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Effect of Play Therapy Intervention on Psychological Well-Being of Physically Abused Male Children

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ABSTRACT

This research aims to assess play therapy's influence in terms of social and emotional well-being for boys who have experienced physical abuse; concerning the hypothesis that indeed play therapy brings about such an influence. There were 9 subjects using purposive sampling based on a requirement of physical abuse aged between 8-12. A mixed methods approach was used that included the Strengths and Difficulties Questionnaire (SDQ) administered to the participants before and after the intervention combined with brief interviews. Consequently an integrated intervention plan was developed including the Tamar module for Physical Abuse and a range of approaches of play therapy. The statistical test applying SPSS 22 yielded a non-significant result with the calculated P value of 0.12 > 0.05 however slight improvement in the mean scores (Pre = 50.67; Post = 49.44) implies the social support need has enhanced the children psychological well-being.

Keywords: *Play therapy; Psychological well-being; Physically abused children; Emotional expression; Intervention strategy; Child welfare practices; Mental health outcomes*

INTRODUCTION

Child abuse or maltreatment constitutes all forms of physical and or emotional ill treatment, sexual abuse, neglect or negligent treatment, or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship or responsibilities, trust or power (WHO, 1999).

Child maltreatment is a term that refers to both acts of commission and acts of omission; it encompasses not only abusive words or actions which cause actual or potential harm to the child, but also in the case of acts of omission, parental neglect. This happens when the child's caretaker fails to provide for the physical, emotional or educational care of the child that has an effect on the child. These abusive acts can be performed by an individual who can either be a parent or at institutions like in hostels or schools or during processes like war or famine which as a result of it damages the prospects of healthy development of a child into adulthood (Mehnaz. 2018).

Research Background

Play therapy, when we use that term, is a treatment modality that is intended for children, but is actually translated into a language that a child understands and can engage in, referred to as the language of play. However, using play does mean there may still be questions for the referring provider or practitioner

about the nature, process and results of play therapy (Kool & Lawver, 2010). It is clear that developmental and cultural approaches can be indicated.

Play is how children take in knowledge, create meaning, make sense of their world, revisit and work through significant parts of their lives, and communicate their meaning with others. Children's ability to communicate their pain through their play makes it one of the most effective means available (Draper et al., 2001). Stimulating the right hemisphere of the brain, which responds to non-verbal modalities such as play, art, music and sand play therapy, assists in the processing of trauma (Gil, 2006). By using play, children will be able to express their abuse and can stay emotionally safe by either making the toy feel the pain rather than themselves or by making a toy the abuser (Landreth, 2001). They will also learn to come to an acceptance of what has happened to them and learn new ways of coping to protect themselves from further abuse (Cattanach, 1992 ; Landreth, 2001). Physical abuse has a detrimental impact on both the physical and emotional well-being of children. In addition to physical injuries, children can suffer emotional, behavioral and social consequences and as a result of it low self-esteem, impaired social skills, learning problems, and an impaired capacity to enjoy life are just some of the consequences predominantly seen in physical abuse which affect children's psychological well-being (Gil, 1991).

In 2016, Zainab and Kadir conducted a study to examine the prevalence of physical abuse among domestic child laborers in Karachi. The study also assessed the children's nutritional status through BMI measurements. Using a cross-sectional approach in Karachi's squatter settlements, the researchers found that 8.3% of domestic child laborers had experienced physical abuse. Additionally, just over 9% were classified as underweight, while nearly 90% were found to be stunted—highlighting significant concerns regarding both abuse and malnutrition in this vulnerable population. The main findings of this study highlighted that 95% of the children involved in domestic labour perform overtime work in their employer's home more than once per week (Zainab & Kadir, 2016). When talking about physical abuse, children usually suffer more victimizations than do adults which includes more conventional crimes, family violence and some forms are virtually unique to children such as family abduction. (Zainab & Kadir, 2016). National data indicate that these forms of victimization can be classified into three main categories. The first encompasses widespread issues such as cyberbullying and sibling aggression, which affect a broad segment of children. Next are acute incidents like physical assault—less common, but still impacting a significant minority. Finally, there are the most severe cases, such as homicide, which are rare and affect only a very small proportion of children. It was also be differentiated by the degree to which they result from the unique dependency status of children and the findings suggested that there is high burden of physical abuse among the domestic child labour and these children are malnourished so there is a dire need to recognize and regulate this form of labour in Pakistan. (Zainab & Kadir, 2016). Building on the findings, the study proceeded to examine the effects of play therapy interventions on the psychological well-being of children who have experienced physical abuse.

Problem Statement

This research seeks to determine whether play therapy interventions can effectively enhance the psychological well-being of physically abused male children.

Purpose of Research

While prior studies have explored the general effectiveness of play therapy, there remains a notable gap regarding its specific impact on the psychological wellbeing of physically abused male children. This research aims to address that gap, offering a structured model to promote psychological health in this vulnerable group.

Furthermore, the study's implications extend beyond the children themselves. Practitioners, parents, and social workers may benefit from insights on how to support children through trauma and help them manage stress using play therapy interventions. The research will also identify protective factors—such as the child's perception of their problem, the availability of family support, coping strategies, and self-help beliefs—that may influence outcomes. These factors will be examined to provide a more comprehensive understanding of the therapeutic process.

Research Objectives

The primary goals of this research are:

1. To enhance the psychological well-being of male children who have experienced physical abuse.
2. To evaluate the effectiveness of play therapy interventions in improving the psychological well-being of these children.

Research Questions

1. To what extent can play therapy interventions improve the psychological well-being of physically abused male children?
2. What impact do play therapy interventions have on the psychological well-being of male children who have experienced physical abuse?

Hence, it is hypothesized that

"There would be a significant difference before and after the play therapy interventions of psychological well-being of physically abused male children".

Importance of the Research

For years, researchers have explored ways to enhance children's wellbeing, often focusing on strategies to prepare and support them for a healthier future. This study contributes meaningfully to that ongoing conversation by specifically addressing the psychological needs of children affected by physical abuse. Through the application of intervention play therapy, the research seeks not only to mitigate the harmful impacts of such experiences but also to promote healing and resilience.

Importantly, the findings offer a practical framework for professionals, parents, and social workers, providing actionable guidance that extends beyond meeting children's physical needs to encompass their psychological welfare. By highlighting these aspects, this study emphasizes the critical role of mental health in overall child development and underscores the necessity of prioritizing psychological care. Ultimately, it aims to raise awareness and inspire more comprehensive approaches to supporting children's well-being.

LITERATURE REVIEW

2.1 Psychological Wellbeing

In order to measure well-being, it is important to be clear from the outset about the form of well-being being measured (Warr & Icenogle, 2012). There are, however, multiple definitions of well-being and no consensus as to what 'well-being' actually is (Selwyn & Wood, 2015). This research doesn't stick to one strict definition, but it's still important to consider the main theories about well-being, especially as they

relate to children in care. The National Institute for Health and Care Excellence (2013) highlights three key aspects: emotional well-being, psychological well-being, and social well-being. So, well-being isn't just one thing—it's made up of several interconnected parts.

Alternatively, Weare (2015), a leading academic in the field of child well-being and mental health, defines well-being as a state of positive mental health and wellness. It involves a sense of optimism, confidence, happiness, clarity, vitality, self-worth, achievement, having a meaning and purpose, engagement, having supportive and satisfying relationships with others and understanding oneself, and responding effectively to one's own emotions (Weare, 2015). Seligman (2018) on the other hand defined well-being through five core elements: Positive emotions -feeling good, Engagement -finding flow, Relationships -authentic connections, Meaning -purposeful existence; and Achievement -a sense of accomplishment (Seligman, 2018).

Assessing wellbeing isn't straightforward due to its deeply personal nature. As Selwyn and Wood (2015) highlight, there's a clear distinction between subjective well-being—defined by individuals themselves—and objective well-being, which is determined externally. The methods for evaluating these differ quite a bit. Objective approaches involve researchers selecting specific criteria they believe are essential for well-being—things like economic status, quality of life measures, or environmental conditions—and then using indicators to gauge whether those criteria are being met. Subjective measures, in contrast, focus on individuals' self-assessments, relying on personal feelings and perceptions to evaluate well-being. This contrast underscores the complexity of capturing a concept as nuanced and individual as well-being.

The placed subjectivity of these measures comes from the focus on what a person feels e.g. life satisfaction, happiness, instead of the fact that they are self-reporting (Selwyn & Wood, 2015). Taking into account the various wellness theories discussed earlier, it's clear that psychological well-being is absolutely central to a person's overall health. Psychological well-being is usually conceptualized as a combination of positive affective states such as happiness (the hedonic perspective) and functioning with optimal effectiveness in individual and social life (the eudemonic perspective (Deci, 2008). Huppert (2009) summarized psychological wellbeing as a combination of feeling good and functioning effectively . Honestly, if the mind isn't doing well, everything else tends to fall apart. Individuals who demonstrate high psychological wellbeing typically report feeling genuinely happy, confident in their abilities, well-supported by others, and generally satisfied with their lives. It's not just an add-on to wellness; it's the foundation. Huppert's (2009) review also claims the consequences of Psychological Well-Being to include better physical health, mediated possibly by brain activation patterns, neuro-chemical effects and genetic factors (Huppert, 2009).

Diener (1997) claims that psychological well-being refers to how people evaluate their lives. These evaluations may be in the form of cognitions or in the form of affect (Diener, 1997). The cognitive aspect essentially involves individuals consciously evaluating their own lives, forming judgments regarding their overall satisfaction. In other words, it's an internal process where a person reflects and assesses, "Am I content with where I am?". The affective part is a hedonic evaluation guided by emotions and feelings such as frequency with which people experience pleasant/unpleasant moods in reaction to their lives (Diener, 1997).

World Health Organization (2004) proposes the following definition of mental health describing it as the 'foundation for well-being': A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2004).

Studies of Midlife America (MIDUS) show that subjective well-being appears to get better from age 25 to 74. As a rule, positive affect increases whereas negative affect decreases as we age. Interestingly, research

suggests that psychological well-being generally increases with age. As people grow older, they tend to view their lives more positively, indicating an upward trend in overall mental satisfaction over time. Four of the six dimensions of psychological well-being increase with age in the midlife in the United State (MIDUS) study by Barry (2014), while personal growth and purpose in life show age decrements. Social well-being, on the other hand, reveals a more balanced profile of age increments (i.e., in social integration and social acceptance) and age decrements (i.e., in social contribution and social coherence), while social actualization is lowest among the young and oldest adults i.e., it peaks in middle-age (Radler et al., 2015).

Well-being of Children

Psychological wellbeing plays a vital role in supporting children in care. It's not enough to simply assess for the presence or absence of mental illness—emotional and mental health go far beyond that. However, Luke et al. (2014) also stress that research on looked after children should have a greater focus on positive outcomes, and less on problems, with children in care wanting studies about them doing well on their own terms (Luke et al., 2014).

The Children Act (2004) actually mandates that local authorities, along with partners like health services and schools, must work together to promote the well-being of children in their area. This responsibility isn't vague either; it's tied to five clearly defined outcomes that guide their efforts. In practice, this means a coordinated approach is expected to ensure no child's needs are overlooked. They are: Physical and mental health and emotional well-being; protection from harm and neglect; education, training and recreation; the contribution made by them to society; and social and economic well-being (Children Act, 2004).

Despite the steps taken by the government to ensure children's well-being they have failed to take into account the difficulties faced in forming healthy attachments and trusting relationships (Sweeney, et al., 2004). Supporting these children as they work through challenges is genuinely important for their overall well-being. Since they're separated from their birth families, their experiences—especially around forming their identities and understanding their own lives—differ quite a bit from those of their peers. Identifying a child's potential and helping them realize it isn't straightforward for carers or professionals; it's actually pretty complex. This is particularly so given the traumatic experiences from which many children in care are recovering and the relatively poor longer-term outcomes associated with being in care (Sweeney, et al., 2004).

There are just so many factors, across all areas of life, that can impact a child's sense of well-being. There are also many domains of well-being that make up objective measures that can be applied with children (Matza et al., 2004). However, a number of researchers have observed aspects involved in measuring children's well-being that come into play in practical situations. For example, children may provide repetitive or extreme responses; may answer the question with an eye toward pleasing the interviewer; may answer questions they do not understand to appear competent (Matza et al., 2004); and they may simply have limited understanding of the most relevant terms.

Several organizations have attempted to develop their own frameworks for assessing the well-being of children in care, acknowledging that children's communication preferences and needs evolve over time and may be influenced by additional challenges. While such frameworks are promising, the authors concede that external observers still possess only limited insight into the internal experiences of these children. This limitation highlights the importance of incorporating self-reported measures of well-being, as these provide a more direct understanding of a child's emotions and perspectives—particularly for those in unstable or short-term placements. These organizations therefore developed different versions of their measurement tools and adapted methods of administration, for example, by asking a trusted adult to

fill out a questionnaire alongside any children who were unable to do this by themselves (Selwyn et al., 2017).

Research on the psychological measures of wellbeing of children thus consistently notes the value of including multiple informants, particularly parents (Nakamura et al., 2011). It can be concluded, as it was by Tarren-Sweeney et al (2004), that where a child is in long-term placement, foster parents or teachers would be best to comment on most aspects of their well-being. Nonetheless, significant work remains. There is a clear need to establish reliable methods for comparing data over time, so that progress and outcomes can be meaningfully assessed. At present, the field is only beginning to address these complexities.

Hannon et al. (2010) and argue that, due to different experiences, it is unfair to compare outcomes for looked after children with children who are not looked after or in need. Sebba et al. (2017) believe a fairer comparison is to look at children who are in need but live at home as they provide an additional, and in some cases more suitable, comparison group. They also argue for a greater examination of progress when in the care system as a means of judging the effectiveness of care (Sebba et al., 2017).

Play Therapy

In recent years a growing number of noted mental health professionals have observed that play is as important to human happiness and well-being as love and work (Schaefer, 1993). Alright, let's be real—people have been obsessed with "why we play" since, well, forever. Seriously, you've got Aristotle and Plato tossing around deep thoughts about it like it's some grand mystery. And honestly, I kind of get it. Play isn't just goofing around (though, hey, that's part of the charm).

Landreth (2002) basically says play is a good time that can totally flip your mood. It's like a mood-lifter and perspective-changer rolled into one. Plus, it helps you figure out who you are, express yourself without all the usual filters, and actually believe you can do stuff (self-efficacy, if you wanna get fancy). Stress and boredom? Play just kicks them to the curb. It also makes connecting with other humans way easier—we're talking more laughs, more creativity, more weird ideas to try out. And yeah, it kind of keeps your emotions in check and pumps up your confidence, too.

But here's the kicker: play is practice for life. Like, you get to try out roles and skills you'll actually need later on, but without all the pressure. And if you've ever wondered what play therapy is all about? It's just using play as a clever way to get people—especially kids—to talk about what they're feeling, without having to blurt it out in a boring conversation. Learning and development are best fostered through play (Landreth, 2002).

Based upon the fact that play is the child's natural medium of self-expression, play therapy is an opportunity that is given to the child to play out his feelings and problems just as in certain types of adult therapy where an individual talks out his/her difficulties (Axline, 1964). Play therapy builds on the natural way that children learn about themselves and their relationships in the world around them (Axline, 1964; Carmichael, 2006; & Landreth, 2002).

The therapy of playing promotes the communicated feelings, understanding of behavioral changes, awareness of problem-solving techniques and learning to relate to others through many different ways of being, all done through play. Play gives children a safe psychological distance to confront their feelings that are developmentally appropriate and allows them to express their thoughts and feelings with a safe facilitator (Carmichael, 2006; Landreth 2002 ,Connor & Schaefer 1994). Play therapy's basically a legit, structured way to help kids work through stuff—think of it as therapy, but with toys, games, and maybe a

little chaos (the good kind). It's not just random playtime; there's actual theory behind it. The whole thing taps into how kids naturally learn and talk—through playing, not sitting quietly in a chair and spilling their feelings like adults do. Playing draws on its curative powers in many different forms. Therapists strategically utilize play therapy to help children express what is troubling them when they do not have the verbal language to express their thoughts and feelings (Gil, 1991). In play therapy, toys are like the child's words and play is the child's language (Landreth, 2002) . Through play, therapists may help children learn more adaptive behaviors when there are emotional or social skills deficits (Reddy, (2010). The positive relationship that develops between therapist and child during play therapy sessions can provide a corrective emotional experience necessary for healing (Moustakas, 1997).

Schoeman and Merwe (1996) consider play therapy to be the use of play to assist children, in therapy, in dealing with their particular problems. This involves the use of various play materials and the therapist being in tune with the needs of each unique child (Schoeman & Merwe, 1996). Even complex challenges can be effectively addressed through play-based approaches. Individuals are able to develop, practice, refine, and ultimately master new strategies within these modalities. Over time, these skills can become integrated into long-term coping mechanisms, forming a foundation for adaptive problem-solving in various contexts. Although everyone benefits, play therapy is especially appropriate for children ages 3 through 12 years old (Carmichael, 2006; Gil, 1991; Landreth, 2002; Schaefer, 1993). Engagement in play-based methods is not limited to children; adolescents and adults can also derive significant benefit from these approaches. To that end, use of play therapy with adults within mental health, agency, and other healthcare contexts is increasing (Carroll, 2005; Schaefer, 2003). In recent years, play therapy interventions have also been applied to infants and toddlers (Schaefer, 2003).

Play therapy is implemented as a treatment of choice in mental health, school, agency, developmental, hospital, residential, and recreational settings, with clients of all ages (Carmichael, 2006; Reddy et al., 2005). Play therapy treatment plans have been utilized as the primary intervention or as an adjunctive therapy for multiple Social, Emotional, and Behavioral Disorders (Bratton et al., 2005; Lin & Bratton, 2015; Ray et al., 2015; Reddy et al.,2005), e.g. anxiety disorders, obsessive-compulsive disorders, depression, attention deficit hyperactivity, autism spectrum, oppositional defiant and conduct disorders, anger management, crisis and trauma, grief and loss, divorce and family dissolution, academic and social developmental, and physical and learning disabilities (Bratton et al., 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, 2015; Ray et al., 2015; Reddy et al., 2005).

There is an ample amount of research that supports the effectiveness of play therapy with children experiencing a wide variety of social, emotional, behavioral, and learning problems, including: children whose problems are related to life stressors, such as divorce, death, relocation, hospitalization, chronic illness, assimilate stressful experiences, physical and sexual abuse, domestic violence, and natural disasters (Reddy et al., 2005). Play therapy helps children become more responsible for behaviors and develop more successful strategies, develop new and creative solutions to problems, develop respect and acceptance of self and others, learn to experience and express emotion, cultivate empathy and respect for thoughts and feelings of others, learn new social skills and relational skills with family, develop self-efficacy and thus have a better assuredness about their abilities (Moustakas, 1997).

Engagement in play-based methods is not limited to children; adolescents and adults can also derive significant benefit from these approaches. Family involvement is a critical component in the healing process for children. The dynamics between a child's challenges and their family environment are often complex. In some cases, a child's difficulties may signal underlying issues within the family system. Conversely, a child's behavioral or emotional struggles can disrupt family functioning as a whole. Regardless of the origin, collaborative healing—where both children and their families participate—tends to produce more rapid progress.

The play therapist carefully evaluates when and to what extent to involve family members in therapeutic interventions. At a minimum, consistent communication with the child's caregivers is maintained, typically through weekly contact. This ongoing dialogue is essential for developing an effective treatment plan, addressing emerging concerns, and monitoring therapeutic progress over time .Other options might include involving the parents or caretakers directly in the treatment by In recent years a growing number of noted mental health professionals have observed that play is as important to human happiness and well-being as love and work (Schaefer, 1993).

Physical Abuse

The term "abuse" appears frequently in conversation, yet its precise meaning is often overlooked. According to the Gale Encyclopedia of Medicine, abuse is defined as any intentional action that causes injury or harm to another individual. This encompasses a wide range of behaviors—physical, psychological, sexual, verbal, financial, spiritual, elder abuse, among others. Within familial contexts, abuse is frequently referred to as domestic abuse or domestic violence (Bratton et al., 2005).

While the dictionary definition is relatively straightforward, the actual experience of abuse is far more complex. At its core, abuse involves deliberate harm, but it is fundamentally about control. No individual has the right to exert control over another through abusive behaviors. Victims must understand that the responsibility for abuse lies solely with the perpetrator; it is never the victim's fault. Every person has the inherent right to live free from abuse (LeBlanc & Ritchie, 2001). Abuse is not limited to adults—children and adolescents are also vulnerable. A comprehensive global meta-analysis, which examined 111 studies and nearly 10 million participants, estimated that over 22% of children have experienced physical abuse. This statistic starkly contrasts with the ideals set forth in the United Nations Convention on the Rights of the Child and underscores the pervasiveness of the problem worldwide (Stoltenborgh et al., 2013).Abuse transcends boundaries of age, gender, socioeconomic status, education, and ethnicity; anyone may become a victim. Recognizing the forms of abuse is essential in identifying and preventing further harm (Lin & Bratton, 2015).

Focusing specifically on physical abuse, the New York State Office of Children and Family Services defines it as the non-accidental use of force that results in bodily injury, pain, or impairment. Physical abuse can range from relatively minor acts such as slapping to more severe injuries like broken bones. Other examples include physical restraint (e.g., being tied to a chair), burning, cutting, slapping, punching, kicking, biting, choking, stabbing, shooting, withholding food or medical attention, drugging, denying sleep, and inflicting pain on others, including animals (LeBlanc & Ritchie, 2001). Physical abuse is frequently cyclical. Not every interaction within an abusive relationship is physically violent, but typical patterns include threats of violence ("If you do that again, you'll be sorry"), acts of physical aggression, subsequent apologies or displays of affection from the abuser, and, ultimately, repetition of the cycle. This cyclical nature complicates both recognition and intervention.

METHODOLOGY

This study utilized a quantitative, pre-post experimental design, conducted with a group of nine male participants. The intervention occurred within a group setting, and assessments were administered before and after the intervention to evaluate its effectiveness.

The study specifically targeted male children, focusing on those between the ages of 8 and 12, all residing in Karachi, Pakistan. Participants were selected through purposive sampling, ensuring that each individual had a documented history of physical abuse.

Inclusion Criteria

- Participants were required to have a documented history of physical abuse.
- Only children aged between 8 and 12 years were considered eligible for the study.

Exclusion Criteria

- Individuals without a past history of physical abuse were not included.
- Children younger than 8 years or older than 12 years were excluded from participation.

Measures

Informed Consent Form

An informed consent form was secured from the parent or appropriate legal guardian, as the participants were between 8 and 12 years old. This procedure was essential to comply with ethical standards for research involving minors. The document explain and offered the assurance of confidentiality and reassured the children of any potential risk or discomforts arising in the course of the research. The document assures confidentiality with respect to the children responses and indicated that the children can choose to extract from the research project at any other time.

Demographic Information

The parent demographic forms collected essential details—age, gender, educational background—for each participant. This process ensured that only children within the targeted 8 to 12 age range were included in the study, aligning with the project's eligibility criteria.

Clinical Interviewing

Each participant underwent a comprehensive clinical interview. The primary aim was to obtain a thorough account of the child's trauma history, with particular focus on incidents of physical abuse, and to explore the coping strategies they utilize in response to stressors. Sessions began with a formal greeting and introduction to establish rapport. Following this, participants were given the opportunity to express themselves freely and discuss their experiences.

Strengths and Difficulties Questionnaire (SDQ) Urdu Version

The Strengths and Difficulties Questionnaire (SDQ), in its Urdu version translated by Humaira Jami and colleagues, is widely recognized as an effective screening tool for assessing emotional and behavioral problems in children and adolescents aged 3 to 17 years. The original SDQ was developed by Robert Goodman in 1998 and has since been adapted into various languages, including Urdu, to ensure broader accessibility.

This instrument comprises 25 statements, each rated by respondents on a three-point scale to indicate the extent of their agreement. The responses are categorized into five subscales: hyperactivity/inattention, emotional symptoms, conduct problems, peer relationship problems, and pro-social behaviors (the latter reflecting strengths rather than difficulties). Each of these subscales generates a score, which are then combined to produce an overall 'total difficulties score' for each individual. This total score ranges from 0 to 40.

Interpretation of the scores is as follows: a score below 14 is classified as 'normal,' scores between 14 and 16 are considered 'borderline concern,' and scores greater than 17 fall within the 'concern' range. The SDQ's structured approach makes it a valuable tool for early identification and intervention in the context of child and adolescent mental health.

Therapeutic Plan with Intervention

The intervention commenced with a thorough exploration of each child's personal history. This process involved clinical interviews, allowing for a comprehensive understanding of the children's traumatic experiences—particularly instances of physical abuse—as well as their individual coping mechanisms for managing stress.

At the beginning of each session, facilitators prioritized establishing a welcoming environment through a formal introduction. Children were given space to express and process their emotions, encouraging a sense of catharsis. To build rapport and ease initial tension or anxiety, the "Bubble Breaths" exercise was introduced as an icebreaker. This activity not only fostered connection between the facilitator and the child but also helped to alleviate feelings of anger or anxiety present at the outset.

Sessions	Aim/ Objective	Materials needed
1 : Relaxation Training	It is very practical and effective technique, developed to give children the opportunity to learn deep and controlled breathing, while they begin to recognize their mind and body connection (Hall, Kaduson & Schaefer, 2002). It is a low-cost, fun technique that offers a sense of non-threatening connection between the child and therapist. This technique is particularly helpful in reducing anger, anxiety, or tension in children.	The practitioner begins by filling the room with bubbles. Most children immediately begin popping them as they fall. After a time, the therapist will ask the child to blow just one big bubble. At first, the therapist teaches the child to breathe slowly and deeply from the stomach, exhaling out slowly from the mouth. The therapist then begins to explain to the children that when they are angry or anxious, their brain wants more air. But their lungs are working too hard being upset to get it. If they breathe correctly, then their brain will tell their heart to slow down and their lungs will

		work better. Then the therapist will tell the children that if they take bubble breaths when they start to be angry, nervous or tense, they can often avoid doing angry behaviors (Hall, Kaduson & Schaefer, 2002).
	The goal of this session would be for each member to define physical abuse and also understand how physical abuse has affected their life (T.A.M.A.R module for physical abuse, 1999).	QUESTIONS 1. In your opinion, what constitutes physical abuse? 2. What process might be at work in terms of the relationship and dynamics between the abuser and the victim, which can make the likelihood of them becoming a victim of physical abuse, greater?
2: Psychoeducation on physical abuse	This session would aim for each participant to define physical abuse, and they would have an understanding of the impact physical abuse had in their life. Participants would be asked a number of questions in order to check their understanding of physical abuse, but it also would help them begin to understand the impact physical abuse has had on her life.	QUESTIONS 1. How do threats and intimidation contribute to physical abuse? 2. How has physical abuse affected your life? Your relationship?
Session 3: The Story of My Family	This activity's purpose would be to mitigate children's feelings of ambivalence when they have a history of child abuse (Slivinske, J., &Slivinske, L., 2011).	A worksheet titled "My Family" would be used to help the child clarify their feelings and conflict surrounding the abuse.
Session: 4 Relationships	Stress and trauma can affect your ability to relate to others. For example, early life trauma may hinder your ability to establish connection with others. Since child abuse usually occurs within the context of a caregiving relationship, this abuse can severely impair the child's relationship concepts and their meaning. An abused child cannot be expected to	The participants will be instructed to create two collages. The first collage will help them explore roadblocks to their ability to connect with others. The second collage will help them to think about important elements of being able to connect with others, and what they need to start connecting.

	experience relationships as safe or life enhancing. Also, healthy relationships with others can assist individuals in replenishing their depleted internal environment from traumatic stress; provide a sense of being needed; establish purpose in your life; and allow the possibility of warmth, care, and playfulness between humans. It is important for the purpose of the session to help children understand that they are responsibly and effectively interdependent, and all the while they can get what they need on their own and also can direct their efforts, talents and abilities in collaboration with other people to achieve the benefit of having this work be significant and satisfying.	
Session: 5 Relationship Building	The same activity that was done during the session 4 will be continued at the fifth session.	
Session: 6 Coping Collage	The purpose of this activity is to assist child's self-awareness, and to practice paying attention to oneself mindfully. This activity will also support positive self- talk through verbalizations of positive self-qualities and increase self-esteem due to identifying and expressing positive characteristics of oneself (Brown, P., 2009)	File folder, markers, Craft supplies such as glitter, scrapbook, papers, glue, stickers (Optional), Paper, pen or pencil

The therapist initiates the session by introducing the activity as a structured intervention designed to address negative thought patterns and provide a repository for affirming and supportive messages. The client is instructed to label a file folder with their name and the title “Feel Good File.” Creative expression is encouraged, and clients may use a variety of craft supplies to decorate the folder with positive imagery.

The next step involves self-reflection: the client is asked to write down ten positive personal qualities on a sheet of paper. This document is then placed inside the Feel Good File for future reference.

Subsequently, the client is encouraged to identify three individuals—such as parents, siblings, friends, teachers, or extended family members—who might be willing to write a letter of affirmation, each containing at least five positive observations about the client. The therapist may provide suggestions if the client has difficulty identifying potential contributors. This task is assigned as homework to be completed before the next session, though it may also be conducted during family therapy if time permits. As these letters are received, they are added to the Feel Good File. Clients are also advised to include any other

forms of positive communication—such as notes, emails, or cards—that convey encouragement or appreciation. Additionally, clients are invited to recall and record past instances in which others have acknowledged their strengths or talents, and to include these written accounts in the file.

The therapist then introduces the concept of mindfulness, guiding the client through a mindful review of the folder's contents. Mindfulness is characterized by intentional, non-judgmental awareness of present-moment experiences (as defined by Kabat-Zinn). During this exercise, the client is prompted to notice their emotional responses, thoughts, and any physiological sensations that arise while reviewing the file. If negative thoughts or feelings emerge, the client is asked to acknowledge them and then practice letting them go—potentially by visualizing these thoughts as clouds drifting away in the sky. Through this visualization, the client practices releasing negative cognitions and returning focus to the present.

Clients are encouraged to engage with their Feel Good File at least once per week, or whenever negative self-talk becomes apparent. Regular review of the file provides opportunities for practicing mindfulness, challenging negative thoughts, and reinforcing positive self-perceptions. Clients are further encouraged to continue adding affirming materials to their file, thereby cultivating an ongoing source of positive reinforcement.

Red flags would be discussed

- Progress would be noted
- "Can you use a puppet so that you may hypothetically create a Symbolic Client for posttesting purposes?"
- Check out the sessions**.**

Procedure

The Ethics Committee at the Institute of Professional Psychology, Buharia University, Karachi Campus, approved this study (No. IPP/BU/OM/102/2020). The investigators then sought permission from the relevant authorities at Aas Trust before approaching potential participants. The clinical head gave consent for the participation of the subjects, and histories for each child were requested from their respective counselors. The present study utilized the Strengths and Difficulties Questionnaire (SDQ) Urdu Version (Jami, Younis, & Masood, 2016) as a pre-test in order to further the intervention process. Of the six mini-intervention group therapy sessions aimed at helping children cope through their traumatic experiences, a post-assessment was done through the Questionnaire Strengths and Difficulties Questionnaire (SDQ) Urdu Version (Jami et al., 2016).

Ethical Considerations

Throughout the research, the investigator maintained respect for each participant's rights and dignity, ensuring their well-being was protected at all times.

Participants received a clear explanation of the study's purpose and procedures before taking part. Consent was obtained from everyone involved. They were also assured that any data collected would remain confidential. Importantly, participants were informed from the start that they could withdraw from the study at any point, without any consequences.

RESULTS

Based on the analysis of both pre- and post-intervention data, the demographic details of the study participants are presented below:

Table 2

Mean Age of Participants for the Study (N=9)

Characteristics	F (%)
Age	
8 year	0(0%)
9 year	3(33.3%)
10 year	1(11.1%)
11 year	3 (33.3%)
12 year	2(22.3%)
Gender	
Male	8(100%)
Education	
Pre-Primary	1 (11.2%)
Primary	4 (44.4%)
No Education	4 (44.4%)
Birth Order	
First	0(0%)
Middle	8(88.9%)
Last	1(11.1%)
Ethnicity	
Urdu Speaking	2(22.2%)
Bengali	5(55.6%)
Punjabi	2(22.2%)
Religion	
Islam	9(100%)
Family Structure	
Nuclear	5(55.6%)

Joint	4(44.4%)

Output

Table 2 presents an overview of the demographic characteristics for participants in this study. The table organizes the demographic variables into subgroups, illustrating how these variables are distributed within the sample (N=9).

Table3

Descriptive statistics and Alpha Reliability Coefficients, Univariable Normality of Study Variables (N=9)

Variable	Items	A	M	SD
SDQ-Pre	25	.682	50.67	6.23
SDQ- Post	25	.715	49.44	6.56

The relationship is notable, reaching statistical significance at the 0.01 level (two-tailed). "SDQ Pre" refers to the Strengths and Difficulties Questionnaire administered before intervention, while "SDQ Post" indicates the measure after intervention. "M" denotes the mean, and "SD" refers to the standard deviation.

Table 4 presents descriptive statistics and results from the paired sample t-test for the Strengths and Difficulties Questionnaire—including all its subcategories—administered before and after the intervention among participants (N=9).

	Pre-Test		Post Test				95% CI	
Scales	M	SD	M	SD	t	P	LL	UL
SDQ	50.67	6.23	49.44	6.56	1.739	.12	-.398	2.843
Internalizing	7.22	2.635	5.67	4.12	1.31	.29	-1.61	4.72
Externalizing	9.22	4.18	8.22	5.54	1.16	.28	-.997	2.997
EP	4.11	1.45	3.44	2.70	.853	.42	-1.14	2.47
CP	4.67	2.18	4.56	3.54	.132	.89	-1.83	2.05
HS	4.11	1.90	3.67	2.29	1.0	.35	-.58	1.47
PPS	3.00	1.58	2.22	1.92	.98	.36	-1.06	2.6
PS	5.67	2.29	6.67	1.50	-1.16	.28	-2.99	.997
TDS	15.89	5.39	13.89	8.88	1.07	.32	-2.33	6.33

Here's a breakdown of the abbreviations: CI denotes confidence interval, LL is lower limit, UL means upper limit, EP refers to Emotional Problem, CP is Conduct Problem, HS stands for Hyperactivity Scale, PPS indicates Peer Problem Scale, PS is Prosocial Scale, and TDS represents Total Difficulty Score.

The table presents descriptive statistics and results from a paired sample t-test, focusing on pre- and post-test scores among physically abused participants. The reported p value for the SDQ exceeds .05,

indicating that the difference is not statistically significant. In summary, there were no meaningful changes observed between the pre-test and post-test scores in this group.

DISCUSSION

In this study, we anticipated a meaningful relationship between play therapy interventions and the psychological well-being of physically abused boys. The sample was admittedly small—eight boys, aged 8 to 12, selected specifically because of their experiences with physical abuse. To track changes in their psychological and emotional health, we administered the Strengths and Difficulties Questionnaire (SDQ) both before and after the intervention.

For the intervention itself, we combined elements from the Tamar module on physical abuse with established play therapy techniques drawn from prior research. The goal was straightforward: to help children manage trauma and stress using play-based strategies, thereby supporting improvements in their psychological health.

Statistical analysis was conducted using SPSS 22. According to the paired sample t-test results (see Table 4), the findings were not statistically significant (P = .12, which is above the conventional .05 threshold). However, there was a slight reduction in mean scores—from 50.67 before the intervention to 49.44 afterward—suggesting a modest improvement in psychological well-being, even if not dramatic.

The effectiveness of psychological interventions for children, especially those involving play therapy, remains a contentious issue within the mental health field. The U.S. Public Health Service (2000) emphasized the urgent need for early, empirically supported interventions tailored to children's developmental needs. While play therapy is widely used among child therapists and is considered developmentally appropriate, it is often criticized for lacking a solid research base to justify its extensive use.

A comprehensive meta-analysis encompassing 93 controlled studies (spanning publications from 1953 to 2000) assessed the overall effectiveness of play therapy. Results indicated that humanistic approaches within play therapy were more effective than non-humanistic ones, and that parental involvement further enhanced outcomes. The analysis also showed consistent benefits across age, gender, and presenting problems.

Given the ongoing debate regarding the evidence base for play therapy—especially for children who have experienced physical abuse—this study sought to contribute further data by focusing on this specific population. We hypothesized that play therapy interventions would have a positive impact on the psychological well-being of physically abused children, helping them cope more effectively with trauma.

It is important to note several potential confounding factors. All participants had been receiving individual therapy on a weekly basis for six to eight months prior to the study, and had established strong therapeutic relationships. Additionally, the rehabilitation center offered a highly supportive environment, prioritizing unconditional positive regard for children who had often endured a spectrum of traumas, including physical, emotional, sexual, and psychological abuse. The collaborative atmosphere among staff and clinicians functioned as a supportive community, all working together to facilitate the children's reintegration into society.

As discussed earlier that this work is done in a rehab center where one of the extraneous variables was irregularity of sessions where they had sudden alteration in their daily routine could be one of the reasons of not having significant results.

Mediator was assigned for this group from the respective clinical supervisor but due to mediator's personal commitments; sometimes she was not available, due to which the facilitator has to manage things single handedly but as it was discussed earlier that good rapport was there so children used to share their things openly but this can be an extraneous factor to look upon.

Group of 12 participants were decided initially to be a part of research study but since the children live in a rehab setting, so few children drop out after pre-intervention or intervention phase. Sometimes it was also seen that they were having mood swings and temper issues due to which they resist to take the group and the facilitator find it as a real challenge.

Another possible factor could be of the sample size which was less due to which the results were insignificant. Additionally, one plausible explanation may be of short-term intervention plan that was not sufficient to observe the efficacy of the procedure of this therapy on the psychological well-being of children whore being physically abused.

IMPLICATIONS

The following research highlights the compelling need to develop evidence-based interventions that meet the multi-faceted demands of child victims of physical abuse. Trauma-informed frameworks that merge psychological, emotional, and physical rehabilitation strategies are a priority area that researchers need to develop. Future research should rigorously test the long-term effectiveness of such programs with measures such as resilience development, cognition restoration, and social reintegration. Interdisciplinary research—across psychology, education, and public health—is also essential to map areas of systems gaps and create scalable, culture-adaptive models that can be replicated in various contexts. By overcoming such research-practice chasms, researchers can yield actionable findings to guide policy reform and resource allocation.

The report calls for unified, immediate action by educators, mental health professionals, policymakers, and social workers. Practitioners need to embrace holistic, trauma-informed care systems that not only reduce acute harm but also empower survivors by building skills, advocating, and providing access to a protected environment. Training programs should help frontline workers identify early warning signs of abuse, provide targeted psycho-social services, and build mutually trusted relationships with traumatized children. Preventive education programmes in community centers and schools can help break the cycle of violence by involving parents and caregivers, and telehealth platforms and mobile outreach can provide wider coverage to underserved people.

Proactive investment in such interventions has the potential to be transformative: to break cycles of abuse spanning generations, cut long-term societal expenses related to trauma (e.g., mental health emergencies, dropout levels), and build safer, more supportive conditions for children. By enabling survivors to take back agency and self-worth, not only will their mental health improve, but they will be better positioned to become resilient, contributing members of society, catalyzing economic and social advancement. For stakeholders, this research is a call to action—to make child protection a non-negotiable pillar of sustainable development and a shared moral responsibility.

LIMITATIONS

The limitations of this study are a non-diverse, single-gender sample with participants of similar socio-economic status, all sourced from a rehabilitation center and thus limiting generalizability. A small initial

sample further decreased due to mid-intervention attrition, with potential skewing of results. Methodological issues were presented with linguistic differences: while the assessment tool was in Urdu, technical jargon could have caused misresponses. Further, non-uniform punctuality by participants, emotional lability (e.g., mood swings, resistance to group norms), and interruptions by unexpected changes to routine added confounding variables that had the potential to bias intervention effects. The limited time span of the study also could have missed important longitudinal effects. These issues point to the necessity of larger, gender-diverse samples, language-framed tools, and longer study lengths to promote validity and generalizability.

RECOMMENDATIONS

Future research should focus on examining gender differences in play therapy effectiveness with abused children, incorporating intersectional examinations of socio-economic and cultural variables, and increasing sample size to encompass diverse samples (i.e., marginalized neighborhoods, rural, suburban, and cross-cultural samples). Studies should use stratified sampling, longitudinal design, and mixed-methods to evaluate long-term effectiveness, ethical protections, and adaptive practices in a range of contexts. Results are to be used to guide scalable, trauma-informed interventions and policy change such as culturally specific modules and training of practitioners aimed at filling system gaps and promoting equitable healing to all.

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