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GROUP-BASED COGNITIVE BEHAVIORAL PLAY THERAPY FOR EMOTIONAL AND BEHAVIORAL PROBLEMS AMONG PAKISTANI MUSLIM ADOLESCENTS: A PILOT STUDY

Sheeza Sarfaraz* and Tahira Yousaf**

Abstract: Muslim teenagers are increasingly experiencing emotional and behavioural problems (EBPs), which frequently go undiagnosed in the early school years and may be a factor in subsequent mental health issues. This pilot study was conducted with Pakistani Muslim adolescents in an urban school setting in Karachi. Cognitive Behavioral Play Therapy (CBPT) is a promising intervention for addressing these issues. This study examined the efficacy of CBPT interventions in reducing EBPs among Pakistani Muslim early and middle adolescents. Thirty-two students were initially screened for eligibility; eight withdrew, resulting in a final sample of 24 participants between the ages of 11 and 17. An equal number of participants from the early and middle teenage years (11–14 and 15–17 years old, respectively) were distributed to the experimental and control groups. A demographic form was used to collect data, along with the School Children's Problems Scale (SCPS). The intervention consisted of 10 weekly CBPT sessions lasting 70–80 minutes each. Results indicated significantly lower overall EBPs scores in the early and middle adolescent experimental groups compared to the control groups ($p < 0.001$), with very large effect sizes ($d = -4.4$ and -4.73, respectively); given the small sample size and pilot nature of the study, these effect sizes should be interpreted with caution. Significant pretest to post-test reductions in SCPS scores were also observed in both experimental groups ($p < 0.001$). These preliminary findings suggest that group-based CBPT may be a promising school-based intervention for reducing adolescents' emotional and behavioural difficulties and improving access to mental health support. However, larger studies are needed to confirm these findings and examine the long-term effects of CBPT.

Keywords: *Cognitive Behavioral Play Therapy interventions*, *emotional and behavioural problems*, *Muslim adolescents*, *school-based intervention*

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INTRODUCTION

Biological, psychological, and social changes during adolescence affect emotional and behavioural functioning. Many teens are vulnerable to mental health issues such as anxiety, depression, anger, and social disengagement during this transitional period.[1] Within Muslim societies, these difficulties may be shaped by their cultural, familial, and religious dynamics, which influence emotional expression and coping strategies. Despite the global rise in emotional and behavioural problems (EBPs) among teens, there remains a notable shortage of culturally sensitive, evidence-based interventions addressing these concerns in low- and middle-income countries, including those with largely Muslim populations.[2] Cognitive Behavioral Play Therapy (CBPT) is an effective approach that combines the cognitive-behavioural model with play-based techniques, which promise to improve emotional regulation and adaptive behaviour among children and adolescents.[3] However, scientific evidence indicates the efficacy of group-based CBPT interventions among Muslim adolescent populations remains largely unexplored. Approximately 792 million people globally are affected by mental health issues, with a significant proportion of cases emerging during adolescence.[4] Children constitute about 42% of the global population, with roughly 20% being adolescents.[5]

Given the considerable developmental differences between ages 10 and 19, "adolescence" is typically segmented into sub-stages. Historically, theorists and clinicians have diverged in their chronological explanations of these stages. Early adolescence is generally defined as approximately 10 to 14 years, middle adolescence as 15 to 17 years, and late adolescence as 18 to 19 years.[6] The innovative challenges and evolving emotional and social expectations during this period often exaggerate adolescents' vulnerability to behavioural and emotional

1 Amy Orben et al., "The Effects of Social Deprivation on Adolescent Development and Mental Health," *The Lancet Child & Adolescent Health* 4, no. 8 (2020); Fatima Sana and Sara Subhan, "A Case Study of a School Child with Emotional and Behavior Problems Treated Using Cognitive Behavioral Therapy," *Research Square* 1 (2022), https://doi.org/10.21203/rs.3.rs-1970357/v1.

2 Idayu Badilla Idris et al., "A Longitudinal Study of Emotional and Behavioral Problems among Malaysian School Children," *Annals of Global Health* 85, no.1 (2019).

3 Susan Knell and Meena Dasari, "CBPT: Implementing and Integrating CBPT Into Clinical Practice," in *Blending Play Therapy with Cognitive Behavioral Therapy: Evidence-based and Other Effective Treatments and Techniques* (John Wiley & Sons, 2009).

4 Adam Mabrouk et al., "Mental Health Interventions for Adolescents in Sub-Saharan Africa: A Scoping Review," *Frontiers in Psychiatry* 13 (2022).

5 Olayinka Atilola, "Child Mental-health Policy Development in sub-Saharan Africa: Broadening the Perspectives Using Bronfenbrenner's Ecological Model," *Health Promotion International* 32, no. 2 (2014); Jiayi Tian et al., "Global Burden of Mental Disorders among Adolescents and Young Adults, 1990–2021: A Systematic Analysis of the Global Burden of Diseases Study 2021," *General Psychiatry* 38, no. 6 (2025).

6 World Health Organization (WHO), *Health for the World's Adolescents: A Second Chance in the Second Decade* (WHO, 2015).

issues such as anxiety, depression, aggression, social withdrawal, and somatic symptoms.[7] Some adolescents experience physiological changes, and others may have long-term issues, potentially leading to permanent concerns for adolescents, their families, educational institutions, and society at large.[8]

EBPs have *internalising* and *externalising* issues. Internalising problems involve inward-focused issues (withdrawal, anxiety, depression, feelings of rejection, and somatic complaints), while externalising problems have outwardly behaviours (aggression, deviance, impulsive acts, and hyperactivity).[9] EBPs have been further explained as psychosomatic problems having social withdrawal, hostility, anxiousness, feelings of rejection, and academic difficulties as particularly relevant within the Pakistani context, which forms the focus of this study. Globally, studies indicate that approximately 75% of adults who have experienced mental health issues report the onset of symptoms before age 24. The prevalence of EBPs among adolescents ranges from 1% to 50%, averaging approximately 15.8%. Specifically, rates for early and middle adolescence range between 13.2% and 16.5%.[10]

Over time, youth development clinics started gaining recognition, shifting the focus of intervention from conduct disorders and delinquency to EBPs more commonly observed in institutions and homes. This shift reflects a mounting understanding of the complexity of adolescent issues. Various therapeutic models have been developed to address adolescents' EBPs, including play therapy, cognitive therapy, applied behaviour therapy etc. However, with over 400 forms of psychotherapy in practice and no single method effective for every case, professionals have designed integrative psychotherapy approaches that combine techniques from multiple models to create individualised, adaptive, and effective treatment plans.[11]

Integrative psychotherapy draws on multiple theoretical perspectives within a dynamic systems framework. One integrative model is CBPT, which merges cognitive-behavioural principles with play-based techniques. CBPT incorporates the cognitive-behavioural methods originally developed by Aaron Beck.[12] Research shows that Cognitive Behavioral Therapy

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7 Hee Young Park and Yeon Hee Choi, "Factors Affecting Emotional Behavioral Problems in Early Adolescence: A Multilevel Model Study," *Research in Community and Public Health Nursing* 28, no. 4 (2017).

8 Low Biam Hong et al., "Temperament and Anxiety of Children in Childcare Centre: Child-Parent Relationship as Mediator," *International Journal of Humanities and Social Science* 8, no. 5 (2018).

9 Shefali Mishra and Navdeep Sing Tung, "Emotional Regulation and Emotional and Behavioral Problems (EBP) among Institutionalised Adolescents," *Indian Journal of Human Relations* 52, no. 2 (2018); Josiane Rosa Campos et al., "Predictors of Behavioral Problems in Adolescents: Family, Personal and Demographic Variables," *Psico-USF* 24, no. 2 (2019); Syed Usman Hamdani et al., "Scaling-up School Mental Health Services in Low Resource Public Schools of Rural Pakistan: The Theory of Change (ToC) Approach," *International Journal of Mental Health Systems* 15, no. 1 (2021); Xue Yu et al., "Internalizing Behavior Problems Among the Left-Behind Children of the Hui Nationality in Rural China: A Cross-Sectional Study," *Psychology Research and Behavior Management* Volume 15 (2022).

10 Tilman Furniss et al., "Prevalence of Behavioral and Emotional Problems among Six-Year-Old Preschool Children: Baseline Results of a Prospective Longitudinal Study," *Social Psychiatry and Psychiatric Epidemiology* 41, no. 5 (2006); Sadia Saleem, *Development and Validation of the School Children Problem Scale (SCPS)* (University of the Punjab, 2011).

11 Cristina Zarbo et al., "Integrative Psychotherapy Works," *Frontiers in Psychology* 6 (2015).

12 Knell and Dasari, "CBPT."

(CBT) can be adapted effectively for individuals aged seven and older.[13] British clinical guidelines recommend group-based CBT for children aged 9–14 with conduct issues, based on randomised controlled trial evidence.[14] Thus, externalising behaviours must be addressed by testing developmentally appropriate CBT therapies for early and middle adolescents.[15]

A Tehran study found that CBPT increased student self-esteem and decreased social anxiety.[16] CBPT also helps seven-to-nine-year-olds with ADHD.[17] School CBPT is a hands-on, accessible method to aid students who cannot get mental healthcare outside school. Early screening, identification, and therapy in schools are crucial for mental health.[18] Integrating CBPT within schools supports mental wellbeing and educational outcomes.

School group therapy has several benefits. It helps counsellors work well with many students, ensures students attend often, and provides a safe location for students who are scared to seek mental health support. Being in a group helps teens feel like they belong and are included, which helps them grow.[19] Group treatment can produce effects like individual therapy.[20] Group therapy is a practical and successful technique to provide emotional and psychoeducational care in schools.[21]

Despite global advances, significant gaps remain in implementing evidence-based interventions for EBPs in low- and middle-income countries, including Pakistan. Pakistani research often adopts Western assessment methods that are not culturally sensitive, making comparisons impossible.[22] Local demographic and cultural features are considered in the School Children's Problem Scale (SCPS) to overcome this constraint. This study examines

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13 Walter Matthys and Dennis J. Schutter, "Increasing Effectiveness of Cognitive Behavioral Therapy for Conduct Problems in Children and Adolescents: What Can We Learn from Neuroimaging Studies?" *Clinical Child and Family Psychology Review* 24, no. 3 (2021).

14 National Institute for Health and Clinical Excellence (NICE), *Antisocial Behaviour and Conduct Disorders in Children and Young People: Recognition and Management* (NICE, 2013–2017).

15 Thomas H. Ollendick and Neville J. King, "Empirically Supported Treatments for Children with Phobic and Anxiety Disorders," *Journal of Clinical Child Psychology* 27, no. 2 (1998).

16 Sareh Ghasemian Siahkalroudi and M. Bahri, "Effectiveness of Cognitive Behavioral Play Therapy Group on Self-Esteem and Social Skills in Girls' Elementary School," *Journal of Scientific Research and Development* 2, no. 4 (2015).

17 Ebrahim Abdollahian et al., "The Effectiveness of Cognitive-Behavioural Play Therapy on the Symptoms of Attention-Deficit/Hyperactivity Disorder in Children Aged 7–9 Years," *ADHD Attention Deficit and Hyperactivity Disorders* 5, no. 1 (2013).

18 Hyun Ju Chong and Soo Ji Kim, "Education-Oriented Music Therapy as an After-School Program for Students with Emotional and Behavioral Problems," *The Arts in Psychotherapy* 37, no. 3 (2010); Alison L. Calear and Helen Christensen, "Systematic Review of School-Based Prevention and Early Intervention Programs for Depression," *Journal of Adolescence* 33, no. 3 (2010).

19 Craig Haen and Sheryl Aronson, *The Handbook of Child and Adolescent Group Therapy: A Practitioner's Reference* (Routledge, 2017); Susan C. Whiston and Rebecca F. Quinby, "Review of School Counseling Outcome Research," *Psychology in the Schools* 46, no. 3 (2009).

20 Janice L. DeLucia-Waack et al., eds., *Handbook of Group Counseling and Psychotherapy*, 2nd ed. (SAGE Publications, 2014).

21 Julie C. Herbstrith and Rhonda M. Tobin, "Best Practices in Group Counseling," in *Best Practices in School Psychology: Student Level Services*, ed. P. Harrison and A. Thomas (National Association of School Psychologists, 2014).

22 Farah Malik et al., "Behavioral and Emotional Problems in Abused and Nonabused Children in a Pakistani Cohort," *Pakistan Journal of Psychological Research* 25, no. 2 (2010); Sajida Abdul Hussein, "Dual-Informant Ratings of Emotional and Behavioral Problems among Primary School Children," *Pakistan Journal of Psychological Research,* 25, no 2 (2010).

the efficacy of group-based CBT for Pakistani Muslim adolescents with EBPs. By applying culturally relevant tools and evidence-based group methods, this research seeks to enhance the understanding and treatment of Muslim adolescent emotional and behavioural challenges in Pakistan.

PROBLEM STATEMENT

Teenagers in Pakistan generally go through emotional turmoil, but the accessibility and implementation of evidence-based therapeutic tools are limited. Statistics reveal that 10–16% of the Pakistani population have mild to moderate psychological issues,[23] while school-based statistics report the occurrence of EBPs from 17% to 35%.[24] In Pakistan, social stigma largely hinders Muslim teenagers from gaining appropriate and timely psychological help.[25] Parents also show hesitation to allow their children to seek therapy due to misperceptions about mental wellness programs and the reliability of Western-developed tools, which may interfere with Islamic values.

Mental health practitioners also face challenges like insufficient training in developmentally appropriate modalities, including CBPT approaches, and a lack of organisational backing. These barriers not only delay early recognition of problems but also lead to the worsening of untreated psychological distress among Muslim teens. The psychological issue is exaggerated by the absence of culturally adapted therapeutic models, putting a major gap between global advances in adolescent mental health and their practical applicability within Pakistani environments.[26] Moreover, this cultural gap highlights the need for contextually appropriate instruments and interventions.[27]

SIGNIFICANCE OF THE STUDY

This study establishes theoretical and practical importance. Theoretically, it contributes to the understanding of Muslim adolescent mental health in Pakistan within a local, culturally based context.[28] Clinically, it highlights the imperative need for evidence-based interventions

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23 Arooj Najmussaqib and Asia Mushtaq, "Estimation and Linkage between Behavioral Problems and Social Emotional Competence among Pakistani Young School Children," *Plos One* 18, no. 5 (2023).

24 Huma R. Chaudry, "Indian Psychiatry and Research in Pakistan," *Indian Journal of Psychiatry* 52 no 7 (2010); Bushra Khan and Bilal Iqbal Avan, "Behavioral Problems in Preadolescence: Does Gender Matter?," *PsyCh Journal* 9, no. 5 (2020).

25 Nazish Imran et al., "Multidimensional Impacts of Coronavirus Pandemic in Adolescents in Pakistan: A Cross-Sectional Research," *PLoS One* 17, no. 1 (2022); Adrian Furnham et al., "A Cross-cultural Comparison of British and Pakistani Medical Students' Understanding of Schizophrenia," *Psychiatry Research* 159, no. 3 (2008).

26 Antonia Lonigro et al., "The Interplay Between Expressive Suppression, Emotional Self-efficacy and Internalizing Behavior in Middle Adolescence," *Child & Youth Care Forum* 52, no. 1 (2022).

27 Furniss et al., "Prevalence of Behavioral and Emotional Problems."

28 Marjorie Montague et al., "Academic and Behavioral Outcomes for Students at Risk for Emotional and Behavioral Disorders," *Behavioral Disorders* 31, no. 1 (2005), https://doi.org/10.1177/019874290503100106; Frank Vitaro et al., "Kindergarten Disruptive Behaviors, Protective Factors, and Educational Achievement by Early Adulthood," *Journal of Educational Psychology* 97, no. 4 (2005), https://doi.org/10.1037/0022-0663.97.4.617.

to address the growing burden of psychological problems. The result may also encourage parents, teachers, and clinicians to recognise problematic patterns early in teens and to ask for effective treatment strategies.[29]

Practically, this study addresses a major gap in Pakistan's academic system, where educators do not have the basic training to identify students' psychological difficulties.[30] By combining CBPT interventions into academic settings, this study enhances a proactive approach to mental health, raising support within the education system.

Prominently, the group-based format of CBPT presents a viable and cost-effective solution for schools with limited resources. Group techniques are as impactful as one-on-one sessions,[31] while developing a sense of inclusiveness and emotional support among peers. Hence, this study not only advances the understanding of adolescent EBPs in Pakistan but also provides an easy, culturally relevant therapeutic plan that increases emotional wellbeing among Muslim adolescents.

METHODOLOGY

Objective

- To evaluate the efficacy of group-based CBPT on EBPs in early and middle Muslim adolescents.

Hypotheses

1. Group-based CBPT interventions will significantly reduce EBPs in early Muslim adolescents compared to the control group.
2. Group-based CBPT interventions will significantly reduce EBPs in middle Muslim adolescents compared to the control group.
3. Group-based CBPT interventions will significantly reduce EBPs among early and middle Muslim adolescents in the experimental group from pretest to post-test.

RESEARCH DESIGN

The present study employed a pre-post quasi-experimental design to examine the efficacy of a group-based CBPT intervention in decreasing EBPs among early and middle Muslim adolescents.[32] The intervention consisted of 10 weekly sessions (70–80 mins each),

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29 Barbara Maughan and Julia Kim-Cohen, "Continuities Between Childhood and Adult Life," *The British Journal of Psychiatry* 187, no. 4 (2005), https://doi.org/10.1192/bjp.187.4.301.

30 Ehsan Ullah Syed et al., "Screening for Emotional and Behavioural Problems Amongst 5–11-year-old School Children in Karachi, Pakistan," *Social Psychiatry and Psychiatric Epidemiology* 42, no. 5 (2007), https://doi.org/10.1007/s00127-007-0188-x.

31 DeLucia-Waack et al., *Handbook of Group Counseling and Psychotherapy*.

32 John W. Creswell and J. David Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, 5th ed. (Sage Publications, 2018).

conducted in group settings with participants in the experimental condition. The experimental and control groups were assessed quantitatively before and after the intervention period.

A total of 32 students were initially screened and enrolled in the study. Participants with moderate to severe SCPS scores were selected and classified into two age-based groups: early adolescents and middle adolescents. Before group allocation, eight participants withdrew, including three for health-related reasons and five due to limited availability and academic commitments.

The remaining 24 participants were matched by class grade and comparable age range before being equally assigned to the experimental and control groups. Half the participants received the group-based CBPT intervention, while the other half were placed in a control condition. All allocated participants were included in the final analysis.

SAMPLING

The research sample was drawn from private school students in Karachi, aged 11 to 17 years, via a purposive sampling strategy. Participants exhibited moderate to severe emotional and behavioural difficulties,[33] identified through the screening process using the SCPS. In this study, 24 screened Muslim adolescents were divided equally into experimental and control groups. All intervention sessions were conducted within the school premises.[34]

Inclusion Criteria

- Be Muslim.
- Be between 11 and 17 years of age.
- Have access to basic education and possess reading and verbal communication skills in English and Urdu.
- Obtain parental consent and provide personal assent for participation.
- Score within the moderate to severe range on the SCPS.
- Belong to an intact family structure.
- Be willing to attend all ten therapy sessions.
- Have no diagnosed physical or mental disorder, apart from EBPs, and not receiving any form of psychotropic medication or psychotherapy.

Exclusion Criteria

- Be non-Muslim.
- Be below 11 or above 17 years of age.
- Not enrolled in private school.
- Be enable to comprehend English or Urdu.

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33 American Psychological Association, *Publication Manual of the American Psychological Association*, 7th ed. (APA, 2020).

34 Alan E. Kazdin, *Research Design in Clinical Psychology*, 5th ed. (Pearson, 2017).

- Be an orphan or child of divorced parents.
- Have a history of psychological or psychiatric illness, or current physical or mental disorder.
- Undergoing psychotherapy or taking psychiatric medication at the time of the study.

MEASURES

Informed Consent

Informed consent was obtained from school principals, parents, teachers, and the participants themselves. Written consent was secured from both schools and parents. All parties were briefed on the study's purpose, expected duration, confidentiality clause, right to withdraw from the study, and potential advantages.

Demographic Form

A self-report demographic form was designed to collect information on basic demographic variables of participants, including details of any current physical or psychological issues. Verbal explanation was provided when asked. The completion of this form took approximately 10 minutes.

School Children's Problems Scale[35]

A 44-item self-report scale was used to measure the EBPs of the sample over six subscales: anxiousness (12 items), academic problems (8 items), aggression (9 items), social withdrawal (6 items), feelings of rejection (5 items), and somatic issues (4 items). Items were scored on a 4-point Likert scale, with higher scores revealing significant problems.

The SCPS consists of two equivalent forms (A and B), designed using the odd-even method. Form A was employed in the current study, having high reliability (split-half coefficients: Form A = 0.89, $p < 0.001$). Inter-factor correlations ranged from $r = 0.72$ to 0.91 ($p < 0.001$).

PROCEDURE

First, official permission to apply for SCPS was obtained from its authors. Then, approvals and written informed consent were obtained from the school authorities and parents/ guardians. Participants first completed the demographic form and the SCPS in a group setting within the institution, under the researcher's supervision. Completion of the questionnaire took approximately 25 minutes.

[35] Sadia Saleem and Zahid Mehmood, "Development of a Scale for Assessing Emotional and Behavioral Problems of School Children," *Pakistan Journal of Social and Clinical Psychology* 9 (2011).

A total of 24 participants with moderate to severe SCPS scores, selected from the initially screened sample, were matched by age and class grade then equally assigned to the experimental (n = 12) and control (n = 12) groups, which were subdivided into early and middle teenage subgroups. The experimental group participants received 10 CBPT intervention sessions (70–80 minutes per week) delivered in a classroom setting by a trained clinical psychologist.[36]

Every session tracked a structured format:

- A clear outline comprising goals and required materials.
- Skill-based and play-based activities.
- Homework assignments.
- Brief emotional check-ins and check-outs.

Participants were allowed to seek individual psychotherapy sessions immediately from a school counsellor if a participant presented with increased emotional distress. Sessions were organised around school timetables, with teachers helping students in making up missed coursework and managing lunch breaks as required.

After completion of the 10-session program, all participants (including the control group) were re-examined using the SCPS. However, due to time constraints faced by students, an informal follow-up session was conducted with the treatment groups after two weeks. On completion of the intervention program, the control group received the same set of interventions. Participants who were not available to attend the full intervention were given a three-hour awareness workshop to promote insights and coping skills.

THERAPEUTIC SESSION DETAILS

A session plan was established using Paul Stallard's workbook *Think Good–Feel Good*,[37] along with guidelines from Susan Knell, author of *Cognitive Behavioral Play Therapy*.[38]

Week	Objectives	Activity/techniques	Proposed outcome
1	Give orientation, set the guidelines, and brief on the areas of punctuality and confidentiality.	Describe yourself with a colour	Develop rapport and build trust among group members.
2	Psychoeducation about core elements of thought, feeling, and behaviour.	**Activity 1:** The Magic Circle **Activity 2:** Feeling Finder word search	Increase awareness of various emotions and develop an understanding of the relationship between thoughts, feelings, and behaviours.

36 World Medical Association, "World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects," *JAMA* 310, no. 20 (2013), https://doi.org/10.1001/jama.2013.281053.

37 Paul Stallard, *Think Good–Feel Good: A Cognitive Behavioural Workbook for Children and Young People* (John Wiley & Sons, 2018).

38 Knell and Dasari, "CBPT."

Week	Objectives	Activity/techniques	Proposed outcome
3	Provide a basic understanding of anger and strategies for expressing it appropriately.	**Activity 1:** Balloons of Anger[39] **Activity 2:** Worksheet (What happens when I feel angry?) and practice anger management techniques (deep breathing, backward counting, use I message, use a calm space).	Minimise inappropriate expressions of anger and replace them with healthier, more constructive alternatives.
4	Develop an understanding of the feeling of anxiousness.	**Activity 1:** Worry Can[40] **Activity 2:** Relaxation techniques (glitter jar, mindfulness, grounding techniques etc.)	Learn healthy ways to manage anxious feelings.
5	Give psychoeducation about the somatic complaints; the importance of healthy habits is emphasised by using a metaphor.	**Activity 1:** The Healthy Habits[41] worksheet was used to teach them basic physical coping tools. **Activity 2:** The progressive muscle relaxation technique was also practiced.	Develop a good understanding of somatic symptoms, where they come from, and how to manage them.
6	Give psychoeducation about positive and negative thoughts	**Activity 1:** Psychoeducation was provided to explain how two individuals in the same situation can experience different thoughts and feelings. Subsequently, participants identified and recorded negative and positive thoughts along with the corresponding emotions.	Understand the distinction between positive and negative thoughts and how they lead to different types of feelings.
7	Examine their negative thoughts by identifying associated cognitive errors.	**Activity 1:** Psychoeducation was provided on cognitive errors, using the negative thoughts identified in the previous session to illustrate how such thoughts influence feelings. These negative thoughts were then replaced with positive self-talk.	Learn strategies to cope positively with challenging situations using a Positive Self-Talk worksheet.
8	Address social withdrawal by exploring ways to overcome avoidance and increase engagement in social interactions.	**Activity 1:** Storytelling using a Turtle puppet[42]	Practice strategies to address avoidance and lack of involvement in social interactions.
9	Focus on problems related to their academic life, such as loss of interest in studies, inability to concentrate, fear of exams etc.	Problem-solving worksheet.	Set goals and identify possible solutions.

39 Heidi Gerard Kaduson and Charles E. Schaefer, eds., *Short-Term Play Therapy for Children* (Guilford Press, 1997).

40 Howard A. Paul, "Review of *Treating Somatic Symptoms in Children and Adolescents*, by Sara E. Williams and Nicole E. Zahka," *Child & Family Behavior Therapy* 40, no. 1 (2018), https://doi.org/10.1080/07317107.2018.1428065.

41 Marlene Schneider and Arthur Robin, *Turtle Manual* (ERIC Clearinghouse, 1974).

42 Liana Lowenstein, *Creative Interventions for Bereaved Children* (Champion Press, 2006).

Week	Objectives	Activity/techniques	Proposed outcome
10	Reflect on the various activities during therapy and review therapeutic gains.	What I Learned Layered Gift[43] activity.	Provide a positive termination experience by reflecting on progress made and describing the improvements or positive changes experienced because of attending therapy.

ETHICAL CONSIDERATIONS

All procedures in this study were taken as per the ethical research standards. Participation was voluntary and participants were given the freedom to withdraw at any stage without penalty. Comprehensive information regarding the study's purpose and proceedings was provided to the school authorities, parents/guardians, and participants. Informed consent was taken before data collection. Confidentiality and anonymity were assured throughout the research process. Sessions were scheduled based on participants' availability and willingness. Permission to use the SCPS was obtained from its developers.

RESULTS

Table 1. Independent sample *t*-tests for baseline scores between experimental and control groups (N=24)

		Experimental		Control				95% *CI*	
	Variables	*M*	*SD*	*M*	*SD*	*t* (10)	*P*	LL	UL
Early Adolescents	EBPs	98.8	2.85	94.0	7.97	1.39	0.192	-2.87	12.53
	Anx	26.6	2.58	26.3	4.80	0.150	0.884	-4.62	5.29
	Acad	17.5	2.5	18.0	3.55	-0.094	0.927	-4.12	3.79
	Agg	21.5	2.66	18.8	4.99	1.15	0.276	-2.48	7.81
	SW	14.5	1.37	14.1	1.47	0.405	0.694	-1.50	2.16
	Rej	10.5	2.16	9.5	2.58	0.725	0.485	-2.07	4.07
	Som	8.1	2.2	7.5	1.22	0.642	0.535	-1.64	2.97
Middle Adolescents	EBPs	94.6	4.22	96	5.23	-0.425	0.680	-7.28	4.95
	Anx	27.0	5.4	27.3	2.80	-0.201	0.845	-6.05	5.05
	Acad	17.5	2.66	18.3	2.16	-0.595	0.565	-3.95	2.28
	Agg	18.1	6.55	19.0	6.43	-0.178	0.862	-9.02	7.68
	SW	14.6	3.14	13.8	2.40	0.516	0.617	-2.76	4.42
	Rej	9.0	2.36	8.8	2.56	0.117	0.909	-3.00	3.33
	Som	8.5	1.37	8.7	1.86	-0.176	0.864	-2.27	1.94

Note. Anx=Anxiousness, Acad=Academic problem, Agg=Aggression, SW=Social withdrawal, Rej=Feelings of being rejected, Som=Somatic problems, EBPs=Emotional and behavioural problems

[43] Ibid.

Table 1 shows no significant baseline differences between the experimental and control groups across total EBPs and all subscales among early and middle adolescents ($p > 0.05$).

Table 2. Independent sample *t*-tests for early Muslim adolescents in post-test of experimental and control groups (N=12)

	Experimental		Control					95% *CI*	
Variables	***M***	***SD***	***M***	***SD***	***t*(10)**	***d***	***P***	**LL**	**UL**
Anx	17.3	5.2	28.7	3.1	-4.593	-2.9	0.001	-16.831	-5.835
Acad	10.3	2.7	16.7	2.3	-4.314	-2.7	0.002	-9.605	-3.062
Agg	13.5	1.6	17.8	3.9	-2.525	-1.5	0.030	-8.157	-0.510
SW	6.7	1.8	11.3	1.9	-4.472	-2.8	0.001	-6.992	-2.342
Rej	5.8	1.5	10.2	3.1	-3.126	-1.9	0.011	-7.423	-1.244
Som	4.3	2.2	7.5	1.0	-3.230	-2.0	0.009	-5.351	-0.982
EBPs	58.0	10.0	92.2	6.4	-7.059	-4.4	< 0.001	-44.951	-23.382

Note. Anx=Anxiousness; Acad=Academic problems; Agg=Aggression; SW=Social withdrawal; Rej=Feelings of rejection; Som=Somatic problems; EBPs=Emotional and behavioral problems

Table 2 presents the results of an independent sample t-test conducted to determine post-test differences between the experimental and control groups of early adolescents. The mean score of overall EBPs in the experimental group (M = 58.0, SD = 10.0) was significantly lower than in the control group (M = 92.2, SD = 6.4), $t(10) = -7.059$, $p < 0.001$. Significant differences also appeared across all subscales.

Table 3. Independent sample *t*-test for middle Muslim adolescents in post-test of experimental and control groups (*N* = 12)

Variables	Experimental		Control					95% *CI*	
	M	***SD***	***M***	***SD***	***t*(10)**	***d***	***P***	***LL***	***UL***
Anx	18.2	5.6	29.3	3.6	-4.103	-2.59	0.002	-17.230	-5.103
Acad	11.2	2.0	18.0	2.8	-4.799	-3.03	0.001	-10.006	-3.660
Agg	11.7	4.0	18.3	4.8	-2.591	-1.63	0.027	-12.400	-0.933
SW	7.3	3.5	14.2	2.4	-3.942	-2.49	0.003	-10.696	-2.971
Rej	5.8	2.9	11.0	2.0	-3.570	-2.25	0.005	-8.391	-1.942
Som	5.5	1.9	8.8	2.0	-2.949	-1.86	0.015	-5.852	-0.815
EBPs	60.3	11.1	99.7	6.4	-7.493	-4.73	< 0.001	-51.030	-27.637

Note. Anx=Anxiousness, Acad=Academic problems, Agg=Aggression, SW=Social withdrawal, Rej=Feelings of being rejected, Som=Somatic problems

Table 3 shows significant differences in EBPs across multiple domains among middle adolescents. The experimental group obtained lower EBPs scores (M = 60.3, SD = 11.1) than the control group (M = 99.7, SD = 6.4), $t(10) = -7.493$, $p < 0.001$, indicating encouraging reductions in overall EBPs following the intervention.

Table 4. Paired sample *t*-test for pre- and post-test scores among early and middle adolescents of experiment groups (N=12)

		Pretest		Post-test					95% *CI*	
	Variables	*M*	*SD*	*M*	*SD*	*t* (5)	*P*	*D*	LL	UL
Early Adolescents	EBPs	98.8	2.85	58.0	9.95	11.342	0.000	5.5	31.57	50.08
	Anx	26.6	2.58	17.3	5.20	5.813	0.002	2.3	5.20	13.46
	Acad	17.5	2.5	10.3	2.73	5.862	0.002	2.7	4.02	10.30
	Agg	21.5	2.66	13.5	1.64	6.928	0.001	3.6	5.03	10.96
	SW	14.5	1.37	6.6	1.75	10.457	0.000	5.0	5.90	9.75
	Rej	10.5	2.16	5.8	1.47	4.889	0.005	2.5	2.21	7.12
	Som	8.1	2.2	4.3	2.16	7.064	0.001	1.7	2.43	5.22
Middle Adolescents	EBPs	94.6	4.22	60.3	11.1	10.090	0.000	4.1	25.58	43.08
	Anx	27.0	5.4	18.1	5.6	15.538	0.000	1.6	7.23	10.10
	Acad	17.5	2.66	11.1	2.04	8.859	0.000	2.7	4.49	8.17
	Agg	18.1	6.55	11.6	4.03	3.763	0.013	1.2	2.06	10.93
	SW	14.6	3.14	7.3	3.50	10.258	0.000	2.2	5.49	9.17
	Rej	9.0	2.36	5.8	2.92	5.270	0.003	1.2	1.62	4.17
	Som	8.5	1.37	5.5	1.87	5.809	0.002	1.8	1.67	4.32

Note. Anx=Anxiousness, Acad=Academic problem, Agg=Aggression, SW=Social withdrawal, Rej=Feelings of being rejected, Som=Somatic problems, EBPs=Emotional and behavioural problems

The results presented in Table 4 reveal EBP scores promising reductions from pretest (M = 98.8, SD = 2.85) to post-test (M = 58.0, SD = 9.95) among early adolescents, with a significant *t*-value ($t(5) = 11.342$, $p < 0.001$) and among middle adolescents from pretest (M = 94.6, SD = 4.22) to post-test (M = 60.3, SD = 11.1), with *t*-value ($t(5) = 10.090$, $p < 0.001$). Similarly, significant mean differences were observed across all factors.

DISCUSSION

Substantial evidence suggests that working with adolescents in therapy can be challenging. Adolescents often respond defensively or reluctantly and may avoid openly discussing their emotional difficulties. Consequently, clinicians working with teenagers must invest considerable effort in establishing rapport and creating a safe therapeutic environment. Adolescents may also have trouble expressing emotions through direct verbal communication. In this context, CBPT provides a developmentally appropriate intervention by integrating cognitive-behavioural principles with play-based and experiential techniques. Through symbolic expression, metaphors, and therapeutic activities, adolescents can explore their thoughts, emotions, and behaviours in a less threatening and more engaging manner. Previous literature further suggests that adolescents continue to benefit from therapeutic play,

metaphorical learning, and experiential approaches within counselling settings.[44] Against this backdrop, the present study examined the efficacy of group-based CBPT in reducing EBPs among early and middle Muslim adolescents.

The first hypothesis proposed that group-based CBPT would significantly reduce EBPs among early Muslim adolescents. The findings supported this assumption, as the experimental group demonstrated significantly lower post-test EBP scores (M = 58.0, SD = 9.95) compared to the control group (M = 92.2, SD = 6.4); $t(10) = -7.059$, $p < 0.05$. These findings indicate that CBPT contributed to reductions in emotional and behavioural difficulties among early Muslim adolescents.

The findings are consistent with a previous study that reported significant reductions in EBPs following a multi-session, school-based CBPT group intervention for Syrian refugee adolescents aged 12–14 years.[45] The major characteristics of adolescence include developmental transitions, emotional instability, and social challenges. Within this context, group therapy provides adolescents with peer support and opportunities for emotional growth within a structured environment enhancing the efficacy of the present research.

One of the best group settings, the school, may also explain the effectiveness of the intervention. In educational environments, group counselling serves as an important tool for enhancing students' resilience, social support, and coping abilities. Schools provide opportunities to their students to interact with peers, share experiences, and collaboratively develop interpersonal and emotional skills that are consistent with the needs of the adolescent age group. Following the findings of earlier literature, highlighting the effectiveness of school-based counselling interventions, the current study was conducted within a school environment.[46] Similarly, another study found that small-group counselling interventions led by school counsellors improved students' interpersonal relationships and academic performance.[47]

Another possible explanation for the significant findings is that this was the participants' first exposure to a comprehensive counselling program. Guidance and counselling services remain underdeveloped in many Pakistani schools despite their importance for students' emotional wellbeing and behavioural adjustment. Previous findings have emphasised that uncertainty and stress during adolescence can negatively affect mental health, while other studies note the lack of school counsellors in Pakistan might adversely influences students'

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44 Leslie R. Rith-Najarian et al., "Durability of Cognitive Behavioral Therapy Effects for Youth and Adolescents with Anxiety, Depression, or Traumatic Stress: A Meta-Analysis on Long-Term Follow-Ups," *Behavior Therapy* 50, no. 1 (2019), https://doi.org/10.1016/j.beth.2018.05.006.

45 Jehad Alaedein and Shadi Alhawamdeh, "The Effect of a Group Counseling Program based on Cognitive-Behavioral Play Therapy in Reducing Emotional and Behavioral Problems among a Sample of Syrian Refugee Students," *Jordan Journal of Educational Sciences* 17, no. 2 (2021).

46 G. S. Ginsburg and K. D. Becker, "Cognitive Behavioral Play Therapy with Children and Adolescents in School Settings," *Psychology in the Schools* 51, no. 2 (2014); J. Trowell and S. Allwood, "Play Therapy and Cognitive Behavioral Techniques for Adolescent Emotional and Behavioral Disorders in Educational Settings," *International Journal of Play Therapy* 29, no. 4 (2020).

47 L. D. Webb et al., "Linking School Counselors and Student Success: A Replication of the Student Success Skills Approach Targeting the Academic and Social Competence of Students," *Professional School Counseling* 8, no. 5 (2005).

academic and behavioural outcomes.[48] Therefore, the introduction of a structured therapeutic intervention may have provided participants with emotional support and coping strategies that were previously unavailable to them.

The effectiveness of CBPT among early adolescents can also be understood through the well-accepted Erikson's psychosocial developmental theory, suggesting that early adolescents are primarily navigating the stage of "Industry vs. Inferiority," in which they strive to develop competence, self-confidence, and a sense of achievement through academic and social experiences. Failure to cope effectively with these developmental demands may lead to feelings of inadequacy and emotional distress. Through its structured and supportive framework, CBPT may help adolescents develop emotional regulation, confidence, and adaptive coping skills, thereby reducing EBPs.

The second hypothesis proposed that CBPT would similarly reduce EBPs among middle Muslim adolescents. The results supported this assumption, as participants in the experimental group demonstrated significantly lower EBP scores (M = 60.3, SD = 11.1) than participants in the control group (M = 99.7, SD = 6.4); $t(10) = -7.493$, $p < 0.05$. These findings suggest that CBPT was effective in reducing EBPs among middle adolescents as well.

These findings align with recent literature signifying that cognitive behavioural and play-based interventions improve emotional wellbeing, behavioural functioning, and academic competence among children and adolescents. CBT, grounded in the cognitive model of emotional disorders, emphasises the relationship between thoughts, emotions, and behaviours.[49] When integrated with play therapy approaches, CBPT becomes a developmentally sensitive intervention that combines cognitive restructuring, modelling, behavioural rehearsal, and problem-solving strategies with therapeutic play activities.

The current findings are also supported by previous research demonstrating the effectiveness of CBPT for adolescents experiencing complex emotional and behavioural difficulties. For example, Khatoon and colleagues examined the effects of CBPT among children and adolescents diagnosed with ADHD aged 8–15 years. Their pre- and post-test findings indicated substantial improvements in behavioural functioning following the intervention.[50]

Several therapeutic components within the present intervention may explain the improvements observed among participants. During the initial sessions, participants selected colours and described themselves through symbolic exercises, which facilitated rapport

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48 Anjum Ahmed and Haya Firdous, "The Transformational Effects of COVID-19 Pandemic on Guidance and Counseling," *International Journal of Advance Research and Innovative Ideas in Education* 6, no. 6 (2020); Aqeela Khatoon, "A Study of the Need and Importance of Guidance and Counseling in Secondary Schools, Hunza Gilgit-Baltistan," *Journal of Social Sciences and Humanities* 53, no. 1 (2014).

49 Thomas M. Achenbach, and Leslie A. Rescorla, *Manual for the ASEBA School-Age Forms & Profiles* (University of Vermont, Research Center for Children, Youth, & Families, 2001).

50 Aqeela Khatoon et al., "Efficacy of Cognitive Behavioral Play Therapy (CBPT) for Children with Attention Deficit Hyperactivity Disorder (ADHD)," *Clinical and Counselling Psychology Review* 2, no. 2 (2020).

building, emotional expression, and therapeutic trust. Psychoeducation further helped participants understand the purpose and process of therapy, while CBPT activities encouraged them to recognise the connection between thoughts, emotions, and behaviours.

As the intervention progressed, metaphors and symbolic activities, such as "anger as a balloon" and "worry as something heavy," enabled participants to process emotions in a safe and age-appropriate manner. Furthermore, the sessions also focused on developing self-confidence, coping strategies, and adaptive behavioural responses. Relaxation techniques were introduced to manage anxiety associated with examinations and classroom presentations, while positive self-talk was practiced to challenge maladaptive thinking patterns.

Later sessions emphasised skill generalisation and relapse prevention through structured and unstructured therapeutic activities. Participants demonstrated improvements in self-confidence, classroom participation, emotional regulation, and interpersonal functioning. Teachers also reported enhanced engagement, academic motivation, leadership qualities, and social-emotional development among participants.

Some adolescents described becoming more confident in pursuing academic opportunities and overcoming negative self-beliefs, while others reported improvements in study habits, empathy, anxiety management, and anger regulation. These findings suggest the benefits of CBPT extended beyond therapy sessions and positively influenced adolescents' academic and social functioning.

The effectiveness of CBPT among middle adolescents can further be interpreted through Erikson's stage of "Identity vs. Role Confusion." During this developmental phase, adolescents attempt to establish a coherent sense of identity while coping with social expectations, academic demands, and emotional stressors. CBPT may therefore provide adolescents with a supportive environment in which they can safely explore emotions and identity related concerns while learning adaptive coping strategies that contribute to healthier emotional and behavioural adjustment.

The third hypothesis proposed that group-based CBPT interventions would significantly reduce EBPs among early and middle Muslim adolescents in the experimental group from pre- to post-test. The paired samples *t*-test findings supported this hypothesis, demonstrating significant reductions in EBP subscale scores during the post-test assessment (Table 4). These findings indicate broad improvements across multiple dimensions of emotional and behavioural functioning following the intervention.

The effectiveness of CBPT in the present study may also be understood within the broader cultural and religious context of Pakistani Muslim adolescents. Pakistan is a collectivistic Muslim-majority society in which family expectations, religious beliefs, and community values strongly shape adolescents' identity formation, emotional expression, and coping strategies. Research indicates that Pakistani adolescents often develop their identity through interconnected dimensions of belief, behaviour, and belonging, influenced by parents, peers,

teachers, and religious leaders.[51] Consequently, emotional difficulties may be experienced and expressed differently than in many Western contexts.

Within collectivistic cultures, adolescents may hesitate to openly discuss emotional concerns because of expectations related to emotional restraint, family honour, and respect for elders. In this context, the CBPT intervention appeared particularly suitable because it incorporated culturally sensitive and indirect methods of communication, including storytelling, role-play, drawing, metaphors, and play-based interaction. These techniques enabled participants to safely explore emotions and personal experiences in a developmentally appropriate manner without requiring direct self-disclosure.

The intervention was further adapted to align with the sociocultural and religious realities of Pakistani Muslim adolescents. Activities and therapeutic discussions incorporated culturally familiar examples drawn from adolescents' everyday experiences within Pakistani school and family settings.

Urdu-English mixed instruction was used to increase comfort and understanding, while the intervention emphasised collectivistic values such as empathy, cooperation, respect, and family connectedness. In addition, age-appropriate and culturally acceptable play materials were selected to enhance engagement and therapeutic responsiveness. Emotional regulation and coping strategies were also framed in culturally sensitive ways that respected local social and religious norms.

Although research on CBPT among Pakistani adolescents remains limited, previous studies on culturally adapted cognitive behavioural interventions provide support for such approaches. Earlier findings indicated that a culturally adapted CBT-guided self-help intervention significantly reduced social anxiety and fear of negative evaluation while improving self-esteem among Pakistani adolescents.[52] Similarly, existing literature revealed that culturally responsive CBT interventions incorporating religious beliefs, family structures, and gender-related considerations were associated with improved psychological outcomes among Pakistani youth.[53] These findings support the importance of culturally responsive therapeutic approaches for adolescents within the Pakistani context.

The present findings may also be interpreted through culturally informed applications of Erikson's psychosocial theory. Studies conducted in Pakistan suggest that adolescents often experience tension between traditional Islamic values, family expectations, and modern societal influences. Previous evidence observed that while some adolescents experience confusion and internal conflict when attempting to balance these competing demands, others develop adaptive "hybrid identities" that integrate religious, cultural, and contemporary

51 Syeda Shahida Batool and Saba Ghayas, "Religious Identity Formation and Development in Adolescents of Pakistan," *Foundation University Journal of Psychology* 5, no. 1 (2021).

52 Rizwana Amin et al., "Effectiveness of a Culturally Adapted Cognitive Behavioural Therapy–Based Guided Self-Help (CACBT-GSH) Intervention to Reduce Social Anxiety and Enhance Self-Esteem in Adolescents: A Randomized Controlled Trial from Pakistan," *Behavioural and Cognitive Psychotherapy* 48, no. 5 (2020).

53 Tania Nadeem et al., "Culturally Responsive CBT for Psychological and Physical Symptoms in Pakistani Youth: Role of Religious and Cultural Attunement," *Cognitive and Behavioral Practice* 31, no. 3 (2024).

aspirations.[54] These findings highlight that identity development in collectivistic societies is shaped not only by individual goals but also by religious, familial, and sociocultural responsibilities.

Within this developmental and cultural framework, CBPT appears to offer a culturally attuned therapeutic approach that supports emotional regulation and identity development in a safe and engaging environment.[55] Because Pakistani culture places considerable importance on family harmony, moral guidance, and social respect, the play-based and experiential nature of CBPT may help reduce stigma associated with emotional disclosure while increasing adolescents' willingness to participate in therapy.

Consequently, the intervention appears to contribute positively to emotional adjustment, behavioural regulation, and psychosocial wellbeing among Pakistani Muslim adolescents.

IMPLICATIONS

This study holds practical significance, as EBPs remain a major concern among adolescents worldwide.[56] Although empirical attention toward adolescent mental health in Pakistan has increased, structured school-based interventions remain limited. Initial findings from the present study indicate that group-based CBPT shows encouraging improvements in reducing EBPs among adolescents, highlighting its potential therapeutic value within Pakistani school settings, where its application remains largely understudied.[57]

The study further aimed not only to explore the potential effectiveness of CBPT interventions but also to provide a structured therapeutic framework for school-based mental health support. As the sample was drawn from mainstream educational institutions representing typically developing adolescents, the findings suggest that EBPs may emerge as part of developmental transitions rather than indicators of severe psychopathology. These findings underscore the important role of educational institutions in promoting students' social and emotional wellbeing. Schools may benefit from structured mental health initiatives delivered by trained psychologists through awareness seminars for teachers, parents, and administrators, teacher-led psychosocial support models, and comprehensive training programs designed to foster psychologically responsive learning environments.

LIMITATIONS AND RECOMMENDATIONS

The study limitations include that only early and middle school-going Muslim adolescents were taken, whereas late and non-school-going teens were excluded. Therefore, the findings

54 Nimra Firdous et al., "Erikson's Identity versus Role Confusion: Navigating Faith and Modernity in Gen-Z Pakistani Muslims," *Research Consortium Archive* 3, no. 2 (2025).

55 Susan M. Knell, "Cognitive-Behavioral Play Therapy," *Journal of Clinical Child Psychology* 27, no. 1 (1998); Ann A. Drewes et al., *Integrative Play Therapy* (John Wiley & Sons, 2011).

56 Mabrouk et al., "Mental Health Interventions"; Tian et al., "Global Burden of Mental Disorders."

57 Knell and Dasari, "CBPT."

may not fully represent the entire adolescent developmental spectrum. Future research could include all adolescent stages to allow comparative analysis across age groups.

Importantly, the small sample size limits the findings' generalisability, thus the results should be interpreted as emerging rather than conclusive evidence. Another limitation is that participants were not randomly allocated. Future studies should consider incorporating randomised allocation to strengthen the research design.

The lack of formal follow-up is another limitation. While analysing the data, it was clear that emotional and behavioural issues were reduced in participants; it is recommended to hold proper follow-up sessions with participants to gain deeper understanding of the short-term and long-term effects of CBPT interventions.

Additionally, this study has not gathered qualitative information to better evaluate adolescents' subjective experiences of change.[58] Future studies could incorporate qualitative analyses to support deep understanding of therapeutic processes.

Furthermore, the sample was entirely urban school-attending Muslim adolescents. Research has verified that mental wellbeing profiles vary based on culture, religion, and environmental contexts, with rural teenagers often facing dissimilar psychological encounters.[59] Conducting similar research with rural populations would enhance understanding of such variations. Additionally, this study was conducted exclusively among Pakistani Muslim adolescents in an urban school setting in Karachi. Therefore, the findings' generalisability is limited to this cultural and educational context, and further research is needed before extending these findings to Muslim adolescents in other national or sociocultural settings.

Finally, the use of a self-report screening tool (SCPS) may introduce response bias. Future research should incorporate structured or semi-structured clinical interviews to enhance diagnostic accuracy and strengthen the validity of findings.

CONCLUSION

This study aimed to examine the efficacy of CBPT as a school-based intervention for reducing EBPs among Pakistani Muslim adolescents. The results indicated that adolescents in the experimental group demonstrated improvements in emotional and behavioural functioning compared to those in the control group. These findings were consistent with previous literature suggesting that EBPs adversely affect adolescents' emotional wellbeing, social functioning, academic performance, and school adjustment.

The study further provided emerging evidence that group-based CBPT may be feasibly implemented within school settings, particularly in regions where professional mental health services remain limited. The intervention may serve as a beneficial approach for the early identification and support of adolescents experiencing psychosocial difficulties.

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58 Ibid.

59 Atilola, "Child Mental Health Policy Development."

Overall, the integration of CBT-based approaches with play therapy continues to expand and appears promising for addressing diverse psychological concerns among adolescents. Although existing case-based and preliminary studies have identified potential benefits of CBPT, further research is needed to examine its differential efficacy across specific populations and to establish clearer guidelines for its application in clinical and school-based practice.

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