Research Paper

The Effectiveness of Play Therapy Combined With a Trauma-focused Cognitive Behavioral Therapy on Trauma Symptoms and the Loneliness Feeling

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ABSTRACT

Objective: This study aimed to evaluate the effectiveness of play therapy combined with a traumatic cognitive-behavioral approach on the symptoms of trauma and the feeling of loneliness of the victims of sexual abuse.

Methods: This research was a quasi-experimental study with a pre-test-post-test design with a control group. The statistical population comprised all sexually-abused Afghan girls. Of whom 20 individuals were selected using the available sampling method. To conduct the questionnaire, the experimental and control group participants were examined before and after the experiment. Data were collected using Asher and Wheeler's child trauma symptoms scale and the child loneliness scale presented by Foa et al. The assessment program consisted of 14 sessions for the treatment group, and the control group did not receive any intervention. Finally, the collected data were analyzed using covariance analysis.

Results: By controlling the effect of the pre-test, a significant difference was observed between the mean scores of participants' trauma symptoms and the mean scores of participants' loneliness in terms of group ($P<0.05$).

Conclusion: The results revealed that the play therapy combined with the cognitive-behavioral trauma-oriented treatment resulted in reduced trauma symptoms but not loneliness in these children.

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Highlights

• Play therapy intervention combined with trauma-based cognitive behavioral therapy reduces trauma symptoms in Afghan girls aged 8-12.

• Family is an important risk factor for children's bullying and loneliness.

Plain Language Summary

This study was done on about 8-12 years old Afghan girls who were sexually abused. Children who are sexually abused are unfortunately traumatized. Following this trauma, the fear of communicating with others leads to isolation and loneliness. These children should be treated as soon as possible because these serious injuries will remain with them until adulthood. We combined play therapy and trauma-focused cognitive behavioral therapy to make the treatment more effective. Fortunately, the trauma symptoms subsided. On the other hand, because the treatment sessions of these children are personal and other reasons, such as lacking a close relationship with their parents, lack of parental support, not having a close friend, etc., these children felt lonely. After retelling the trauma, it increased. The important factor in treating injuries caused by sexual abuse is the support, understanding, and empathy of parents and other family members and, more importantly, believing the child's words. The most important factor is not to blame the children for this terrible incident because they are not guilty, and we should kindly tell them many times.

1. Introduction

Child sexual abuse (CSA) is a traumatic experience and a global phenomenon with negative continuous and extensive consequences for millions of children worldwide (Najjar et al., 2022; Steil et al., 2021). Unfortunately, this incident affects abused children physiologically and psychologically and increases the possibility of mental disorders and substance abuse among them in the future (Agu et al., 2018; McCabe et al., 2022).

CSA is defined as aggressive behavior that can include caressing, rape, and contactless rape, such as forcing a child to engage in pornography, showing off, and nudity (Niolu Lisi & Siracusano, 2018). Although the CSA is viewed as a human rights contravention, it is also a general health worry estimated to affect 27% of females and 5% of males by age 18 (Shipe et al., 2022).

Other statistics show that approximately one million children in the United States are abused each year, and on average, 4-5 children die every day at the hands of guardians, parents, relatives, and friends (Okonya, 2018). However, it was evidenced that 86% of 60 participants who were sexually abused had tried to expose the rape before the age of 18, and 66% had tried to explain what had happened to them, but the point was that no one believed them. Thus, although the children may try to say something, they are not always heard (Borg et al., 2019), which in turn causes problems such as loneliness and depression.

The significant role of loneliness in advancing mental health problems in the victims of childhood violence has been documented in previous studies (Borg et al., 2019; Shevlin et al., 2015). Also, the role of child abuse and loneliness has been emphasized in the severity of psychosis symptoms in everyday life. Similarly, CSA is associated with loneliness (Boyda et al., 2015).

CSA survivors are compelled to provide sex or occupy unwanted sexual practices to obtain affection or forestall abandonment (Steil et al., 2022). Also, these children feel betrayed, deceived, scared, vulnerable, and embarrassed, making them different from other children. When these children try to make friends out of their peers, they have no social strategy other than sexual ones, which they think could attract other children to accept them. This condition leads to the rejection of the abused child by other children who get confused by these behaviors. As a result, their loneliness increases, and the feeling of isolation and "difference" is accentuated by abused children. A child who has been sexually abused feels abandoned and does not know what adults want from them. Thus, they often communicate with sexual signals because this is the only way they know to be used in finding friends (Cattanach, 2008).

It is reported that the most significant symptom of CSA is trauma, and the most complex disorder associated with trauma is posttraumatic stress disorder (PTSD) (Niolu et al., 2018).

In psychological pathology, trauma is defined as damage, injury, or traumatic episode due to an event or series of events that suddenly and destructively occur throughout life (Maragakis & O'Donohue, 2018). The most common complications after CSA are PTSD and depression (Ucuz et al., 2022). PTSD is intrusive thoughts, distress, physiological reactivity, and avoidant behavior after the traumatic event (Association & Association, 2013). Specialists also find negative changes in recognition and mood in children who develop PTSD presented as social withdrawal, reduced positive emotions, and increment negative emotional states (Association & Association, 2013). The empirical investigation of various theoretical approaches has shown that conscious trauma therapy effectively improves overall functioning, self-esteem, and symptom reduction (Harvey & Taylor, 2010). There are many issues that play therapists, and cognitive-behavioral therapists can learn from each other, such as combining play therapy with trauma-focused cognitive-behavioral therapy (TF-CBT) as an effective approach for abused children with PTSD (Drewes, 2009).

TF-CBT has also been tested in several challenging research settings and is an effective and widespread treatment for childhood trauma, with strong evidence of improvement in trauma symptoms in various populations of traumatized children (Cohen et al., 2018). CBT interventions have been widely used in the treatment of trauma-related symptoms. For example, TF-CBT focuses on 9 components: Psychoeducation, parenting skills, relaxation, emotion regulation, coping and tolerance, processing, trauma narrative, and coping (Cohen et al., 2016). It also emphasizes reality. Life situations are also used in therapy sessions with the presence of the child and parents to create a therapeutic approach in the future. In this method, treatment includes three stages: 1) Stability and safety, 2) Traumatic processing, and 3) Reconnection/reintegration. Although described separately, researchers note that this stage rarely occurs linearly (Courtois & Lindsay, 1997).

On the other hand, the game itself has many therapeutic factors (Drewes, 2009), and play therapy is a type of psychotherapy in which the child expresses his feelings and experiences through a natural and spontaneous process and can ultimately lead to social integration and achieve mental growth. Play therapy symbolically helps children overcome traumas and pressures that have robbed them of vitality (Cohen et al., 2018).

Therefore, play is used as one of the most important methods of child therapy (Cohen et al., 2018), and when combined with other effective treatment methods, it becomes a potentially transformative factor in the treatment and recovery of children and adolescents (Drewes, 2009).

According to several interviews conducted with the help of these children's social workers, a huge number of rapes among Afghan girls has been detected, and these children have been experiencing many problems, such as anxiety, nightmares, and loneliness. Thus, to assist and improve their health, these Afghan girls were selected as the statistical population of this study. No research has been conducted on the effectiveness of play therapy by combining traumatic CBT with trauma symptoms in Iran. It seems necessary to introduce new methods of the integrated approach to improve trauma symptoms and loneliness feelings, which are empirically valid.

The main question of the present research was, "can the STAR[1] treatment program reduce symptoms of trauma and loneliness feeling in Afghan girls who are victims of sexual abuse?" By examining the following two hypotheses, we tried to collect basic evidence to evaluate the effect of the independent variable on the dependent variable.

Research hypotheses

Play therapy combined with TF-CBT is effective in the trauma symptoms and loneliness of 8-12 years old Afghan girls who are victims of sexual abuse.

Play therapy combined with TF-CBT is effective in the trauma symptoms of 8-12 years old Afghan girls who are victims of sexual abuse.

Play therapy combined with TF-CBT is effective in the feeling of loneliness of 8-12 years old Afghan girls who are victims of sexual abuse.

1. The STAR program is a coping model in which the letter S stands for Stop, in fact, when we feel bad, we wait and review our feelings with ourselves. The letter T stands for Thought, which means what I am thinking. The letter A stands for Act, which means what useful work I can do, and the letter R stands for Rewarded, which means I did very well, what should I reward myself.

According to the theoretical foundations and findings, the current research investigated the effectiveness of play therapy combined with TF-CBT on trauma symptoms and the feeling of loneliness in Afghan girls who were sexually abused.

2. Materials and Methods

The present research is a quasi-experimental study with a pre-test-post-test design and a control group. The statistical population of this study consisted of all Afghan female children from the Imam Ali Society in Yazd City, Iran, who were sexually abused from 2018 to 2019. This research is sensitive to cultural and individual differences, and no discrimination based on race, ethnicity, culture, nationality, gender, age, religion, language, disability, health status, or socioeconomic status was considered. Also, the subjects' rights were respected, and their well-being was not endangered. Based on the principle of secrecy, the subjects and their parents were assured that their information would remain strictly confidential. The researcher followed the highest professional and scientific standards, and during and after the research, each person's health and safety were considered. All the subject's questions were answered patiently and accurately. This research was done with the informed consent of the subjects and their legal parents without coercion and with understandable language and a respectful tone. In the design and implementation of this research, the possibility of obtaining false results was minimized. Also, the results were published honestly, accurately, and completely.

Study participants

In the present study, the available sampling method was used. The sample was 20 randomly assigned to the control and experimental groups (10 people for each group). The inclusion criteria were as follows: Being 8-12 years old, normal IQ based on the individual's file, verbal ability, a definite diagnosis of trauma symptoms, surviving parents, the presence of a caregiver/social worker in the first session, and no participation in other treatment programs. The exclusion criteria were no history of delinquency and specific mental illness. In this study, gender was considered as a control variable. After selecting a sample, individual interviews were conducted with each member to discuss their specific medical history and the location and nature of the sessions.

To implement play therapy combined with TF-CBT, information about the research, its objectives, and the time and schedule of play therapy sessions were first presented. Then, the officials were requested to coordinate the commuting of the subjects for the play therapy sessions on the announced dates. After selecting the sample group, informed consent was obtained from the subjects and their parents. All authorities and subjects were assured that their information was confidential. Subjects were randomly assigned to the experimental and control groups. Then, the participants of both groups responded to Asher and Wheeler's child trauma symptoms scale (CPSS) and child loneliness scales before the play therapy sessions. The control group participants were placed on the waiting list so that the interventions could be performed on them after the end of the experiment, and they lacked any information about the implementation of the research in the experimental group. The intervention program was presented to the experimental group in 14 sessions (one session of 45 minutes each week). Still, no intervention program was implemented in the control group, and mutual contact between the members of the experimental and control groups was prevented. A week after the last performance, a meeting was held to summarize, thank, and appreciate the children, and on the same day, the post-test was conducted. The content of the play therapy sessions with the integration of TF-CBT is presented in Table 1.

Study tools

The child trauma symptom scale (CPSS)

A 24-item scale of pediatric PTSD symptoms was used in the present study. The scale (Foa, et al., 2001) that is used in late childhood and adolescence was applied to assess the symptoms of trauma. This scale had four questions and is scored on a four-point Likert scale: Zero (not at all), one (once a week or less), two (two to four times a week), and three (five or more times a week) (Foa et al., 2001).

The CPSS is a scale for assessing the severity of PTSD and is a valid criterion to examine the harshness of this disorder in victims aged 8-18 years with different types of trauma. The language of this questionnaire was adjusted with the children's level for their better understanding. This scale included a question for each of the 17 signs of PTSD in the DSM-IV to determine their frequency over the past month. This scale had re-experience, avoidance, and arousal dimensions. For assessing the reliability, the α coefficient was calculated as 0.89 for the total score, 0.80 for re-reminder, 0.73 for avoidance, and 0.70 for stimulation. There was a high correlation between the sub-scales and the whole scale, and it was obtained as 0.89 for recall, 0.91 for avoidance, and 0.90 for arousal. Verbal communication among the three

Table 1. Summary of the treatment sessions on trauma symptoms and loneliness feeling

Session	Objectives of the Session	Content of the Session
1	Mental and social strengthening of the child	Familiarizing parents with the treatment process The presence of the child in the meeting and creating a safe environment The purpose of this meeting was to establish a therapeutic relationship and trust the therapist
2	Relationships	This session aims to identify the context of the child's family, caregivers, and support networks.
3	Time schedule	The main purpose of this session was to collect information and determine the level of cooperation and trust between the therapist and the child as a kind of initial encounter.
4	Teaching emotions	The main purpose of this session is to identify feelings.
5	Coping skills	Physical reactions Introduction of the 1st stage of the STAR program until reaching physical reactions Normalization of physical reactions related to anxiety and traumatic events Improving coping skills Role-playing Introducing and practicing relaxation, deep breathing, and relaxation
6	Thoughts	Introducing the 2nd stage of the STAR program Practicing coping skills and role-playing
7	Active coping and problem-solving	Making the child feel better in uncomfortable situations Providing problem-solving skills to challenge the unhelpful thought and replace the useful thoughts Talking to someone or using mindfulness techniques to reduce uncomfortable feelings
8	Evaluation, rewarding, and meeting with parents	Review of the 1st eight sessions to evaluate the learning of the skills taught
9-12	Processing the traumatic event (gradual exposure)	Introduction of visual exposure and gradual exposure (during sessions 9-12) The purpose of these sessions was to use visual exposure to create a story related to the traumatic event and provide the possibility of emotional processing of the memories associated with this event using the tools chosen by the child
13	Special issues and the end of treatment and meeting with parents	Identifying specific issues that still bother the child and talking about feelings related to those issues
14	Prevention of recurrence	Review the STAR plan It was explained to the child that from now on, she is her therapist and should help herself by using the STAR program and all the skills she has learned, and at the same time, whenever she needs the help of her parents, parents will surely come to her aid

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sub-scales ranged from 0.70 to 0.89. In this research, the validity of this scale was measured as 0.80.

The child loneliness scale (Asher et al., 1984)

This scale was used in late childhood and adolescence to assess loneliness. This scale had three questions and a 5-point response scale (strongly agree=1 to strongly disagree=5). This questionnaire was translated by Azadet al. in 2013 and has been approved by several psychologists. In 1985, Asher and Wheeler showed that loneliness distinguishes the rejected children and children of other classes (neglected, controversial, and popular) (Asher & Wheeler, 1985). The calculated Cronbach α was equal to 0.90, and the 1-year re-test reliability was equal to 0.55. By performing this scale on children in Tehran (Azad et al., 2013), a Cronbach α of 0.81 and a reliability coefficient of 0.79 were achieved.

TF-CBT is an appropriate treatment to reduce injury symptoms in some children and their caregivers with trauma (de Arellano et al., 2014). Play itself has many healing factors and, when combined with other effective treatment methods, becomes a potential altering factor

in treating children and adolescents. This therapy makes children willing to participate in treatment and attracts their attention.

On the other hand, there are many issues regarding play therapy and CBT that specialists can learn from each other. Therefore, we should have a common and unbiased view that play can be considered a healing and useful factor in documented therapeutic approaches. It is time for the child and adolescent psychology to unite and establish proper coordination to have mutually respectful cooperation and adopt the best approaches in both fields (Drewes, 2009). In this study, efforts were made to combine play therapy and TF-CBT to treat the female victims of sexual abuse more effectively. The package, which was used in this study was designed by Jacqueline Set al. in 2009 and consists of four phases: 1) Psychological strengthening, 2) Coping skills, 3) Trauma processing, 4) Special issues and completion of the therapy (Feather & Ronan, 2009).

To implement the play therapy combined with TF-CBT, the research, its goals, and the time and date of play therapy sessions were first notified to all. After that, the officials were asked to coordinate the children's play therapy sessions if the scheduled time and date were acceptable. After selecting the sample group, the subjects were randomly assigned to the experimental and control groups, and then the participants of both groups were investigated (Asher et al., 1984). The CPSS and the childhood loneliness scale were conducted before the play therapy sessions.

It should be noted that this research did not have any experimental mortality, and the children were with us until the end of the study.

Statistical analysis

The present research used SPSS software, version 25 for data analysis. Also, descriptive statistics, including standard deviation and inferential statistics, including covariance test, were used.

3. Results

The mean age of the control group was 10.9, with a range of 8-12 years, while the mean age of the experimental group was 9.5 years. The total number of subjects was 10. Tables 2 and 3 indicate significant differences between the mean of trauma symptoms and loneliness before and after the intervention. In addition, in the experimental and control groups, the father's occupation of most participants was labor. Also, in both groups, the mothers of most research participants were unemployed.

Table 4 exhibits that the difference between the mean scores of the two groups in the pre-test stage was also significant. Hence, the covariance analysis was the best option for data inferential analysis to control the effects of the pre-test. Using this analysis, a significant difference was found between the mean scores of participants' trauma symptoms in terms of group membership (treatment and control) ($P<0.05$). The effect size also demonstrated that 64% of the changes in the subjects' trauma symptoms in the post-test were related to the intervention effects. The statistical power of 0.99 is very desirable. Therefore, play therapy combined with TF-CBT effectively reduced trauma symptoms in sexually abused Afghan girls aged 8-12 years old.

Table 5 indicates that the difference between the mean scores of loneliness in the pre-test stage was also significant in both groups. By controlling the effect of the pre-test, a significant difference was found between the mean scores of participants' loneliness in terms of group membership (experimental and control) ($P<0.05$). The effect size indicated that the intervention resulted in a 36% change in the loneliness of the subjects. However, according to the averages of the experimental group in the pre-test and post-test, these changes caused an increase in loneliness scores in the post-test. Therefore, it seems that the intervention of play therapy combined with TF-CBT increased the loneliness felt by the children victims of sexual abuse after the intervention.

Table 2. Descriptive findings of the pre-test and post-test in terms of loneliness feeling in Afghan girls who were victims of sexual abuse (n=10)

Group	Mean±SD	
	Pre-test	Post-test
Experimental	47±10.94	55.2±11.76
Control	41.7±10.47	42.4±10.24

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Table 3. Descriptive results of the pre-test and post-test concerning the traumas of sexual abused Afghan girls (n=10)

Group	Mean±SD	
	Pre-test	Post-test
Experimental	36.1±5.23	17±11.97
Control	34.9±4.62	31.1±4.43

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4. Discussion

The first hypothesis of the research was that play therapy combined with TF-CBT effectively impacts the trauma symptoms of 8-12 years old Afghan girls who are victims of sexual abuse. The results obtained in this research show that play therapy combined with TF-CBT can reduce trauma symptoms in these children.

This result supports the goals of previous research that play therapy and TF-CBT reduces trauma symptoms, including intrusive thoughts, distress, physiological reactions, avoidance behaviors (Cummings & O'Donohue, 2018), nightmares, flashbacks of traumatic scenes, and other symptoms of high arousal, such as difficulty falling or staying asleep, resistance to sleep, and frequent awakenings unrelated to nightmares in children, listening to excessive alarms about safety or increasing the awareness of the environment, more caution than limiting changes, and increasing the control of locking doors or jumping reaction (Black & Grant, 2014) in children (Drewes & Cavett, 2012; Sánchez-Meca et al., 2011).

Combining play therapy and TF-CBT facilitated the release of children's emotions and thoughts during play therapy, and as a result, avoidance and resistance behaviors were reduced, and they could communicate well with the therapist. In addition, they could also learn how to cope without avoiding their fears and react differently to their symptoms and problems.

These findings are consistent with previous reports (Baggerly, 2015; Cohen et al., 2016; Deblinger et al., 2016; Drewes, 2009; Drewes & Cavett, 2012; Feather,

Table 4. The effect of play therapy in combination with trauma-based cognitive-behavioral therapy on the trauma symptoms of sexual abused Afghan girls

Variables	Sum of Squares	df	Mean Square	F	Sig.	η^2	Test Power
Pre-test	781.067	1	781.067	19.361	0.001	0.532	0.985
Post-test	1212.472	1	1212.472	30.054	0.001	0.639	0.999
Error	685.833	17	40.343				
Total	2460.95	19					

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Table 5. The effect of play therapy in combination with trauma-based cognitive-behavioral therapy on the loneliness feeling of sexual abused Afghan girls

Variables	Sum of Squares	df	Mean Square	F	Sig.	η^2	Test Power
Pre-test	1797.228	1	1797.228	77.788	0.001	0.821	1
Post-test	225.358	1	225.358	9.754	0.006	0.365	0.873
Error	392.772	17	23.104				
Total	3009.2	19					

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2006; Feather & Ronan, 2009; Gutermann et al., 2016; Jensen et al., 2014; Kameoka et al., 2015; Misurell et al., 2011; Neelakantan et al., 2019; Shamsi pour et al., 2019; Silverstone et al., 2016).

In explaining these findings, we can refer to Feather's TF-CBT (Feather, 2007). Based on this approach, the symptoms of trauma can be reduced by performing the steps of psychosocial strengthening, training coping skills, gradual exposure using expressive methods, and special issues (Feather, 2007).

TF-CBT believes that the presence of both children and parents in treatment is the best way to treat children who are victims of sexual abuse has been confirmed (Cohen et al., 2018). Therefore, TF-CBT is the treatment of parents and children, and it emphasizes the primary caregivers, and the initial stages focus on strengthening the child's support network.

Using metaphorical concepts in therapy could enhance the interaction between the child and the therapist. These metaphorical concepts were as follows: Sand trays or miniatures with different shapes, clay, puppets (hand puppets), balls, and also stickers (various labels), such as heart shape, for those we love, bee shape for the people who have excruciated us, or different colors, such as red, which indicates the feeling of anger towards the people, or black, which is a sign of fear and panic, which could increase the interaction between the child and the therapist and reduce the child's resistance in the confrontation stages. Integrating these expressive techniques into TF-CBTs can also help children who have verbal difficulty narrating a traumatic event and can describe the injury.

On the other hand, one of the main symptoms of trauma is the occurrence of physiological reactions. For this reason, one of the important elements of TF-CBT is psychological training to identify physical reactions to traumatic events.

Another important element of this approach is teaching relaxation techniques. For this reason, emphasis was placed on teaching relaxation techniques in the initial sessions and repeating these techniques during and at the end of each session as a game.

In TF-CBT, when the subjects can control their negative thoughts after traumatic events, the trauma symptoms reduce, and the ground is laid for post-event growth (del Palacio-González et al., 2017). In addition, the game creates a way to process the details of unpleasant events in the children's thinking patterns, which promotes the development and acquisition of new skills (Drewes, 2009). For this reason, the STAR program was combined with the game and taught to children.

This plan can help children stop ruminating, distinguish healthy from unhealthy thinking, stop unhealthy thinking, discover what they can do to feel better, and then reward themselves. Because children are so vulnerable to stress due to their lack of life experience, they often need help from adults to relieve anxiety and learn new coping skills (Webb, 2015). Therefore, during several sessions with the participation of parents/caregivers, the program was practiced with the children so that they could implement these techniques with the help of the parents in their daily life and places other than the treatment room.

Useful and repeated exercises in CBT focused on trauma to improve the symptoms of trauma caused by sexual abuse, and the participation of parents/caregivers of children in the treatment led to the improvement and reduction of the severity of trauma symptoms in these children. Also, the treatment results due to these exercises even continued in follow-ups after one, two, and three months and indicated that if the techniques used in this treatment are used well and according to the child's age, they can improve the trauma symptoms of these children in the post-treatment and follow-up periods. Considering that one of the important goals at the end of the treatment is for the children to become their therapists, this issue was proved in this research according to the follow-up results.

The second hypothesis of the research was that play therapy combined with a TF-CBT is effective on the feeling of loneliness of 8-12 years old Afghan girls who are victims of sexual abuse.

The results indicated that play therapy combined with TF-CBT did not decrease children's feelings of loneliness. The rejection of this hypothesis can have various reasons.First, loneliness is based on social loneliness. Suppose children's loneliness is caused by social loneliness and lacking a social network. In that case, it cannot be expected that the TF-CBT skills reduce the loneliness score in children because this approach focuses on reducing trauma symptoms but does not teach social skills.

We all need belonging (Ornish, 1998). When we lose intimate relationships in a wide social network, we experience social and emotional loneliness (Geerlings et al., 2019). These children are immigrants and are not accepted in school and society, and they also feel that the peo-

ple around them do not understand their challenges and feel alone. Facing this issue at school and in the community can make children feel bad about themselves. They may even avoid dealing with various issues and others. Children with such special challenges are likely to feel rejected and isolated and experience frustrating social relationships that lead to feelings of loneliness. These findings are consistent with those of Heinrich and Gullone (2006) that loneliness is a reflection of frustrating social relationships.

Second, there is a strong relationship between coping style and loneliness (Deckx et al., 2018; Elahe et al., 2017). According to our research results, if these children's coping style is avoidant, it cannot be expected that this approach reduces the feeling of loneliness because avoidant coping styles have an opposite relationship with social acceptance. These findings were consistent with other reports (Akbari et al., 2021).

Third, the cultural value of these families was such that they refrained from expressing uncomfortable family events, which caused a feeling of loneliness.

Fourth, research shows that social solidarity can prevent the development of mental health problems, including depression (Cruwys et al., 2013). But these children and their families, due to being immigrants and not integrating with society, did not have social solidarity and even socialize with their relatives, making them feel lonely.

On the other hand, all previous studies were conducted as group play therapy, during which the children participated in the sessions in a cooperative manner and talked about their feelings and emotions, which led to an increase in the sense of participation, empathy, responsibility and a decrease in the feeling of loneliness in these children. However, in this research, we could not hold the meetings in groups due to the treatment of trauma symptoms and the necessity of explaining the incident to the children individually.

Therefore, the investigated factors possibly caused the lack of significance of loneliness.

5. Conclusion

It was proved in this study that sexual abuse in Afghan girls causes problems that can affect them throughout their lives. Therefore, the use of play therapy combined with TF-CBT can effectively reduce the symptoms of trauma in these children. Nevertheless, this approach may not be appropriately effective in the feeling of loneliness in these children.

Research limitations

The important role of loneliness in increasing mental health problems in victims of childhood violence has been recorded in previous studies and considering that lonely people may feel insecure and more sensitive to threats and attacks and are more likely to engage in hostility, defense, and depression and give up their control. Therefore, therapeutic strategies to reduce loneliness in girls and boys who are victims of sexual abuse are valuable and strongly recommended.

Suggestions for future research

A few studies have been done on the sexual abuse of children, so it is recommended to do more research in this field.

Also, play therapy can naturally enhance TF-CBT, so it is recommended that trauma cognitive behavioral therapists learn the practical skills and techniques of play therapy and combine them with their methods rather than in sessions. Child therapy can attract children's attention and interest.

Violent behavior against children can be a potential aggressive reaction that should be considered in preventive strategies to reduce harm in affected families.

Ethical Considerations

Compliance with ethical guidelines

This study was approved by the Ethics Committee of Shahid Sadoughi University of Medical Sciences (Code: IR.SSU.REC.1398.057).

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Authors' contributions

Supervision: Azra Mohammadpanah Ardakan and Yaser Rezapour Mirsaleh; Project administration and visualization: Azra Mohammadpanah Ardakan; Conceptualization and data analysis: Yaser Rezapour Mirsaleh; Investigation, data collection and writing the original draft: Melina Jafarzadeh; Review and editing: Azra Mohammadpanah Ardakan and Melina Jafarzadeh.

Conflict of interest

The authors declared no conflict of interest.

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