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Implementation of Mental Health and Psychosocial Support (MHPSS) in Supporting the Recovery of Child Sexual Abuse Survivors in Kediri

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ABSTRACT

Child sexual abuse is a violation of children's rights and a gender justice issue with lasting psychological and psychosocial consequences. Mental Health and Psychosocial Support (MHPSS) is recommended to address survivors' needs, yet evidence on its implementation in community-based child protection services in Indonesia remains limited. This study explored MHPSS implementation for child sexual abuse survivors in Kediri, focusing on trauma-related symptoms, psychological comfort, participation, and adaptive functioning. This descriptive exploratory study involved nine survivors under 18 years old who had experienced abuse by the same perpetrator. Trauma-related symptoms were assessed using the Child and Adolescent Trauma Screen (CATS), while psychological comfort was measured using an adapted 0–10 rating scale. Data were collected through assessments, observations, interviews, documentation,

and a four-hour MHPSS session involving emotional validation, therapeutic play, positive affirmation, traditional games, and parental discussion. Data were analyzed using descriptive statistics and thematic analysis. Seven participants (77.8%) screened positive for potential PTSD symptoms, while one (11.1%) fell within the moderate range and one (11.1%) within the normal range. Psychological comfort varied, with three participants reporting very low comfort, two low comfort, two moderate comfort, and two comfortable levels. Observations showed active participation, peer interaction, and adaptive behaviors among several children despite trauma-related symptoms. The activities provided opportunities for emotional expression, supportive interaction, play, and caregiver involvement. However, the absence of pre- and post-intervention measurements and a comparison group prevents conclusions about intervention effectiveness. These findings highlight the importance of assessing trauma-related symptoms alongside psychological comfort and adaptive functioning. Child-centered, trauma-informed, culturally responsive, and family-oriented approaches may support community-based psychosocial services, warranting further research.

Keywords: child sexual abuse; Mental Health and Psychosocial Support (MHPSS); Child and Adolescent Trauma Screen (CATS); psychological comfort; adaptive functioning.

A. Introduction

Child sexual abuse (CSA) is a serious violation of children's rights that can affect their psychological, emotional, social, and developmental well-being (Nabillah, 2019). Survivors may experience fear, shame, emotional difficulties, reduced self-worth, and trauma-related symptoms (Boumpa et al., 2024). However, recovery varies among individuals: children may continue experiencing psychological distress while demonstrating positive social interactions and adaptive functioning. Therefore, recovery should be understood not only through clinical symptoms but also through psychological comfort, relationships, participation, and everyday functioning.

Beyond its immediate violation of bodily autonomy and safety, child sexual abuse can disrupt a child's sense of predictability, trust, and control. Responses vary, and not every survivor expresses distress in the same way or at the same time. Some children may experience intrusive memories, avoidance, heightened alertness, sleep difficulties, shame, self-blame, or fear, while others may show difficulties in relationships, school participation, or everyday routines. Reviews have documented an association between childhood sexual abuse and later post-traumatic stress symptoms, although the form and severity of the response vary across individuals and circumstances (Boumpa et al., 2024; Centre of Expertise on Child Sexual Abuse, 2023). Indonesian studies have also discussed emotional, behavioral, and social consequences for child survivors, underscoring the need for responses that extend beyond the immediate reporting of a case (Nabillah, 2019; Dhyatmika et al., 2024).

Children's experiences are also shaped by their social and cultural environments. In Indonesia, families, schools, communities, and child protection institutions influence how abuse is recognized, disclosed, and addressed (Sarah, 2023). Although these networks can provide essential support, stigma, shame, fear of social judgment, concerns about family reputation, and unequal power relations may discourage disclosure and delay access to assistance, particularly when perpetrators are known to the child (Nurbayani et al., 2022). Gender norms and expectations concerning obedience and family roles may further influence children's vulnerability, help-seeking, and responses to abuse (UNICEF, 2020). Consequently, psychosocial support must consider children's individual circumstances and the social environments that may either facilitate or hinder recovery.

In the Indonesian context, the pathway from disclosure to sustained support may involve family members, schools, community leaders, health services, and formal child-protection agencies. Each setting can either support a child's safety or unintentionally increase

pressure through disbelief, blame, repeated questioning, or concern about social reputation. Research reviewing sexual abuse in Indonesia points to the importance of examining the social conditions in which cases are identified and handled, rather than treating abuse solely as an individual or private family matter (Sarah, 2023; Napitupulu & Julio, 2023). Family communication and caregiver responses matter because children often depend on adults for protection and care, yet caregivers may need guidance on how to respond without blaming or silencing the child (Septiani, 2021; Syahfitri et al., 2024).

Mental Health and Psychosocial Support (MHPSS) provides a framework for addressing the psychological and social consequences of trauma through emotional support, age-appropriate activities, safe emotional expression, caregiver involvement, and referral to specialized services when necessary (Inter-Agency Standing Committee, 2019). A child-centered and trauma-informed approach prioritizes safety, dignity, and individual needs (UNICEF & International Rescue Committee, 2023). From a social-ecological perspective, recovery also depends on interactions among children, caregivers, schools, communities, and protection services (Stockman et al., 2023). MHPSS should therefore be understood as a process involving both individual support and the wider social systems surrounding children.

Despite the development of psychosocial and trauma-focused interventions, questions remain about how MHPSS is implemented in community-based settings. Previous research has often emphasized clinical outcomes, such as PTSD symptoms, anxiety, and depression, or the effectiveness of specific interventions (Arega, 2023). However, these outcomes alone do not fully explain how children participate in support activities, respond psychologically, or experience psychosocial recovery within their social environments. This limitation highlights the need to examine intervention implementation alongside children's experiences and functioning, particularly in settings where access to

specialized mental health services may be limited.

Clinical intervention research provides useful context but should not be treated as interchangeable with community-based MHPSS. Trauma-focused cognitive behavioral approaches have been examined in structured treatment settings, including trials involving children and adolescents and adaptations delivered in group formats (Goldbeck et al., 2016; Deblinger et al., 2015). These approaches differ from the present session in intensity, therapeutic aims, practitioner roles, and outcome evaluation. Reviews of MHPSS interventions for children in low- and middle-income settings likewise point to variation in intervention models and evidence quality, supporting careful description of what is delivered and what can reasonably be concluded from the available data (Arega, 2023). The current study therefore examines the implementation and immediate experience of a community-based session rather than positioning it as a substitute for evidence-based clinical treatment.

This study addresses three related research gaps. First, context-specific evidence on MHPSS implementation for child sexual abuse survivors within community-based child protection services in Indonesia, particularly in Kediri, remains insufficiently developed (Pradika et al., 2024). Second, psychosocial interventions need greater attention to children's participation, psychological comfort, and behavioral responses, rather than focusing exclusively on clinical outcomes. Third, the relationship between trauma-related symptoms and adaptive functioning requires further examination. Children may experience psychological distress while remaining socially engaged, meaning that observable participation does not necessarily indicate recovery. Examining these dimensions together may provide a more comprehensive understanding of children's psychosocial needs.

To address these gaps, this study adopts a contextual and process-oriented approach, examining how MHPSS is delivered and how children respond during intervention activities. It considers trauma-related

symptoms alongside psychological comfort, participation, and adaptive functioning without assuming that observed responses are directly caused by the intervention. Children's experiences are interpreted within the local service context, recognizing the potential relevance of caregiver support, safety, community attitudes, and institutional coordination.

Accordingly, this study examines the implementation of MHPSS among child sexual abuse survivors in Kediri, Indonesia. Specifically, it describes participants' mental health and psychosocial conditions, identifies the forms of support provided, and explores their psychological responses, participation, and adaptive functioning during the intervention. The findings are expected to contribute to a more context-specific understanding of community-based MHPSS and inform child-centered, trauma-informed, gender-sensitive, and locally responsive practices within child protection services.

B. Method

This study employed a descriptive exploratory mixed-methods design to examine the implementation of Mental Health and Psychosocial Support (MHPSS) among child sexual abuse survivors in Kediri, Indonesia. Quantitative data described trauma-related symptoms and perceived psychological comfort, while qualitative data explored participants' emotional responses, participation, social interactions, and adaptive functioning. The descriptive exploratory approach was appropriate because the purpose was to document the implementation process and participants' experiences in a specific service context, rather than to test an intervention effect or establish causal relationships. Community-based MHPSS guidance emphasizes understanding local needs, existing resources, and the social context in which support is delivered (Inter-Agency Standing Committee [IASC], 2019). Accordingly, the study integrated numerical summaries with contextual

observations while keeping the two forms of evidence analytically distinct. The study was not designed to evaluate the intervention's clinical effectiveness.

The participants were nine 8–16 years old girls who had experienced sexual abuse by the same perpetrator. They were selected through purposive sampling based on their age, experience of sexual abuse, participation in psychosocial recovery activities, and parental or legal guardian permission. Purposive recruitment was consistent with the exploratory objective of documenting the experiences of children who met the study's specific eligibility criteria; it was not intended to produce a statistically representative sample. The narrow participant group also means that findings should be understood in relation to this particular service context and not generalized to all child sexual abuse survivors.

Data were collected through the Child and Adolescent Trauma Screen (CATS), a psychological comfort rating, direct observation, interviews, parental discussions, and documentation. The MHPSS intervention was conducted in one four-hour session, from 08.00 to 12.00 on May 18, 2026, comprising six activities: aspiration exploration, emotional exploration and trauma validation, therapeutic play, positive affirmation, caplok-caplokan (snapping jaw) traditional group game, and parental discussion. Activities followed child-centered and trauma-informed principles adapted to participants' developmental needs and the community setting. Using multiple sources was intended to provide a fuller description of the session: standardized screening summarized reported trauma-related symptoms, the comfort rating captured children's immediate subjective appraisal, and qualitative material documented behavior and participants' expressed experiences. The combination was especially relevant because children's trauma symptoms and observable

participation may describe different dimensions of functioning (Sachser et al., 2017; Stockman et al., 2023).

Trauma-related symptoms were assessed using CATS, with scores interpreted according to the scoring guidelines for the version used. The results were treated as screening findings, not clinical PTSD diagnoses. Psychological comfort was measured using an adapted 0–10 numerical rating scale: 0–2 (very uncomfortable), 3–4 (uncomfortable), 5–6 (moderately comfortable), 7–8 (comfortable), and 9–10 (very comfortable). As this scale was adapted for the study, it was used descriptively rather than as a validated psychometric instrument. The CATS was selected because it was developed for assessing trauma exposure and post-traumatic stress symptoms in children and adolescents, and its psychometric properties have been examined across settings (Sachser et al., 2016). In this study, the CATS results were interpreted only as screening indicators. They were not treated as a substitute for a comprehensive clinical assessment, which requires consideration of symptom patterns, impairment, context, and professional judgment. The comfort rating was kept separate from the CATS because the two measures were intended to describe different constructs: trauma-related symptoms and perceived comfort at the time of assessment.

Quantitative data were analyzed using descriptive statistics, including frequencies, percentages, and categorical distributions. Individual CATS and comfort scores were compared descriptively to identify variations among participants. Qualitative data were analyzed thematically by reviewing the data, coding recurring observations and statements, grouping codes into categories, and identifying themes related to emotional responses, social interaction, participation, and adaptive functioning. Both datasets were integrated descriptively to

identify convergence and differences between trauma symptoms, psychological comfort, and observed functioning. No inferential statistical tests or causal conclusions were drawn because of the small sample and exploratory design.

The study prioritized informed consent, confidentiality, privacy, psychological safety, and prevention of retraumatization. The activities were conducted at the request of the Kediri Regency Office of Women's Empowerment, Child Protection, Population Control, and Family Planning (DP3AP2K3), with the researcher serving as the clinical psychology facilitator. Four participants had previously received psychological support from another psychologist. Written informed consent was obtained from parents or legal guardians, and age-appropriate assent was obtained from the children before the activities began.

Children's assessment and psychosocial sessions were conducted separately from institutional staff, village officials, and parents or guardians, with only the child and clinical psychologist present. Participants were identified using codes A–I to protect their identities. Parents, guardians, and institutional representatives participated separately when necessary, particularly during parental discussions.

To ensure psychological safety, the CATS assessment was explained in age-appropriate language and, when needed, through storytelling. Participants could choose a comfortable sitting position, proceed at their own pace, request breaks, decline questions, or discontinue activities if uncomfortable. The facilitator monitored emotional responses and adjusted activities accordingly. The intervention minimized the need for detailed verbal disclosure of abuse and emphasized emotional validation, therapeutic play, positive affirmation, and supportive

interaction. Physical contact was neither required nor encouraged and occurred only when a child initiated it voluntarily within appropriate professional boundaries. Parental discussions addressed children's emotional responses, supportive caregiving, and continued psychosocial support at home.

After the session, participants could provide verbal feedback. Reports of feeling more comfortable, less afraid, and more willing to resume daily activities were treated as subjective immediate responses, not evidence of clinical improvement or reduced PTSD symptoms. These safeguards aimed to preserve voluntary participation, children's autonomy, confidentiality, and psychological well-being throughout the study.

C. Discussion

1. Mental Health and Psychosocial Conditions of Child Sexual Abuse Survivors

This study involved nine child sexual abuse survivors under 18 years old who had experienced abuse by the same perpetrator and were receiving psychosocial assistance through an MHPSS program in Kediri. Trauma-related symptoms were assessed using the Child and Adolescent Trauma Screen (CATS), while participants' perceived psychological comfort was assessed using a 0–10 rating scale. The first objective of the study was to describe the mental health conditions of the participants based on the CATS assessment.

Category	Frequency (n)	Percentage (%)
Potential PTSD	7	77.8 %
Moderate	1	11.1 %
Normal	1	11.1 %
Total	9	100 %

Table 1: Distribution of PTSD Categories Based on the Child and Adolescent Trauma Screen (CATS)

As presented in Table 1, seven participants (77.8%) were categorized as having potential PTSD symptoms based on the CATS. In contrast, one participant (11.1%) fell within the moderate category, and one participant (11.1%) was within the normal range. The high proportion of participants screening positive for potential PTSD symptoms indicates that trauma-related difficulties remained present among most participants at the time of assessment. However, these findings should be interpreted as screening results, not clinical diagnoses. The presence of potential PTSD symptoms does not by itself establish that a participant met diagnostic criteria for PTSD. Nevertheless, the findings indicate that trauma-related psychological difficulties remained relevant among the children involved in the study and support the importance of continued psychosocial attention during the recovery process.

This distribution matters for service planning because a positive screen should prompt further assessment and follow-up rather than an immediate diagnostic label. The CATS was developed as a screening instrument for trauma-related symptoms in children and adolescents, and its use can support systematic identification of possible needs (Sachser et al., 2016). However, screening results must be interpreted in light of the version administered, the child's understanding of the items, the assessment context, and the limits of a brief instrument. In this study, the categories are reported as screening classifications only. The results do not establish the presence of a clinical disorder in any individual participant, and they should not be used to make claims about the prevalence of PTSD among survivors in Kediri more broadly.

Participants' perceived psychological comfort was assessed separately using a 0–10 rating scale. The scale

was adapted for this study based on the Child and Adolescent Trauma Screen (CATS). Still, it was used specifically to describe participants' subjective perceptions of psychological comfort rather than to measure PTSD symptoms. The scores were grouped into five categories: very uncomfortable (0–2), uncomfortable (3–4), moderately comfortable (5–6), comfortable (7–8), and very comfortable (9–10).

Comfort Category	Score Range	Frequency (n)	Percentage (%)
Very Uncomfortable	0-2	3	33.3 %
Uncomfortable	3-4	2	22.2 %
Moderately Comfortable	5-6	2	22.2 %
Comfortable	7-8	2	22.2 %
Very Comfortable	9-10	0	0 %
Total		9	100 %

Table 2: Distribution of Psychological Comfort Levels

As shown in Table 2, three participants (33.3%) reported very low psychological comfort, while two participants (22.2%) reported uncomfortable levels. Two participants (22.2%) reported moderate comfort, and two participants (22.2%) reported comfortable levels. No participants reported a score in the very comfortable category. Overall, five participants (55.5%) reported scores within the two lowest comfort categories. These findings suggest that a considerable proportion of participants continued to experience psychological discomfort during the recovery process. At the same time, the variation in scores indicates that the participants did not experience the psychosocial recovery environment in the same way.

To further understand the relationship between trauma symptoms and psychosocial well-being, individual CATS scores were compared with participants' psychological comfort scores.

Participant	Age	Gender	CATS Score	CATS Category	Comfort Score	Comfort Category
A	16	Female	25	Potential PTSD	0	Very Uncomfortable
B	14	Female	49	Potential PTSD	1	Very Uncomfortable
C	12	Female	44	`Potential PTSD	6	Moderately Comfortable
D	10	Female	15	Moderate	3	Uncomfortable
E	12	Female	8	Normal	5	Moderately Comfortable
F	8	Female	23	Potential PTSD	0	Very Uncomfortable
G	10	Female	29	Potential PTSD	7	Comfortable
H	15	Female	36	Potential PTSD	3	Uncomfortable
I	12	Female	36	Potential PTSD	7	Comfortable

Table 3: Comparison of CATS Scores and Psychological Comfort Levels

As presented in Table 3, considerable variation was observed between trauma-related symptom scores and perceived psychological comfort among the nine female participants. Participant B recorded the highest CATS score (49) and reported a comfort score of 1, whereas Participant C recorded a CATS score of 44 and reported a comfort score of 6. Participants G and I, who also screened positive for potential PTSD symptoms, reported comfort scores of 7. In contrast, Participant E was within the normal CATS range but reported only moderate psychological comfort (score = 5). These descriptive differences indicate that trauma-related symptom severity was not consistently accompanied by a corresponding level of psychological discomfort.

The contrast between participants' CATS and comfort scores should be read as descriptive heterogeneity rather than a statistical relationship. The participant with the highest CATS score also reported very low comfort, but other participants with elevated CATS scores reported

moderate or comfortable ratings. Such differences are plausible because a symptom screen summarizes trauma-related experiences, whereas a momentary comfort rating captures a narrower appraisal of the assessment or support setting. They should not be collapsed into one measure or interpreted as evidence that one construct predicts the other. Research on social support and post-traumatic stress identifies an association between interpersonal resources and symptoms among young people. Still, an association at the literature level does not establish the mechanism operating in this small group (Allen et al., 2021).

From a gender-sensitive perspective, these findings highlight the heterogeneity of trauma responses among female survivors rather than suggesting a uniform pattern among girls. From a social-ecological perspective, the variation may be considered within the broader interaction between individual psychological responses and the interpersonal and social environments in which children experience recovery. However, because the present study did not directly measure gender norms, social support, family functioning, stigma, or perceived environmental safety, these factors should be regarded as possible contextual considerations rather than explanations established by the data.

Gender-sensitive interpretation requires attention to social expectations without assuming that the participants' scores were caused by gender. Norms about obedience, respectability, and family reputation can affect how children communicate distress and whether they feel able to refuse an adult's request. At the same time, this study did not collect direct measures of gender norms, disclosure experiences, or gender-based barriers. The fact that all nine participants were girls limits the analysis to their experiences and prevents comparison with boys or

children of other gender identities. Literature on gender dimensions of violence against children and on sex- and gender-related PTSD risk factors supports the relevance of this lens, but it does not allow the present data to confirm a specific gender mechanism (UNICEF, 2020; Haering et al., 2024).

The findings should therefore not be interpreted as demonstrating a direct relationship between PTSD symptoms and psychological comfort. CATS scores and comfort scores represent different aspects of participants' experiences. CATS focuses on trauma-related symptoms, whereas the comfort rating was intended to capture participants' subjective perception of psychological comfort at the time of assessment. A child may continue to experience trauma-related symptoms while feeling relatively comfortable in a supportive environment. Conversely, a child with fewer trauma symptoms may still experience discomfort because of fear, uncertainty, interpersonal concerns, or other contextual factors.

Observations during the MHPSS activities provided additional information about participants' psychosocial functioning. Despite the relatively high proportion of participants with potential PTSD symptoms, most participants were able to participate in the activities. They showed enthusiasm when discussing their aspirations and hobbies, expressed emotions during trauma-validation activities, and participated in therapeutic play and group activities. During positive affirmation activities, participants appeared attentive and engaged. Group games were accompanied by spontaneous laughter, peer interaction, and other positive emotional expressions. Participants also interacted with facilitators and peers during the activities.

Most participants communicated, followed instructions, interacted with peers, and remained involved

throughout the four-hour session. Some participants initially appeared hesitant when discussing emotionally difficult experiences, but they subsequently participated in group discussions and recreational activities. These observations suggest that trauma-related symptoms can coexist with observable adaptive functioning within a supportive psychosocial setting. However, because these observations were conducted during a single intervention session, they should be understood as descriptions of participants' functioning in that particular context rather than evidence of long-term recovery or resilience.

Taken together, the findings indicate that child sexual abuse survivors may experience trauma-related symptoms and psychosocial functioning in different ways. The presence of potential PTSD symptoms did not prevent all participants from engaging socially, communicating with others, or participating in structured psychosocial activities. At the same time, active participation should not be interpreted as an absence of psychological difficulties. Considering both trauma symptoms and observable psychosocial functioning may therefore provide a broader description of children's experiences during recovery.

2. Relationship Between Trauma-Related Symptoms, Psychological Comfort, and Adaptive Functioning: Gender and Social-Ecological Perspectives

The findings revealed variations in trauma-related symptoms and psychological comfort among nine female child sexual abuse survivors. Based on the Child and Adolescent Trauma Screen (CATS), seven participants (77.8%) screened positive for potential PTSD symptoms. In contrast, one participant (11.1%) fell within the moderate range and one (11.1%) within the normal range. Psychological comfort also varied: three participants reported feeling very uncomfortable, two uncomfortable, two moderately comfortable, and two comfortable.

Individual scores further illustrated this variation. Participant B had the highest CATS score (49) and the lowest comfort score (1), whereas Participant C scored 44 on CATS but reported moderate comfort (6). Participants G and I screened positive for potential PTSD symptoms while reporting comfortable levels (7). Meanwhile, Participant E, whose CATS score was within the normal range, reported moderate comfort (5). These findings suggest that trauma-related symptoms and perceived psychological comfort do not necessarily correspond directly.

From a gender-sensitive perspective, these differences highlight the importance of recognizing individual experiences rather than assuming that all girls respond to trauma in the same way. Gender norms, unequal power relations, and social expectations may influence children's experiences of abuse, disclosure, and help-seeking. However, because this study involved only female participants, it cannot establish gender differences or determine whether gender-related factors explain the observed variations.

A social-ecological perspective further emphasizes that psychological experiences occur within interconnected environments. Individual coping processes, relationships with caregivers and peers, community attitudes, stigma, and access to psychosocial services may all shape children's experiences of safety and comfort. Nevertheless, these factors were not directly measured in this study and should therefore be understood as possible contextual influences rather than established explanations.

An ecological perspective also shifts attention from the child alone to the relationships and systems around the child. At the individual level, children may differ in symptoms, coping resources, and readiness to participate.

At the interpersonal level, caregiver responses and peer interaction may influence whether support feels available. At the community and institutional levels, stigma, confidentiality practices, referral pathways, and coordination among agencies can affect access to continued care. A systematic meta-review of sexual violence research highlights the value of understanding impacts through ecological layers rather than isolating one level of explanation (Stockman et al., 2023). The present study did not directly measure these layers, so they are best understood as a framework for interpreting the service context and planning future assessment, not as empirical findings about these nine children.

The findings indicate that psychological comfort represents a dimension of children's experiences that may not be fully captured by trauma symptom scores alone. Children may continue to experience trauma-related symptoms while participating positively in supportive activities. Conversely, lower symptom scores do not necessarily indicate that a child feels comfortable in every situation. Assessments of psychosocial recovery should therefore consider trauma symptoms alongside subjective comfort and observable functioning. Future research should examine these relationships in larger samples and use direct measures of gender-related and social-ecological factors.

These distinctions have implications for assessment practice. A brief symptom measure can help identify possible trauma-related needs. Still, a child-centered service should also invite children to communicate whether they feel safe, whether they want to continue, and what forms of participation feel manageable. Observations of communication and play can complement these reports, provided that they are recorded descriptively and not treated as proof of recovery. Combining child report,

observation, and caregiver discussion can provide a more rounded picture, while each source retains its limitations. Caregiver information may be valuable, but it should not override a child's own account or compromise privacy. Family support has been identified as relevant to psychological rehabilitation after sexual violence, and family communication is important in child protection, making caregiver engagement a meaningful but carefully bounded component of support (Syahfitri et al., 2024; Septiani, 2021).

3. Implementation of Mental Health and Psychosocial Support (MHPSS) for Child Recovery

The MHPSS program was implemented as a trauma-informed psychosocial intervention addressing the emotional, psychological, and social needs of child sexual abuse survivors. Rather than focusing solely on reducing PTSD symptoms, the program provided opportunities for emotional expression, play, social interaction, positive affirmation, and caregiver involvement. The intervention consisted of six interconnected activities delivered during a four-hour session.

The activities moved from strengths and interests to emotional expression, structured play, affirmation, group interaction, and caregiver discussion. This progression offered different routes for engagement rather than requiring every child to disclose or discuss the abuse verbally. Beginning with aspirations and hobbies allowed participants to present themselves through interests and future-oriented hopes, not solely through the identity of a survivor. Emotional validation then acknowledged difficult feelings without requiring detailed disclosure. This distinction aligns with trauma-informed practice, which prioritizes safety, choice, collaboration, and awareness of the risk of retraumatization (UNICEF & International Rescue Committee, 2023). The activities

should nevertheless be understood as a locally delivered support session, not as a validated treatment protocol.

The first activity explored participants' aspirations, interests, and hobbies, encouraging children to recognize positive aspects of their identities beyond their experiences of abuse. The second focused on emotional exploration and trauma validation, providing a supportive space to express difficult feelings such as fear, shame, guilt, and self-blame. Some participants became more willing to communicate as the session progressed, although this observation does not establish the intervention's effectiveness.

The third activity involved therapeutic play through interactive games emphasizing attention, movement, and cooperation. Some participants voluntarily approached and hugged the female facilitator, suggesting comfort within the immediate setting, but not necessarily restored trust or broader psychological recovery. The fourth activity provided positive affirmation and motivational guidance emphasizing self-worth, hope, courage, and future possibilities. The fifth involved caplok-caplokan traditional game, which encouraged laughter, peer interaction, and active participation. Observations of increased enthusiasm and spontaneous communication indicated positive social engagement during the session, but they cannot establish sustained improvements in psychological well-being or resilience.

The sixth activity involved discussions with parents or guardians about children's emotional conditions and supportive caregiving strategies. This component emphasized the role of caregivers in maintaining emotional and social support beyond structured intervention sessions and responding appropriately to children's trauma-related needs.

Following the activities, several participants reported feeling more comfortable, less afraid, and more willing to resume their daily activities. These statements provided additional qualitative information about participants' immediate experiences and complemented the quantitative findings and behavioral observations. However, they were interpreted as subjective perceptions rather than evidence of clinical improvement, given the absence of standardized pre- and post-intervention measurements.

The reported immediate changes are best understood as feasibility and acceptability signals. They suggest that some children identified a positive subjective experience after the session, which is useful information for practitioners reviewing how activities are received. Yet a single post-session report cannot separate the influence of the intervention from temporary changes in mood, the effect of attention from an adult, social desirability, or the natural variation of emotional states. Without baseline measures and follow-up, no conclusion can be drawn about symptom reduction, sustained comfort, or long-term adaptive functioning. In contrast, intervention trials of trauma-focused cognitive behavioral therapy have used more structured designs to assess outcomes, illustrating the difference between describing a support session and testing treatment effectiveness (Goldbeck et al., 2016; Deblinger et al., 2015).

Overall, the six MHPSS activities provided opportunities for emotional expression, play, social interaction, positive affirmation, and caregiver engagement. Participants' involvement despite ongoing trauma-related symptoms suggests that psychosocial participation can coexist with psychological difficulties. This finding supports a multidimensional understanding of recovery that considers trauma symptoms,

psychological comfort, and observable functioning rather than relying exclusively on symptom scores. The findings are consistent with the importance of supportive relationships, family involvement, and emotional expression in children's psychosocial recovery. The study contributes a descriptive perspective by examining these dimensions together within a community-based MHPSS setting.

From a practical perspective, the findings highlight the importance of child-centered and trauma-informed support that incorporates developmentally appropriate activities, safe social interaction, supportive communication, and caregiver involvement. Nevertheless, the findings must be interpreted cautiously because the study involved only nine participants who had experienced abuse by the same perpetrator and received MHPSS in the same setting. The descriptive design included neither a control group nor pre- and post-intervention measurements. Furthermore, the psychological comfort rating was adapted for this study and should be interpreted as a descriptive measure rather than an established psychometric instrument. Consequently, the findings cannot demonstrate that the program reduced PTSD symptoms or increased resilience.

Psychosocial recovery among child sexual abuse survivors should therefore be understood as a multidimensional process. Trauma-related symptoms may persist even when children participate positively in social interactions and supportive activities; conversely, observable engagement does not necessarily indicate the absence of trauma or complete recovery. Future research should involve larger and more diverse samples, validated measures of psychological well-being and resilience, and longitudinal or comparative designs to

examine changes in trauma symptoms, psychological comfort, and adaptive functioning over time.

D. Conclusion

This study demonstrates that the psychosocial experiences of child sexual abuse survivors are multidimensional. Although seven of the nine participants screened positive for potential PTSD symptoms, their psychological comfort and participation varied. Some participants engaged actively with peers and facilitators despite ongoing trauma-related symptoms, suggesting that trauma symptoms and adaptive functioning may coexist.

The MHPSS program provided opportunities for emotional expression, therapeutic play, positive affirmation, culturally familiar group activities, and caregiver engagement. These observations demonstrate the feasibility of delivering child-centered psychosocial activities in the study setting. Still, they do not establish clinical effectiveness because no pre- and post-intervention comparison or control group was used.

The findings highlight the importance of assessing trauma-related symptoms alongside psychological comfort and observable functioning. Psychosocial support should prioritize children's safety, individual needs, opportunities for expression, and supportive relationships. Collaboration among mental health professionals, caregivers, educators, and child protection services may help sustain support beyond intervention sessions.

Future studies should use larger samples, validated assessment instruments, and longitudinal or comparative designs to examine the relationship between trauma symptoms, psychological comfort, and adaptive functioning. Further research across different service

settings is also needed to determine whether these findings apply to other populations of child sexual abuse survivors.

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