefficient beliefs. Indeed, the main components in both TF-CBT and ToM methods are social competence and emotional, cognitive, and behavioral dimensions. It is strongly recommended that during these therapy sessions, the children are thought techniques to recognize and control their emotions. Recognition of theirs and others' thought and emotion is emphasized in the ToM method similarly to the TF-CBT method.

Furthermore, in both TF-CBT and ToM methods, children were thought to recognize their own emotions and understand that others may have differing interests, goals, feelings, and beliefs from them. By increasing their social and emotional interactions, these children have an opportunity to expand their social competence and communicate to attain their reasonable intent. In such a way, they gradually become familiar with different emotional states and different types of communication and find a greater understanding of social clues and form patterns of interactions in their minds to influence their environment and others. The basis of social competence is formed through these models. Equipped with these models, abused children assume the power of predicting the behavior of others as a consequence of their behaviors and of gaining control over the environment. In total, it can be argued that using these two methods can help to improve the social competence of abused children.

### Limitations of the study

The current study is limited as it draws on self-reporting questionnaires which raises the possibility of response bias. Furthermore, the limited statistical population pool of the research prevents us to assess the impact of the aforementioned methods on other types of child abuse. Finally, due to time constraints and prediction of sample drop, following up effectiveness of TF-CBT and ToM methods was not possible in intervals of several months after the treatment.

## Conclusion

As these abused children are parents of next generation, their problem often has consequences extending beyond to families and the society. Timely intervention during childhood can prevent a more severe mental harm and can reduce the possibility of violent behaviors during adulthood. Therefore, due to the effects of TF-CBT and ToM methods in improving the social competence of abused children, these methods can be used in psychotherapy practices and centers such as the State Welfare Organization used for keeping such children.

The strength of the present study was that it used novel approaches to help abused children since it is of high significance to focus on the consequences of child abuse and on effective methods and treatments to reduce the problems of these children. The disadvantage of the present

Social competence questionnaire includes behavioral skills (negotiation, role play, self-expression, and conversational skills, social skills, and learning to be friendly with others), cognitive skills (information warehouse, high social knowledge, perceptions proportion to perspective of others, understanding how to establish interpersonal relationships, processing skills and information acquisition, and decision-making ability), emotional skills (establishment of effective communication with others, development of mutual trust and mutual support, and identification of or proper response to emotional symptoms in social events), and motivational competence (including individual worth, moral development level, feeling of effectiveness, self-efficacy, effective communication with others, and relationship management). The estimation of reliability and validity of this test is performed by Parandin in Tehran Province (Iran) on 450 people. To estimate the scale reliability coefficient, Cronbach's alpha method was used to investigate the internal consistency of the scale and subscales. The alpha coefficient obtained from omitting the items that had little correlation with the total score was 88%, indicating that the questionnaire has acceptable internal consistency coefficient. In addition to the alpha coefficient, test–retest was used to estimate the reliability. Retest coefficient between two runs was obtained to be 0.89. The total correlation with the subscales is very high and is significant at the 99% level. In addition, the construct validity of the scale was investigated via factor analysis. On the other hand, all correlation values between the items and the total questionnaire score for analyzing the principal components were above 0.50, indicating a high correlation between each item with the whole test.[24]

### Data analysis

To analyze the descriptive data, the statistical methods (i.e., Chi-square method) are used by utilizing SPSS statistical software version 17.0 (IBM Corp.: Armonk, NY, USA). Inferential data are investigated through the analysis of covariance and Tukey's *post hoc* test.

### Ethical consideration

This study was reviewed and approved by the Ethical Committee of the Vice Chancellery of Research and Technology, Shahid Chamran Ahvaz University. Each participant was informed and their written consent form was obtained from all participants.

## Results

In the current study, 39 abused children who refer to the family-like center are selected. They are randomly divided into two experimental groups and one control group. Table 1 shows that the three groups have relatively similar attributes and properties. As shown in Table 1, among the participants aged 9–12 years, the highest frequency of child abuse was related to physical child abuse (33.33%) and the lowest frequency belonged to child neglect (20.51%). Parental education was mostly at the high school level (61.54%), and family history of addiction was often positive (69.23%).

Table 2 presents the statistical indices relevant to the social competence score and its subscales for each group. According to the table, in the preintervention phase, the mean and standard deviation of social competence scores in the groups were similar. However, in the postintervention phase, a significant difference was observed.

As shown in Table 2, the mean score of social–behavioral competence before and after intervention in TF- CBT group is 114.923 and 133. In the ToM and control groups, this score is 112 and 127.153 and 114.076 and 111.384, respectively. The mean score of social cognitive competence before and after the intervention in TF-CBT group is 5.461 and 9, and in the ToM and control groups, it is 6.769 and 8.846 and 6.384 and 6.615, respectively.

In addition, the mean score of social motivational competence before and after intervention in the group TF- CBT is 16.38 and 19.076, and in the ToM and control groups, it is 15.153 and 17.230 and 16.30 and 14.538, respectively. On the other hand, the mean score of emotional–social competence before and after intervention in TF- CBT group is 6.615 and 7.384, and in the ToM and control groups, it is 7.461 and 7.615 and 7.615 and 7.461, respectively. The mean of total social competence before and after the intervention in TF-CBT group is 143.384 and 168.461, and in the ToM

**Table 1: Demographic properties of abused children in the study groups**

| | *n* (%) or mean (SD) | | | |
|---|---|---|---|---|
| **Groups** | **TF-CBT** | **Theory of mind** | **Control** | **Total** |
| Kind of child abuse | | | | |
| Physical | 7 (53.84) | 6 (46.15) | 5 (38.46) | 18 (46.16) |
| Emotional | 3 (23.07) | 4 (30.76) | 6 (46.15) | 13 (33.33) |
| Negligence | 3 (23.07) | 3 (23.07) | 2 (15.38) | 8 (20.51) |
| Father's educational level | | | | |
| High school | 9 (69.23) | 7 (53.84) | 8 (61.53) | 24 (61.54) |
| Advanced degree | 4 (30.76) | 6 (46.15) | 5 (38.46) | 15 (38.46) |
| Father's job | | | | |
| Employed | 5 (38.46) | 6 (46.15) | 8 (61.53) | 19 (48.72) |
| Unemployed | 8 (61.53) | 7 (53.84) | 5 (38.46) | 20 (51.28) |
| History of addiction in family | | | | |
| Yes | 8 (61.53) | 10 (76.92) | 9 (69.23) | 27 (69.23) |

TF-CBT=Trauma-focused cognitive-behavioral therapy, SD=Standard deviation

study was that the therapeutic methods were used only for girls and that child sexual abuse was not investigated because of the research limitations. The ultimate message of the present study is that TF-CBT and ToM can promote the social competence of abused children. Thus, such methods can be utilized in rehabilitation centers, psychology clinics, and crisis intervention centers based on the welfare organizations that accept these children.

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## Conflicts of interest

There are no conflicts of interest.

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# Efektivitas Animation-Cognitive Behavior Therapy (A-CBT) Terhadap Efikasi Diri untuk Mencegah Seksual Pelecehan di kalangan Anak-anak di Sekolah Dasar Kota Surabaya

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**Abstrak.** Krisis moral sangat berbahaya dan mengancam anak-anak di Indonesia. Salah satu ancaman terbesar adalah pelecehan seksual. Anak rentan menjadi korban pelecehan seksual karena tidak bisa mengurus dirinya sendiri; Kemampuan anak untuk mencegah pelecehan seksual dapat dilakukan jika anak memiliki efikasi diri yang tinggi. Tujuan dari penelitian ini adalah untuk mengkaji terapi perilaku kognitif (A-CBT) dalam mencegah pelecehan seksual pada anak. Metode: Eksperimen semu, pre-test, dan post-test dengan desain kelompok kontrol diterapkan dalam penelitian ini. Tujuh puluh sampel direkrut dengan menggunakan simple random sampling dan dibagi menjadi kelompok eksperimen dan kontrol. Hasil penelitian menunjukkan bahwa A-CBT berpengaruh positif terhadap efikasi diri (p = 0,000). Studi lebih lanjut diperlukan untuk melakukan pengaturan A-CBT untuk keluarga, sekolah, dan masyarakat untuk memastikan efektivitas intervensi ini.

**Kata kunci:** terapi perilaku animasi-kognitif, efikasi diri, pelecehan seksual



## PENGANTAR

Anak-anak rentan menjadi korban pelecehan seksual karena mereka tidak bersalah dan dapat dipercaya terhadap orang dewasa. Selain itu, ketergantungan mereka tinggi, sementara kemampuan mereka melindungi diri sendiri terbatas, anak-anak tidak dapat mempertahankan diri(1). Kondisi ini menjadi sangat mengkhawatirkan. Bagaimanapun, itu berisiko terjadi pada semua anak. Siapapun bisa menjadi pelaku dan bisa terjadi dimana saja di sekitar kita. Korban kekerasan seksual terhadap anak dapat berasal dari berbagai tingkat sosial ekonomi dan usia, baik laki-laki maupun perempuan(2).

## OBJEKTIF

Penelitian ini bertujuan untuk menguji efektivitas A-CBT dalam meningkatkan self-ref vf Sebuah Saya aku C kamu Sebuah-cy untuk pencegahan pelecehan seksual pada anak sekolah dasar.

## METODE

Desain penelitian ini adalah quasi-experiment, pre-test, dan post-test dengan desain ekivalen control group design. Tujuh puluh sampel dipilih dan dibagi menjadi dua kelompok, yaitu 35 sampel pada kelompok eksperimen dan 35 sampel untuk kelompok kontrol. Kriteria inklusi meliputi 1) anak kelas IV SD, 2) Anak usia 10-11 tahun 3) anak yang mendapat izin dari orang tua untuk menjadi responden. Kriteria eksklusi adalah 1) Siswa yang tidak mengikuti program dari awal sampai akhir, 2) Anak tidak kooperatif, 3) Anak yang tidak hadir dikeluarkan dalam penelitian ini.

Variabel efikasi diri diukur dengan kuesioner efikasi diri yang terdiri dari 29 pertanyaan dan memiliki nilai R sebesar 0,939. Kuesioner self-efficacy dalam penelitian ini merupakan pengembangan dari kuesioner self-efficacy oleh Bandura dan telah melewati tahap uji validitas isi.(14)

## HASIL

### *Karakteristik responden*

Tabel 1. Menunjukkan bahwa karakteristik responden berdasarkan jenis kelamin, umur, tipe keluarga, informasi pelecehan seksual, media informasi pelecehan seksual, orang terdekat responden, responden yang menonton video porno, dan responden yang tubuhnya bagian pada Mei - Juni 2019

Tabel 1. Karakteristik Responden

| Karakteristik Responden | Kelompok intervensi N % | | Grup kontrol | % | |
|---|---|---|---|---|---|
| **Jenis kelamin** | | | | | 0,253 |
| Manusia | 14 40 | | 18 | 51.4 | |
| Perempuan | 21 60 | | 17 | 48.6 | |
| Total | 35 100 | | 30 | 100 | |
| **Usia** | | | | | 0,546 |
| Sepuluh tahun | 28 | 80 | 29 | 82.9 | |
| berumur 11 tahun | 7 | 20 | 6 | 17.1 | |
| Total | 35 | 100 | 35 | 100 | |
| **Hidup bersama** | | | | | |
| Orangtua | 32 | 91.4 | 28 | 80 | |
| Kakek/Nenek Keluarga | 3 | 8.6 | 3 | 8.6 | |
| besar | - | - | 4 | 11.4 | |
| Total | 35 | 100 | 35 | 100 | |

Data CSA (Child Sexual Abuse) di Asia Tenggara sangat bervariasi, dengan 40 kasus pelecehan anak di 14 negara di kawasan ini menyimpulkan bahwa sekitar 10% anak laki-laki dan 15% anak perempuan pernah mengalami setidaknya satu bentuk pelecehan seksual. (3). Indonesia menurut KPAI tahun 2010-2014 mencatat 21.869.797 kasus kekerasan terhadap anak dan setengahnya adalah kekerasan seksual.(3). Terdapat 1.032 kasus kekerasan terhadap anak yang terdiri dari: kekerasan fisik 290 kasus (28%), kekerasan psikis 207 (20%), kekerasan seksual 535 kasus (52%). KPAI menyatakan bahwa laporan kekerasan terhadap anak didominasi oleh kejahatan seksual dari tahun 2010-2014, berkisar antara 42-62%.(4). Hasil studi pendahuluan penelitian di Polda Jatim Surabaya melaporkan kasus pelecehan seksual dari tahun 2015-2018. Terdapat 576 kasus pemerkosaan, pelecehan seksual, dan sodomi pada anak usia 5-18 tahun. Peneliti mengambil kasus di SD X dan SD Y secara random sampling karena Sekolah X dan Sekolah Y berada di wilayah Surabaya timur. Hasil wawancara penelitian pada tanggal 20 April 2019, di kepala sekolah sekolah X dan Y bahwa di sekolah ini belum ada intervensi mengenai pelecehan seksual.

Pelecehan seksual melibatkan keterlibatan anak dalam aktivitas seksual, tetapi anak tidak mengerti apa yang terjadi (5). Aktivitas seksual seperti menyentuh bagian sensual, menampilkan video porno, hingga hubungan seksual (pemerkosaan), dan menunjukkan alat kelamin(6). Pelecehan seksual berupa kekerasan seksual terhadap anak dan remaja dapat menyebabkan kerentanan fisik dan psikis pada anak(7). Seorang anak yang dianiaya tidak dapat bereaksi atau menentang otoritas yang dilakukan oleh pelaku, dan meskipun dia tidak setuju, dia merasa tidak dapat mencegah kejadian ini, dalam menghadapi ancaman, anak-anak sering menyimpan fakta bahwa mereka telah dilecehkan.
(7).

Self-efficacy pada anak untuk mencegah pelecehan seksual dapat dilakukan jika anak memiliki self-efficacy (8). Self-efficacy menurut Bandura (1997) adalah pengukuran individu terhadap kemampuannya untuk menyelesaikan tugas-tugas tertentu, self-efficacy mempengaruhi cara hidup individu dalam kehidupan sehari-hari, mengatasi hubungan satu sama lain, menentukan upaya untuk melindungi diri dari kondisi berisiko.(8)

Oleh karena itu untuk mencegah terjadinya pelecehan seksual pada anak, maka diperlukan CBT untuk mencegah terjadinya pelecehan seksual pada anak yaitu CBT. Terapi ini merupakan terapi yang efektif untuk mencegah pelecehan seksual pada anak, termasuk stres pasca trauma, kecemasan, penghindaran, gejala depresi, distorsi kognitif yang terkait dengan kekerasan, dan perilaku seksual yang tidak pantas.(9). CBT adalah bentuk terapi yang dirancang untuk mencegah/mengobati korban pelecehan seksual. CBT merupakan terapi berbasis psikoedukasi untuk pencegahan dan penanganan kekerasan seksual pada anak, dan terapi ini memenuhi kriteria asuhan yang didukung secara empiris. CBT berisi komponen-komponen berikut: strategi psiko-edukasi dan relaksasi, ekspresi afektif dan regulasi emosi, mengatasi masalah kognitif, dan memproses emosi yang terkait dengan penyalahgunaan pengalaman, meningkatkan keamanan pribadi.(10). Diperlukan strategi baru dalam memberikan terapi CBT agar mudah diterima, salah satunya adalah media film animasi(11). Animasi adalah proses merekam dan memutar ulang serangkaian gambar statis untuk mendapatkan ilusi gerakan(12). Kelebihan animasi sebagai media audio visual adalah mencakup seluruh panca indera, mudah dipahami, lebih menarik karena terdapat suara dan gambar yang bergerak, serta penyajiannya dapat dikontrol dan dapat diulang, didengar dan dilihat.(13). Animation Cognitive Behavior therapy (ACB) Therapy merupakan terapi berbasis psikoedukasi dengan menggunakan media animasi 2D yang diberikan kepada anak dalam upaya pencegahan pelecehan seksual. Oleh karena itu, terapi ACB dapat mempengaruhi pengetahuan anak, efikasi diri, dan mempengaruhi perilaku protektif pada anak. Selain itu, terapi ACB juga dilengkapi dengan pengetahuan dan keterampilan terhadap sentuhan yang tidak diinginkan atau langkah-langkah apa yang harus dilakukan anak ketika terjadi pelecehan seksual. Metode pendekatan kognitif dikemas dalam bentuk edukasi yang menarik
seperti animasi

dari kedua kelompok menunjukkan p = 0,000 (α < 0,05) yang berarti terdapat perbedaan tingkat efikasi diri yang signifikan antara kedua kelompok.

Tabel 2. Perbedaan rerata efikasi diri sebelum dan sesudah menerima animasi-kognitif terapi perilaku antara kelompok intervensi dan kelompok kontrol control

| Efikasi Diri | | Berarti | SD | nilai-p |
|---|---|---|---|---|
| Kelompok intervensi | Pra-tes | 35.11 | 4.69 | 0,000 |
| | Post-test | 44.23 | 6.65 | |
| Grup kontrol | Pra-tes | 36.06 | 4.58 | 0,200 |
| | Post-test | 36.49 | 5.38 | |

## DISKUSI

Berdasarkan hasil penelitian, tingkat efikasi diri antara anak pada kelompok intervensi, dan kelompok kontrol sebelum mendapat intervensi menunjukkan rasa kurang percaya diri. Dari hasil penelitian, sebagian responden menyatakan belum mendapatkan informasi tentang pelecehan seksual. Sebagian besar anak belum pernah menerima informasi tentang pelecehan seksual baik melalui media internet, televisi, maupun informasi dari orang tua dan guru. Selain itu rasa percaya diri anak yang rendah karena faktor pendidikan responden yang masih duduk di bangku sekolah dasar dan belum masuk kurikulum tentang pencegahan pelecehan seksual. Penelitian ini juga menunjukkan bahwa sebagian dari responden adalah usia sekolah, fokus pada kegiatan sekolah, dan bermain tanpa berpikir, seperti pelecehan seksual.(15). Hasil yang diperoleh anak-anak yang memiliki kepercayaan diri rendah memiliki persepsi negatif bahwa mereka tidak yakin untuk mencegah pelecehan seksual karena anak-anak tidak tahu tentang pelecehan seksual. Terbentuknya rasa percaya diri anak akan mempengaruhi fungsi kognitif, afektif, motivasional, dan selektif seseorang dalam memandang suatu masalah. (16).

Hal yang paling kuat yang mempengaruhi efikasi diri adalah pengalaman diri; pengalaman diri dapat ditingkatkan dengan menguasai pengalaman tertentu(14). Di sekolah, anak-anak, penguasaan dapat diterapkan dengan menyelesaikan tugas, menafsirkan, dan mengevaluasi hasilnya(17). Interpretasi ini dapat menciptakan penilaian anak terhadap kompetensi tertentu dan meningkatkan kepercayaan diri dalam menyelesaikan tugas yang sama atau berbeda(17). Pendapat Bandura tentang aspek kognitif dapat diartikan sebagai kemampuan seseorang untuk memikirkan cara menggunakan dan merancang tindakan yang akan diambil untuk mencapai tujuan yang diharapkan.

Berdasarkan hasil penelitian serupa (18) bahwa CBT dapat meningkatkan efikasi diri pada anak. Bandura mendefinisikan self-efficacy sebagai keyakinan manusia pada kemampuan mereka untuk melatih beberapa ukuran kontrol fungsi diri dan peristiwa di lingkungan mereka dan percaya bahwa self-efficacy adalah dasar dari agensi manusia. Selain itu, berdasarkan hasil penelitian(19) bahwa CBT merupakan terapi berbasis psikoedukasi untuk mencegah dan menangani kekerasan seksual pada anak. CBT mengandung komponen yaitu psikoedukasi, mengatasi masalah kognitif, dan meningkatkan keamanan pribadi, terapi CBT diberikan kepada anak, seperti mengajarkan anak untuk meningkatkan rasa percaya diri dan kemampuan anak untuk mengenali, melawan, dan melaporkan pelecehan seksual.(20). Penelitian sebelumnya menunjukkan bahwa menyediakan media animasi juga mampu meningkatkan efikasi diri seseorang. Efikasi diri positif adalah keyakinan untuk dapat melakukan perilaku yang diinginkan(21). Masalah efikasi diri pada anak karena kurangnya pengetahuan dalam

| Karakteristik Responden | Kelompok intervensi N % | | Grup kontrol | % | *Nilai-P* |
|---|---|---|---|---|---|
| **Mendapatkan Pelecehan Seksual** | | | | | 0,015 |
| **Informasi** | | | | | |
| Iya | 5 | 14.3 | 9 | 25.7 | |
| Tidak | 30 | 85.7 | 26 | 74.3 | |
| Total | 35 | 100 | 35 | 100 | |
| | | | | | 0,017 |
| **Orang yang Paling Dekat Dengan Anak** | | | | | |
| Orangtua | 33 | 94.3 | 28 | 80 | |
| Kakek/Nenek Teman | - | - | 2 | 5.7 | |
| | - | - | 2 | 5.7 | |
| Paman bibi | - | - | 3 | 8.6 | |
| dll | 2 | 5.7 | | | |
| Total | 35 | 100 | 35 | 100 | |
| **Anak Selalu Berbagi Dengan Orang Terdekat** | | | | | 0,433 |
| Iya | 31 | 88.6 | 32 | 91.4 | |
| Tidak | 4 | 11.4 | 3 | 8.6 | |
| Total | 35 | 100 | 35 | 100 | |
| **Tonton Video Porno** | | | | | 0,010 |
| Iya | 6 | 17.1 | 2 | 5.7 | |
| Tidak | 29 | 82.9 | 33 | 94.3 | |
| Total | 35 | 100 | 35 | 100 | |
| **Sentuhan Bagian Pribadi Anak** | | | | | 0,012 |
| Iya | 7 | 20 | 2 | 8.6 | |
| Tidak | 28 | 80 | 33 | 91.4 | |
| Total | 30 | 100 | 35 | 100 | |

**Perbedaan rerata efikasi diri sebelum dan sesudah diberikan terapi animasi-kognitif perilaku antara kelompok intervensi dan kelompok kontrol**

Tabel 2. Tingkat efikasi diri pada kelompok perlakuan dan kelompok kontrol sebelum (pre-test) dan sesudah (post-test) diberikan A-CBT (Animation-Cognitive Behavior Therapy) di SD X dan SD Y, Surabaya 2019.

Berdasarkan Tabel 2 terlihat pada awal pengukuran, seluruh responden pada kelompok intervensi efikasi diri rendah. Setelah diberikan Animation Cognitive Behavioral Therapy (A-CBT), setiap 5 sesi selama 3 minggu menunjukkan efikasi diri anak meningkat. Seluruh responden mengalami peningkatan efikasi diri. Rerata jumlah skor sebelum (pra) adalah 35,11 setelah diberikan perlakuan (pasca) 44,23. Hasil Wilcoxon Signed Ranks Test menunjukkan p = 0,000 (p < 0,05) yang artinya terdapat perbedaan yang signifikan tingkat efikasi diri sebelum dan sesudah A-CBT ada pengaruh efikasi diri sebelum pre-test atau sesudah post -uji.

Pada kelompok kontrol, selama kelompok intervensi diberikan A-CBT, kelompok kontrol menjalani rutinitas sekolah seperti biasa, rata-rata jumlah skor pada kelompok kontrol rata-rata sebelum (pra) adalah 36,06 setelah (pasca) 36,49. Hasil uji Wilcoxon Signed Ranks Test menunjukkan nilai p = 0,0200 (p>0,05), yang berarti tidak ada perbedaan yang signifikan atau tidak berpengaruh terhadap efikasi diri sebelum pre-test atau sesudah post-test. Hasil tes Mann Whitney

anak tentang pencegahan kekerasan seksual, sehingga anak tidak yakin dengan kemampuannya untuk mencegah pelecehan seksual.

Animation Cognitive Behavior Therapy adalah intervensi kognitif-perilaku berbasis psikoedukasi (19) menggunakan media animasi. Animasi dapat membantu memvisualisasikan materi pendidikan menjadi lebih mudah dipahami dan membentuk konsep yang lebih spesifik serta mendorong anak untuk mengeksplorasi lebih banyak animasi(21). Hal ini juga membuat kegiatan belajar menjadi kegiatan interaktif yang lebih menyenangkan dalam membangun pemikiran konseptual yang jernih(21). Mekanisme terapi ACB dalam mengatasi rasa percaya diri anak dilakukan dengan metode edukasi menggunakan media animasi. Tahap pertama, seperti peneliti, mengidentifikasi masalah perasaan negatif, pikiran, dan pengalaman otomatis dalam perspektif anak tentang pelecehan seksual yang memengaruhi kepercayaan diri anak dalam menghadapi masalah.

Berdasarkan hasil identifikasi selama intervensi, anak menunjukkan perubahan kognitif dan perilaku yang mempengaruhi efikasi diri anak, seperti kemampuan anak untuk mengetahui kekerasan seksual, jenis kekerasan seksual, dan cara pencegahan kekerasan seksual.

## KESIMPULAN

Terapi perilaku kognitif dapat meningkatkan efikasi diri anak dalam upaya mencegah pelecehan seksual. Berdasarkan temuan, perawat profesional dapat menggunakan animasi terapi perilaku kognitif untuk menjadi intervensi preventif dalam mengatasi pelecehan seksual.

### KEKUATAN DAN KETERBATASAN

Penelitian ini berbeda dengan penelitian sebelumnya karena intervensi yang digunakan adalah intervensi CBT dengan memberikan materi menggunakan media animasi 2D. Penelitian ini memiliki keterbatasan pertama, teknik pengambilan sampelnya adalah simple random sampling, sehingga datanya tidak homogen. Teknik sampling yang diambil menyebabkan penentuan responden, dimana jumlah responden berdasarkan karakteristik tidak berbeda-beda. Hal ini menimbulkan ketidakseimbangan variasi responden yang tidak mampu mewakili seluruh karakteristik responden.

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# CURRICULUM VITAE

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