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Recovery from Traumatic Experiences among Children in Conflict-Affected Communities: The Role of Child-Centred Play Therapy and Psychoeducation Interventions

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Abstract. Communities in North Central Nigeria has persistently experience one form of conflict or the other. Children exposed to conflicts are mostly neglected in terms of intervention. The mental health and psycho-social needs of these young survivors are critical, yet there is inadequate data on child-centred evidence-based psychological interventions. This study employed a between-group, pretest-post-test quasi-experimental design to evaluate the effectiveness of a combined Child-Centred Play Therapy and Psychoeducation interventions on trauma-related symptoms among children. The sample consisted of 64 children drawn from selected conflict-affected communities of Bassa and Bokkos local government areas of Plateau state, Nigeria. The participants were equally divided into an intervention group (n = 32) and a control group (n = 32). Baseline assessments indicated no statistically significant differences between groups for Post-Traumatic Stress Disorder (PTSD) and Disturbances in Self-Organization (DSO), establishing group comparability. Following the intervention, a Multivariate Analysis of Variance (MANOVA) was conducted at significance level of p = 0.05. The results demonstrated that the intervention had a significant effect on post-test PTSD symptoms, $F(1, 62) = 57.139$, $p < .001$, $\eta^2 = .480$, representing a large effect size and a substantial reduction in PTSD symptoms. Similarly, a significant effect was found for post-test DSO, $F(1, 62) = 47.481$, $p < .001$, $\eta^2 = .434$. This large effect size indicates that the intervention significantly decreased DSO symptoms among participants. The findings suggest that integrating child-centered play therapy with psycho-education is an effective strategy for reducing trauma-related symptoms in children exposed to conflict affected communities.

Keywords: Post-traumatic Stress Disorder, Disturbances in Self-Organization, Mental Health Intervention, Multivariate Analysis of Variance, Nigeria

1. Introduction

Communities in North Central Nigeria continues to experience the aftershocks of communal and extremist violence; children are often the silent victims of these traumatic events. The mental health and psycho-social needs of these young survivors are critical, yet under-addressed in recovery programs. Emerging findings indicate that conflict exposure during childhood significantly increases the likelihood of post-traumatic stress symptoms, aggression, withdrawal, and poor cognitive functioning if left untreated (ElBarazi, 2025; Alpugan, 2024; Huesmann et al., 2023).

Although interventions such as trauma-focused cognitive behavioural therapy have demonstrated effectiveness in western contexts, recent scholarship highlights the need for culturally grounded and developmentally appropriate methods in African settings (Thomas et al., 2022; Ennis et al., 2020). Child-centred play therapy and psycho-education have proven to be low-cost, scalable, and non-stigmatizing interventions that engage children in processing traumatic events, expressing emotions, and building coping mechanisms (Le Vay & Cuschieri, 2022). In the management of PTSD, play therapy provides a structured and safe environment which children can engage their traumatic experiences indirectly which reduce the risk of re-traumatization, symptoms of avoidance, hyperarousal and re-experience (Ziloudi, & Liagkos, 2026). Similarly, Aliannezhadi, (2026) reported that child-centred play therapy significantly demonstrates effectiveness in reducing trauma symptoms among children.

In response to these challenges, the literature has increasingly turned its focus towards non-pharmacological, developmentally appropriate, and culturally relevant psychosocial interventions. Among these, child-centred play-based therapy, expressive arts, and family psychoeducation have gained prominence for their accessibility, low cost, and adaptability in post-conflict settings (Barua et al., 2023; Laviero, 2023). These approaches depart from traditional adult-centric therapeutic models, recognizing that children often lack the cognitive and verbal sophistication required for conventional talk therapy. Instead, they emphasize experiential, symbolic, and narrative forms of expression that align with children's natural modes of communication and emotional processing (Bamberg & Reilly, 2014). Empirical studies have further demonstrated that play therapy can reduce trauma-related symptoms such as anxiety, aggression, and social withdrawal (Jafarzade et al., 2023; Humble et al., 2019). In conflict-affected contexts, the structured use of play also serves as a protective and normalizing routine, fostering psychological resilience and providing emotional relief (Argyriadi et al., 2025; Chatterjee, 2018). Outcome of a quasi-experimental study with a pretest-post-test design with a control group conducted among Afghan girls aged 8-12, showed that play therapy intervention combined with trauma-based cognitive behavioral therapy reduces trauma symptoms among the study participants (Jafarzade, et al., 2023).

According to Terradas, and Asselin, (2023) play therapy provides children that were exposed to trauma the opportunity to modify their past and work on their feelings and intrusive images associated to the traumatic event.

In parallel, psychoeducation has emerged as a critical intervention strategy that not only equips children with age-appropriate knowledge about trauma but also engages caregivers in supportive roles. Psychoeducation typically involves structured sessions designed to explain trauma responses, normalize emotional reactions, and teach adaptive coping strategies (Wood, 2024; Wilson, et al., 2022; Sarkadi, et al., 2018). The inclusion of caregivers in psychoeducation is particularly relevant in collectivist societies, where familial and communal bonds play an essential role in children's recovery processes. By demystifying trauma and providing clear frameworks for understanding and managing symptoms, psychoeducation reduces psychological distress and enhances the efficacy of other therapeutic components (Mirhosseini et al., 2024; Bhattacharjee et al., 2011). In a study aimed at determining the impact of psychoeducation intervention on PTSD among secondary school students exposed to conflict in Kano state, Nigeria. Utilizing a pretest and post-test control group design among 40 participants showed a significant difference in PTSD mean scores between students that were in the intervention group and those in the control group with students in the intervention group having lower PTSD mean scores (Mebu, 2019). Despite growing empirical support for both interventions, their implementation and evaluation remain underexplored in the Nigerian context, particularly in communities with prolonged exposure to communal and extremist violence. Much of the existing literature on trauma recovery in Nigeria has focused on adult populations, with relatively few studies dedicated to child-specific interventions in internally displaced or conflict-affected settings (Kadir et al., 2025).

1.1 Statement of the Problem

Children in conflict-affected communities are frequently exposed to traumatic events including loss of loved ones, displacement, and direct violence. Despite the known psychological consequences of such exposure, there is limited evidence in Nigeria regarding practical interventions that can reduce trauma symptoms among children in conflict-affected communities (Okoye et al., 2023; Tareke et al., 2023). The emotional toll of conflict is often compounded by inadequate mental health infrastructure, cultural stigma, and limited understanding of child-centred therapeutic approaches.

Existing studies in conflict-prone areas have identified an increase in symptoms of PTSD, nightmares, emotional numbing, and regressive behaviour among children (Biset et al., 2023; Dandaura-Samu, 2016; Kohli, 2013). Yet, response strategies remain adult-focused and reactive, rather than preventive and child-specific. Moreover, there is inadequate understanding of how culturally responsive therapeutic play and psycho-education can serve as tools for healing in communal African societies. This study is premised on the urgent need to address this gap by piloting interventions that recognize children's developmental stage, cultural identity, and the community's social fabric. It will help guide policy on mental health recovery, inform trauma-informed education models, and contribute to the development of contextually grounded, psycho-social support frameworks for vulnerable population. Therefore, this study is aimed assessing the impact of child-centred play and psycho-education interventions on psychological trauma symptoms among children aged 6–15 in conflict-affected communities of Bassa and Bokkos LGA's of Plateau State, Nigeria.

1.2 Hypotheses

- Child-centred play therapy and psychoeducation will have significant effect on post-traumatic stress disorder among children in conflict-affected communities.
- Child-centred play therapy and psychoeducation will have significant influence on disturbances in self-organization among children in conflict-affected communities.

2. Research Materials and Methods

2.1 Research Design

A between-group pretest-post-test quasi-experimental design was employed to rigorously evaluate the effectiveness of a combined child-centred play therapy and psychoeducation intervention on trauma-related symptoms among children in conflict-affected communities. This design involves the comparison of two distinct groups—an intervention group, which receive the therapeutic treatment, and a control group, which did not receive the intervention during the study period. Both groups were assessed at two time points: before the intervention (pretest) and after the completion of the intervention (post-test).

Although the study incorporates elements of randomization in the allocation of participants to groups, it is described as "quasi-experimental" because it is conducted in real-world settings where full experimental control (such as random sampling of the entire population or double-blind administration) may not be feasible due to ethical and contextual constraints (Shadish, et al., 2002). Nonetheless, the use of pre- and post-intervention measures, combined with between-group comparisons, enhances the internal validity of the research and allows for causal inferences regarding the intervention's impact.

2.2 Participants

The target population for this study comprises children aged 6 to 15 years who have experienced or been exposed to violent attacks within conflict-affected communities in Bokkos and Bassa LGAs of Plateau State. This age range was selected due to its developmental significance, as children within this bracket possess the cognitive capacity to engage meaningfully in both structured play and psychoeducational activities, while also being developmentally vulnerable to the effects of trauma. The total of 64 children (*n*- 32 in the intervention group and *n* - 32 in the control group) participated in this study with mean age of 10.66 and standard deviation of 2.52. The total of 32 children were selected from each local government area. In terms of gender distribution majority 36 (56.3%) were females compared to 28 (43.8%) that were males. Majority 42(65.6%) of the participants were in primary school compared to 22 (34.4%) that were in secondary school. A total of 31 (48.4%) of the children reported that they lost a love one (which include, parents, grandparents, friends, uncles and neighbours) during the attacks in their respective communities while the total of 33 (51.6%) did not lost any of their love ones.

2.3 Inclusion criteria

Selection/participation in the study consist of (a) confirmed exposure to one or more forms of violence (e.g., witnessing or experiencing attacks that happened within Bassa and or Bokkos LGA's, displacement, or loss of loved ones), and (b) residence in a community with a history of violence within the last 12 months.

2.4 Exclusion criteria

Children with severe cognitive impairments or chronic physical illnesses that may hinder consistent participation and those who did not witness any form of violence within the selected communities were excluded from the study.

2.5 Sample Size

The sample size was determined using G*Power version 3.1.9.7, which estimated the minimum number of participants required to detect a medium effect size ($f = 0.25$) with 80% power ($\beta = .80$) and an alpha level of .05 for a two-group MANOVA with repeated measures (pretest and post-test). Based on this calculation, a total of 64 participants were required, 32 in the intervention group and 32 in the control group.

2.6 Sampling Technique

To ensure representativeness and to control for potential confounding variables such as age and gender, a stratified random sampling technique was employed. Children were first stratified into subgroups based on age bands (6–10 years and 11–15 years) and gender. Within each stratum, participants were randomly selected using a computer-generated random number sequence. This approach ensures that both age-related developmental differences and gender-specific trauma experiences are adequately accounted for in the study's comparative analyses.

2.7 Instrument for Data Collection

International Trauma Questionnaire - Child and Adolescent Version (ITQ-CA) developed by Cloitre, et al., (2018) was used in data collection. The instrument is a 22-item self-report measure with two sub-scales designed to assess Post Traumatic Stress Disorder (PTSD) and Disturbances in Self Organization (DSO). The scale can be score using either the dichotomous scoring for diagnostic purposes or the dimensional scoring for symptom severity (Cloitre, et al., 2018). For the purpose of this study the dimensional scoring was utilized in determining symptom severity for PTSD and DSO. Kazlauskas et al., (2020) reported a Cronbach's alpha of .79 for PTSD sub-scale and .86 for DSO sub-scale. Also, Haselgruber et al., (2020) reported an excellent composite reliability of (CR = .85-.86) and (CR = .91-.95) for PTSD and DSO sub-scales respectively.

2.8 Ethical Statement

The study was conducted in strict accordance with standard best practices for human research in accordance with the Helsinki Declaration of 1975 as revised in 2000 and was approved by Plateau State University Research Ethics Committee, Directorate for Research and Development (R and D). The approval conveyed vide Ref: PLASU/R and D/AA/26/01. Prior to commencement, formal permission was obtained from the community heads of each study site. Written informed consent was obtained from the parents, caregivers, or legal guardians of each participating child, who provided authorization on behalf of their children. Additionally, each participating child provided their individual assent, ensuring full compliance with ethical guidelines governing research involving minors, the researchers ensured each participating child understood their right to withdraw at any time they want to without any form of penalty. Participation was entirely voluntary, and all participants were guaranteed strict confidentiality throughout the duration of the study. The right of each participating child was respected throughout the study period.

2.9 Procedure for Data Collection

Following participant selection (pretest), children were randomly assigned to either the intervention group or the control group. After randomly assigning participants into groups, the intervention group received a combined trauma-focused program consisting of; child-centred play therapy sessions and psychoeducation, conducted ones weekly for six (6) consecutive weeks, delivered in small groups of 16 children. The control group did not receive any therapeutic intervention within the six weeks of intervention but were offered psychoeducation upon completion of the study (post-test) for ethical reasons. Both groups were debriefed at the end of the study. The study lasted for a total period of 8 sessions/weeks (session 1 pretest, session 2 - 7 intervention and session 8 post-test) All sessions were conducted in secure, child-friendly community centres, participation was tracked through attendance records and session logs. During the session, especially play therapy the safety of each participating child was ensured through the support of research assistants. The researchers focused on identifying possible potential re-traumatization throughout the study period by utilizing a trauma informed approach that laid emphasis on each participating child's safety over the goals of data collection. Parents, caregivers and or legal guidance of each participating child accompanied their children only during pretest and post-test. However, during the intervention four research assistants (two in each of the LGA's) who were known to the participating children were present to give the children assurance of their safety throughout the study period.

2.10 Method of Data Analysis

Data was analysed using Multivariate Analysis of Variance (MANOVA) to assess between-group (intervention vs. control) pretest and post-test differences across the measured trauma symptom domains. MANOVA is selected due to its robustness in handling multiple dependent variables simultaneously, reducing the risk of Type I error. Preliminary analyses include checks for assumptions such as multivariate normality, homogeneity of variance-covariance matrices, and absence of multicollinearity. IBM Statistical Package for Social Sciences version 27 was used for all analyses. Descriptive statistics were presented using means and standard deviations, while inferential statistics report effect sizes (e.g., partial eta-squared) alongside p-values. The results were interpreted in relation to the research hypotheses, with a focus on the practical significance and clinical implications of the observed changes.

3. Results

Findings of the study, including both descriptive and inferential results on the effects of child-centred therapy and psychoeducation on posttraumatic stress disorder (PTSD) and disturbances in self-organization (DSO) among children in conflict-affected communities. The results are organized in line with the

study hypotheses and supported with appropriate statistical analyses

3.1 Descriptive Result

Table 1 presents the pre-test data analysis used to establish the baseline levels of PTSD and DSO symptoms among the participants prior to the implementation of the intervention. This provided a basis for assessing initial group equivalence and for comparing subsequent changes in trauma-related outcomes following the child-centred therapy and psychoeducation programme.

Table 1: Descriptive Statistics for Pretest PTSD and DSO Scores by Group

Study Group	Mean	Standard Deviation	F-test	*p*-value
PTSD				
Intervention	15.59	3.93	.005	.941
Control	15.66	2.70		
DSO				
Intervention	14.63	5.25	2.997	.088
Control	16.50	3.16		

Table 1 presents the baseline descriptive statistics and group comparisons for pretest PTSD and DSO scores. For PTSD, participants in the intervention group reported a mean score of 15.59 (SD = 3.93), while those in the control group had a mean score of 15.66 (*SD* = 2.70). The results of the analysis showed no significant difference between the groups ($p > .05$). This indicates that both groups had comparable levels of PTSD symptoms at baseline.

For DSO, the intervention group had a mean score of 14.63 (*SD* = 5.25), whereas the control group had a higher mean score of 16.50 (SD = 3.16). The difference between the groups was not statistically significant ($p > .05$), although it approached significance. This suggests that, while the control group showed slightly higher DSO symptoms at baseline, the difference was not strong enough to be considered statistically meaningful.

The overall results indicate that both groups were comparable at pretest for PTSD and reasonably similar for DSO, with no statistically significant differences observed. This supports the internal validity of the study, as any post-intervention differences can more confidently be attributed to the intervention rather than pre-existing group differences.

3.2 Inferential Result

Table 2: Box's M test of Equality of Covariance Metrices

Statistics	Value
Box's M	6.244
F	2.009
*df*1	3
*df*2	691920.000
P	.110

Table 2 presents Box's M Test of Equality of Covariance Matrices conducted to assess the assumption of homogeneity of covariance matrices across the groups prior to the MANOVA analysis. The result showed that the test was not statistically significant, Box's M = 6.244, F (3, 691920) = 2.009, $p = .110$. Since the significance value exceeded the recommended threshold of .001, the null hypothesis of equal covariance matrices was retained. This indicates that the assumption of homogeneity of covariance matrices was satisfied, thereby supporting the appropriateness of proceeding with the MANOVA analysis using the standard multivariate test statistics.

Table 3: Levene's Test of Equality of Error Variances

Dependent Variable	F	df1	df2	P
Post PTSD	0.777	1	62	.381
Post DSO	3.055	1	62	.085

Table 3 presents Levene's Test of Equality of Error Variances conducted to examine the assumption of homogeneity of variance for the dependent variables across the groups. The results indicated that the assumption was satisfied for both dependent variables. For Post PTSD, the test based on the mean was not statistically significant, $F(1, 62) = 0.777$, $p = .381$, indicating equal error variances across groups. Similarly, for Post DSO, the test was also not statistically significant, F(1, 62) = 3.055, $p = .085$. Since the significance values for both dependent variables were greater than

the conventional alpha level of .05, the null hypothesis of equal variances was retained. These findings suggest that the assumption of homogeneity of error variances was met, supporting the suitability of proceeding with the MANOVA analysis.

Post-test data were analysed following the implementation of the child-centred play therapy and psychoeducation intervention to assess changes in PTSD and disturbances in self-organization (DSO) symptoms among the participants. This facilitated the evaluation of the effectiveness of the intervention by comparing post-intervention outcomes with baseline measures using appropriate inferential statistical techniques.

Table 4: Multivariate Test for PTSD and DSO symptoms across levels of child-centred play and psychoeducation interventions among children in conflict-affected communities

Effect		Value	F	Hypothesis df	Error df	Sig.	η^2
Intercept	Pillai's Trace	.953	619.523	2	61.000	<.001	.953
	Wilks' Lambda	.047	619.523	2	61.000	<.001	.953
	Hotelling's Trace	20.312	619.523	2	61.000	<.001	.953
	Roy's Largest Root	20.312	619.523	2	61.000	<.001	.953
Child-centred Therapy and psychoeducation	Pillai's Trace	.533	34.832	2	61.000	<.001	.953
	Wilks' Lambda	.467	34.832	2	61.000	<.001	.953
	Hotelling's Trace	1.142	34.832	2	61.000	<.001	.953
	Roy's Larget Root	1.142	34.832	2	61.000	<.001	.953

Table 4 shows the multivariate test for PTSD and DSO symptoms across levels of child-centred play and psychoeducation interventions. The table reveals that there was a statistically significant multivariate effect of the intervention on the combined dependent variables, $F(2, 61) = 34.832$, $p < .001$; Wilks' $\Lambda = .467$, partial $\eta^2 = .533$. This result indicates that child-centred play and psychoeducation interventions significantly influenced the combined dimensions of trauma symptoms among children in conflict-affected communities. The effect size ($\eta^2 = .533$) suggests that the intervention accounted for approximately 53.3% of the variance in PTSD and DSO symptoms, representing a large effect. Overall, this finding demonstrates that exposure to the intervention was associated with substantial reductions in trauma-related outcomes when considered jointly across both PTSD and disturbances in self-organization.

Table 5: ANOVA Source Table for effect of child-centred therapy and psychoeducation interventions on PTSD and DSO among children in conflict-affected communities

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	η^2
Corrected Model	Post-test PTSD	33.063	1	33.063	57.139	<.001	.480
	Post-test DSO	47.266	1	47.266	47.481	<.001	.434
Intercept	Post-test PTSD	689.063	1	689.063	1190.854	<.001	.951
	Post-test DSO	570.016	1	570.016	572.613	<.001	.902
Child-centred therapy and psychoeducation	Post-test PTSD	33.063	1	33.063	57.139	<.001	.480
	Post-test DSO	47.266	1	47.266	47.481	<.001	.434
Error	Post-test PTSD	35.875	62	.579			
	Post-test DSO	61.719	62	.995			
Total	Post-test PTSD	758.000	64				
	Post-test DSO	679.000	64				
Corrected Total	Post-test PTSD	68.938	63				
	Post-test DSO	108.984	63				

Table 5 shows the ANOVA source table for effect of child-centred therapy and psychoeducation interventions on PTSD and DSO. Result of hypotheses tested revealed that child-centred therapy and psychoeducation have significant effect on post-test PTSD among children in conflict-affected communities, $F(1, 62) = 57.139$, $p < .001$, $\eta^2 = .480$, indicating a large effect size. This means that the intervention had a substantial impact on reducing PTSD symptoms among children in conflict-affected communities. Thus, hypothesis one is supported.

Similarly, there is a significant effect of child-centred therapy and psychoeducation on post-test DSO among children in conflict-affected communities, $F(1, 62) = 47.481$, $p < .001$, $\eta^2 = .434$, indicating a large effect size. This suggests that the intervention significantly

reduced disturbances in self-organization among the participants. Therefore, hypothesis two is supported.

4. Discussion

Outcome of this study aimed at assessing the impact of child-centred play and psycho-education interventions on psychological trauma symptoms among children revealed that the multivariate test for PTSD and DSO symptoms across levels of child-centred play and psychoeducation interventions were significant. This implies that child-centred play therapy and psychoeducation interventions significantly influenced the combined dimensions of trauma symptoms (PTSD and DSO) among children in conflict-affected communities. Overall, outcome of the study revealed that child-centred play and psychoeducation was associated with substantial reductions in trauma-related outcomes when considered jointly across both posttraumatic stress disorder and disturbances in self-organization. This implies that the intervention had significant impact on reducing PTSD symptoms among children in conflict-affected communities. The effectiveness of child-centred play therapy and psychoeducation observed in this study aligns with a wide body of literature such as Humble et al., (2019) and Jafarzade et al., (2023). Furthermore, researches like Mirhosseini et al., (2024); and Bhattacharjee et al., (2011) reported that psychoeducation reduces psychological distress and enhance the efficacy of other therapeutic components. Mebu (2019) found that among secondary school students in Kano state Nigeria, participants that were exposed to psychoeducation had lower PTSD mean scores compared to those that were not exposed to psychoeducation. Play therapy reduce the risk of re-traumatization, symptoms of avoidance, hyperarousal and re-experience (Ziloudi, & Liagkos, 2026).

Results of hypotheses tested reveal that that child-centred therapy and psychoeducation have significant effect on post-test PTSD among children in conflict-affected communities. This showed that the intervention had a substantial impact on reducing posttraumatic stress disorder symptoms among children in conflict-affected communities. Also, outcome of hypothesis two revealed a significant effect of child-centred play and psychoeducation on post-test DSO among children in conflict-affected communities. This suggests that the intervention significantly reduced disturbances in self-organization among the study participants. This finding is consistent with previous studies. Le Vay and Cuschieri, (2022) found that child-centred play therapy and psychoeducation help children in expressing emotions, processing traumatic events and building positive coping mechanisms. The play therapy offers an environment wherein children can gradually confront and process trauma which also enable them control of their traumatic experiences (Landreth, 2023). The use of play in conflict-affected contexts serves as a protective and normalizing routine for fostering resilience and providing emotional relief (Argyriadi et al., 2025; & Chatterjee, 2018). Among girls in Afghanistan, play therapy significantly reduces trauma symptoms among the study participants (Jafarzade, et al., 2023). Aliannezhadi, (2026) reported that child-centred play therapy significantly reduces trauma symptoms among children. Findings from outcome of this study and literature review indicate that child-centred focus play therapy and psychoeducation are effective psychological interventions for the management of trauma (PTSD and DSO) among children exposed to traumatic experiences in conflict affected communities of Plateau state Nigeria.

This study contributes to theoretical development in trauma psychology and child psychology. Outcome of the study provides evidence-based outcome on how child-centred play therapy and psychoeducation jointly influence trauma recovery among children in conflict-affected communities in Bassa and Bokkos local government areas of Plateau state Nigeria. The study revealed the impact of culturally adapted child focused interventions utilizing child-centred play therapy and psychoeducation in reducing trauma symptoms among children. Outcome of this study can influence future theoretical development and enhancing existing trauma related theories among children exposed to traumatic experiences in conflict-affected communities.

The study also contributes to professional practice of clinical psychology, child psychology, developmental psychology, counselling psychology, and mental health service providers in general by providing evidence-based strategies for supporting recovery, reduction of trauma symptoms and trauma healing among children in conflict-affected communities. Utilizing child-centred play therapy and psychoeducation indicate that age-appropriate, structured culturally adaptable psychological interventions can play a pivotal role in reducing trauma symptoms, enhance recovery and promote coping mechanism among children. For trauma healing among children, this model can be adopted in communities, internally displaced persons camps, schools and children related centres. Notably, outcome of this study bridges research gap between psychological theories and practice among psychologists because of its applicability and

suitability in conflict-affected communities in Nigeria which can also be translated to other conflict-affected communities globally.

Findings of this study further provides evidence-based insights relevant for policy development in mental health and child protection in conflict-affected communities. Based on outcome of this study it is necessary to integrate psychological services into community-based mental health policies that targets traumatized children and children generally affected by conflict. Policymakers in Nigeria can use outcome of this study as a reference document to advocate for the inclusion of child structured trauma focused psychological intervention in developing child welfare policies, humanitarian services and within school curriculum. This indicates the need for improved government policies and investment in training mental health practitioners, teachers and community health workers to offer trauma-informed psychological first aid to vulnerable children. For effective service delivery policies should encourage collaboration between government agencies and non-governmental organizations for sustainable child focused trauma informed psychological interventions.

5. Limitations of the study

The following limitations were noted in this study, inadequate sample size which may limit generalization of outcome of this study. Also, the study fails to compare the effectiveness of the therapeutic intervention (child-centred play therapy and psychoeducation) separately.

6. Recommendations

Future studies in this area should consider the use of larger sample size to enable generalization of findings. Also, the efficacy of the therapeutic interventions should be tested separately so as to determine if both interventions are effective in reducing trauma symptoms among children separately or jointly.

7. Conclusion

In conclusion, findings of this study align with the growing body of evidence that integrating child-centred play therapy with psychoeducation is an effective strategy for reducing trauma-related symptoms in children exposed to conflict. Outcome of this study addressed both theoretical and practical gap by offering localized insights into trauma recovery for children by generating evidence-based findings. Therefore, the authors recommend that clinical psychologists, other mental health practitioners and policy makers should consider utilizing child-centred play therapy and psychoeducation interventions in management of trauma especially among children. There is need for psycho-social programming and mental health policy in Nigeria especially among children.

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