A STUDY OF VIDEO SELF-CONFRONTATION THERAPY INVOLVING CHILDREN ENGAGED IN INDIVIDUAL PLAY THERAPY

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The problem of study concerns whether the video self-confrontation technique would have a beneficial behavioral effect on children engaged in play therapy, as had previously been demonstrated on adults receiving psychotherapy. Using this technique, videotape equipment records a patient during a therapy session after which the patient is confronted with the reality of his own image and behavior. The objectives of the video technique are to accelerate insight and positive behavior change.

In this study four adolescent boys, ages ten through fourteen, received six weeks of play therapy and six weeks of video self-confrontation therapy. During the play therapy sessions, ten-minute segments of therapy were recorded for patient feedback and for rating behavior. During the video therapy sessions, the boys viewed the previous tapes made of them and discussed their impressions and feelings about the video tape. The last half of each of these video sessions was spent in play therapy, during which ten-minute segments were taped for rating behavior. Behavior was rated on two verbal categories, two non-verbal categories, and two play activity categories.
The second method of collecting data was the three independent testing sessions which were designed to produce a sample of the patient's behavior under normal and stressful conditions. These three sessions before any therapy, after play therapy, and after video self-confrontation therapy, determined whether the overall treatment method (play therapy and video therapy) was effective.

Two hypotheses were considered. I. The overall treatment method is effective. This was tested by ranking the three testing sessions according to behavior showing no improvement, some improvement, and most improvement. A chi square test for $k$ independent samples was computed and the hypotheses proved to be statistically significant at the .001 level ($p=49$). II. The video self-confrontation therapy sessions have a more beneficial treatment effect than do the play therapy sessions. This did not prove to be statistically significant, in that the video therapy sessions showed a decline in positive behavior.

Several explanations are given for these results. Quite often as play therapy progresses, the patients begin to feel more relaxed and secure with their therapist and their surroundings. With this increased security they reveal more of their problems through aggression and other inappropriate behavior. Since the ten-minute videotaped segments of therapy were scored on the boys' behavior in therapy, this could explain the decrease in positive behavior during video therapy. It might also be stated that the independent testing sessions seemed to be a better indicator of the progress of therapy since they were independent of actual therapy behavior.
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CHAPTER I

INTRODUCTION

The Problem and Its Significance

The concept of self-confrontation improving the personality was suggested in a poem written 200 years ago by Robert Burn; "O wad some Power the giftie gie us, to see ousrelvs as ithers see us!" Today, with the use of videotape equipment, Moore, Chernell, and West (1965) feel that allowing patients to view themselves "will have a marked and beneficial effect on their degree of improvement [p. 217]."

Since 1960, workers in the field of psychotherapy have been experimenting with this new and innovative, therapeutic medium of self-confrontation. The use of a television tape recorder has provided a convenient and objective means of self-image confrontation for the patient. Furthermore, this process allows for self-understanding and behavior change.

Experimental studies have shown that the video self-confrontation technique is a potentially useful adjunct to the psychotherapy process (Stoller, 1967; Danet, 1968). In such studies, regular psychotherapy sessions were conducted in which all or portions of the sessions were videotaped. These tapes were then played back to the patients with the motive of accelerating insight and positive behavior change.
Although this technique has become very popular in clinic and school settings within the last twelve years, few reports of its use and effectiveness have been published. Most of the available studies have been primarily of the exploratory type in which authors state that the technique seems to produce beneficial changes in behavior.

Furthermore, reports on therapeutic self-confrontation have all been conducted on adults. Nothing has been published in this field involving children. Therefore, with essentially no guidelines to follow, the present experiment was conducted on children engaged in play therapy. An experiment was designed to explore whether the use of videotape feedback would also produce beneficial effects on children as had been demonstrated on adults. It was hoped that this simple pilot project would lay the groundwork for more sophisticated experiments concerned with these variables.

Hypotheses

Two hypotheses were considered in this study:

I. The overall treatment method (play therapy and video self-confrontation) is effective.

II. The video self-confrontation sessions have a more beneficial treatment effect than do the play therapy sessions.
Definition of Variables

**Individual Play Therapy**

In this experiment play therapy, a type of psychotherapy, is based upon the methods of Axline (1947) and Ginott (1961). Axline (1947) defines play as "the child's natural medium of self-expression [p. 9]." And according to Ginott (1961), play is "equivalent to freedom to act and react, suppress and express, suspect and respect [p. 7]." During the first six sessions of the experiment the boys engaged in individual play therapy, in which they were allowed to play and speak as they wished.

**Video Self-Confrontation Therapy**

Video Self-Confrontation is the therapeutic use of videotape equipment to record a patient during a therapy session and then to confront the patient with the reality of his own images and behavior. This therapeutic medium will in turn promote conditions in which the individual is motivated to free his own self-perceptual capacities. Stoller (1967) believes that:

The clearer the feedback format, the more likelihood there is of piercing the perceptual defenses of the individual... insofar as it is his own behavior, recently perpetuated, an individual seeing himself on videotape is receiving the clearest, least distorted, and most comprehensive feedback possible [p. 4-5].
Therapist

The role of the therapist can best be defined by Ginott (1961) as

To provide security for children to explore and express their innermost selves -- their fears, hatreds, and guilts as well as their strivings for appreciation, independence, and status [p. 125].

The therapist provides this security for the children by being acceptive, supportive, and reflective of them and their beliefs. When this sense of security is provided, the child will be able to understand himself a little better.

Limitations of Study

Despite the fact that the experimental design had relatively no guidelines to follow, several limitations were evident. Due to the nature of the study involving two types of therapy, inadequate time coverage was a drawback to the study. Because of outside influencing factors, only six weeks (six sessions) could be allotted for each type of therapy. It was hoped that within this short time span, significant change of behavior would occur.

Other limitations of the study were too few experimental subjects and too many therapists. In order to obtain more reliable results, more than four subjects should have participated in the study; however, finding the four suitable subjects for the study was a difficult task. Another desirable variable for the study would have been to have one therapist work with all of the subjects throughout the experiment, thus eliminating the
extraneous variable of differing therapists' behavior toward their clients. However, since acquiring a therapist who was willing to devote the required necessary time was not possible, four student therapists, one for each client, were employed.
CHAPTER II

REVIEW OF THE LITERATURE

A study by Cornelison and Arsenian (1960) was perhaps the first reported work suggesting that self-confrontation might be an effective technique to enhance therapeutic goals. They were impressed with the responses given by psychotic patients to photographs of their own images. The patient's reactions varied

from abruptly enhanced impassivity to emotional outbursts.

... All responses conveyed an impression of sudden shock. Facial expressions and posture, if not words, reflected an onrush of thoughts and feelings ... Eight of the sixteen patients showed discernible change during the self-confrontation sessions [p. 6].

Several studies have since been published that use the videotape equipment in different ways to serve as a therapeutic function. The use of the video self-confrontation method has been used with individual psychiatric inpatients and outpatients and with psychotherapy groups.

Video Self-Confrontation with Psychiatric Inpatients

Moore, Chernell, and West (1965) attempted perhaps the first controlled study which measured behavioral changes in video self-confrontation therapy. Eighty patients of varying diagnostic categories, admitted to the neuropsychiatric unit of the University of Mississippi Medical Center,
received an initial twelve-minute interview which was videotaped behind one-way mirrors. Immediately following this session alternate patients with the interviewing psychiatrist viewed the playback of their interview. Comments made by the experimental group to their playbacks were recorded by the attending psychiatrist, who offered no comments of his own. The control group did not view the video playbacks of their interviews.

Follow-up interviews were conducted, each lasting approximately five minutes. These sessions concentrated on how the patient was progressing and on the comparison of his present condition with his condition on admission as he remembered it. The experimental patients were allowed to view the current interview plus all previous tapes of themselves, enabling them to compare their earlier status with the present reality. This video therapy required only sixty minutes of their time during their hospitalization.

Residents in the patient's wards acted as independent judges of the patients' behavior. They classified their behavior after the interviews as being (1) cured or maximally improved, (2) moderately improved, or (3) minimally improved or unchanged. The patients who viewed themselves showed significantly (chi square analysis, $p<.01$) more improvement than the nonview group, according to the indicated behavioral changes. In conclusion the authors acknowledged that there may have been variables that were not adequately controlled.
Another research experiment on neuropsychiatric inpatients attempted to study the meaning and usefulness of immediate self-image confrontation as a therapeutic technique under controlled conditions. Using Leary's Interpersonal Check List (ICL), Boyd and Sisney (1967) measured changes in self-concept and concepts of interpersonal behavior of inpatients at the Oklahoma City Veterans Administration Hospital.

Fourteen patients were individually given a standardized ten-minute interview concerning their reactions and feelings about other patients on the ward, themselves, and their families. Immediately following the interview, seven of the subjects viewed a ten-minute segment of a daytime television comedy. The ICL was administered several days before, immediately following, and two weeks after the self-confrontation session.

Results indicated depending upon the validity of the Leary ICL that after only one exposure [to self-confrontation] the pathology level of the experimental group became less extreme, while in the control group the pathology level remained the same or became more extreme, and these results remained over at least a 2-week period. Moreover, the various concepts of self, including the ideal self and public self, moved closer together for the experimental group than they did for the control group. . . . Finally, the S's public self-concept and the S's own concept of himself moved closer together in the experimental group [pp. 293-294].

Video Self-Confrontation with Psychiatric Outpatients

Geertsma and Reivich (1965) utilized a television tape recorder to allow a psychiatric outpatient to view herself on regularly repeated occasions in the interaction of a psychotherapeutic interview. The purpose
of their study was concerned with the psychological reactions of their patients to the video self-confrontation technique. Since they postulated that "all self-observational experiences are potentially anxiety producing," the video playbacks would be dealt with by "defensive or adaptive ego operations [p. 29]."

The subject for this experiment was a twenty-seven-year-old, white, unmarried mother of two illegitimate children who applied for treatment at the psychiatric outpatient clinic of Kansas University Medical Center. She complained of financial difficulties, inability to hold a job, and trouble with men. After an initial interview, a forty-five-minute psychotherapy session was held and recorded on videotape.

Each subsequent week for a total of six weeks, the subject returned to view the previous week's therapy session, and to record the next. Before viewing the video playback each week, she filled out a rating scale to describe herself as she thought she was at that time. Then after viewing the video playback she repeated this procedure to describe herself as viewed in the taped performance. The therapist and subject viewed the playbacks together and their comments were recorded on a tape recorder.

Eight student nurses were also asked to rate the taped sessions so as to determine what the videotape interviews might communicate to other observers.

Geertsma and Reivich (1965) made the following conclusions from their study:
1. The videotape playback material provided a powerful stimulus; strong affect was evoked in the subject both from the characteristics of her videotape image and the psychological content of the playback.

2. The subject's relationship with the therapist was a critical factor in determining what she would do during the playback sessions. The therapist served as a cueing and motivating function in order to help the subject overcome her resistance to looking at important facets of her behavior, as evidenced in the videotaped material.

3. The subject demonstrated substantial changes in several traits central to her self-regard. She came to rate herself as less intelligent, less cheerful, less conscientious, less bold, venturesome, and more tenderminded. All of these shifts were directed toward the levels of ratings given by the student nurses, thus suggesting the subject came to assess herself more realistically [pp. 40-41].

Kagan, Krathwohl, and Miller (1963) using videotape equipment have developed a technique designed to examine and manipulate interpersonal behavior, called IPR (Interpersonal Process Recall). This new stimulated recall methodology provides participants in a recently concluded dyadic encounter with maximum cues for reliving the experience by means of videotape playback. The participants hear the playback in separate rooms and are encouraged by interrogators at significant points in the playback to recall feelings and to interpret behavior. Parallel reactions are obtained from the participants through simultaneous interruption of the videotape playback [p. 237].

Kagan and his associates (1963) presented a case study of a thirty-eight-year-old woman in which they demonstrated the IPR method to be an accelerator of psychotherapy. The patient, who had been married for sixteen years, complained of suffering from periods of depression. Prog-
nosis for psychotherapy was poor, since despite previous attempts at therapy she revealed little insight into her relationships with people.

The patient experienced IPR sessions in a counselor-client situation for three months. During this time the IPR method seemed to have accelerated the productivity of the therapeutic experience. "The client gained insight into her own behavior, interpreted relatively slight incidents and postures in a much deeper manner than in the initial interview, and brought repressed affect to the surface [p. 242]."

This study is important not only for its support of the self-confrontation technique, but also for its inclusion of the attending therapist in the videotape experience. By means of the IPR technique, the therapist independently also viewed the sessions and responded to them. The usefulness of the recorded responses of both the client and the therapist could be used to gain new insight into various interpersonal situations and to train practicing therapists.

Video Self-Confrontation in Group Psychotherapy

Stoller (1967) recognized the effectiveness of the video self-confrontation technique when he first utilized television cameras to conduct open group therapy with chronically repressed, hospitalized patients who had not previously responded to rehabilitation efforts.

He had noted that when patients viewed themselves on videotape in a passive manner, they tended to concentrate on aspects of their physical
appearance rather than on meaningful elements of their interpersonal impact. Subsequently he coined the term "focused feedback."

By having the therapist focus on what he considers to be significant aspects of their manner of interacting, it was found that patients had the opportunity to see themselves within a meaningful framework. Under these circumstances, the opportunity for self-perception is unsurpassed [p. 160].

Stoller further stated that for this technique to be most effective, immediate playback should occur.

In 1967 Danet published the first study involving an outpatient group therapy population experiencing video feedback. His study attempted to investigate the impact of video playback on both individual group members and on group processes. The experimental group received ten consecutive minutes of playback at the beginning of each of nine weekly sessions. The control group, although recorded under the same conditions, did not view the playbacks.

Danet (1967) was not able to make any positive statistical conclusions; however, some interesting suggestions emerged. Since playback seemed to make denial extremely difficult, a greater degree of anxiety due to the self-confrontation experience was noted. Introduction of playback had a disrupting influence on the group's processes such that the mode of interaction and amount and type of cohesiveness were all affected. It was further suggested that "how the group's functioning was affected depended upon when playback was introduced in the group's
history (at the outset or after it had already formed into a cohesive unit) [p. 254].” He also noted that the manner in which the therapists handled the playback material seemed to have an impact on the group.

It is interesting that this study is the first to report any negative aspects of the video self-confrontation technique on both individual and group psychotherapy. The author concludes by stating that "some patients may lack sufficient ego strength to deal with the strong emotional impact and potential anxiety arousal inherent in any self-viewing experience [p. 256]." With this in mind, further research will need to determine when self-confrontation therapy might be harmful to an individual or to a group.

A more recent study, involving audiotape playbacks instead of videotape playbacks, found results similar to those of Danet (1967). Bailey (1970) in a controlled experiment asked whether audiotape playback in group therapy could produce positive personality changes above those to be expected by standard therapeutic methods. A three-group design was employed in which Group A (self-confrontation group) met for thirty sessions. Fifteen of these sessions were regular group therapy sessions and fifteen were playbacks. Group B met for the same amount of time, with every other session being recorded, but they received no playbacks. Group C received pre- and posttesting, but no therapy.

Results of the study indicated the three groups did not significantly differ; however, excerpts from the taped sessions showed that the playback group was more verbally productive than the regular therapy group.
Bailey (1970) interpreted this result to be an indication of the deterioration effect; the patient's increased verbal involvement could mean defensiveness, increased anxiety, or "play acting."

While the majority of the reviewed studies are preliminary, it seems inevitable that the use of video self-confrontation as a therapeutic aid in treating psychiatric patients will become an important technique of psychotherapy. Viewing oneself by means of a videotape recorder provides the individual with the most convenient and objective self-image confrontation ever available. The videotape playbacks are aimed at facilitating and accelerating the self-understanding and positive behavior change. A number of studies have been reviewed which have attempted to illustrate the various ways videotape can serve as a therapeutic function. However, many more studies are needed before any final conclusions may be made on its effectiveness.
CHAPTER III

METHODS AND PROCEDURES

Research Setting and Equipment

The present experiment was conducted at the Center for Psychological Services (CPS), which is operated by the Department of Psychology at North Texas State University, Denton, Texas. The purpose of the CPS is twofold: to serve the public need for clinical evaluations and minimal psychotherapy and to serve as an on-campus practicum center for clinical psychology graduate students under the guidance of the center directors.

The experiment was confined to two rooms, referred to as the Activity Room, where therapy was held, and the Video Equipment Room, which housed the videotape equipment. The rooms, approximately twelve by fifteen feet each, were located next to each other so that a one-way mirror (six by three feet) was installed between the adjoining wall of the two rooms. The mirror enabled observation and filming of the therapy sessions without the client's knowledge.

The physical setting of the Activity Room contained materials and activities that provided therapeutic media appropriate for adolescent boys.
(ages nine through thirteen), as suggested by Ginott (1961). Materials available in the room included tool bench supplies and wood, Bozo the Clown, miniature army and cowboy men, guns and rifles, puppet family, boxing gloves, table bowling, and trucks and cars. Since some of the boys who participated in the program displayed tendencies of withdrawal and inhibition, other activities were also included in the room, such as doll house family, sandbox, clay, water colors, finger paints, and games, including checkers and chess.

The room also contained table and chairs, cabinets and drawers for the materials, and two closets. Each boy had his own drawer, in which he could put materials he wanted to use during the next session (such as a finger paint picture or something he had built). A bathroom also adjoined the Activity Room. The walls and ceiling were sound-proofed, and adequate lighting was installed. In the ceiling above the one-way mirror, a Panasonic microphone (Model # Wm-2105p) was placed to pick up all conversations while video recording.

The Video Equipment Room contained a Panasonic video tape recorder (Model # NV-3020), a Panasonic video camera, and a Panasonic monitor television. Panasonic video tapes (Model # NV-P71) capable of recording 2,400 feet of material were used throughout the therapy program. Approximately fifteen tapes were utilized during the program.
Description of Subjects

Four boys between the ages of ten and fourteen were chosen to participate in the program, with the belief that they could benefit from videotape therapy. These boys, who live in Denton, Texas, or surrounding communities, had previously been referred to the CPS for psychological testing by their school counselors. The major reasons for referral of these boys stemmed from their tendencies toward isolation from peers and active disruptive classroom behavior.

Tom, age twelve, who placed in the bright normal range of intelligence, was functioning far below his capabilities in school. Although he liked to be the center of attention, he often withdrew from classroom discussions and projects. His mother was observed as being overly coercive and demanding of Tom. He, in turn, felt that he was denied much freedom.

Larry, age fourteen, previously diagnosed as having a brain dysfunction, placed in the borderline range of intelligence. Because of his disabilities he was overly sensitive and defensive. He refused to compete with peers on any basis and demonstrated trends toward isolation and emotional insulation, such as feeling the necessity of always being correct.

Frank, age fourteen, was referred for school problems both in learning and behavior. He scored within the normal range of intelligence and displayed tendencies toward depression and anxiety.
John, who is ten years of age, was functioning in the lower end of the normal range of intelligence. He had a speech impediment, and there were indications of minimal brain damage. He was hostile and sneaky in his actions toward adults, and displayed destructiveness and over-control in particular.

Qualifications of Director and Therapist

An assistant professor of the Department of Psychology served as director of the therapy program.

Four male graduate psychology students were chosen to act as therapists throughout the project. All of the therapists had previously had some working therapy experience with boys and had completed the required psychology therapy courses. Each therapist was matched by the director of the program with one of the four boys on the basis of personality traits, so as to establish maximum rapport and a strong working relationship.

Others Involved in the Program

Other persons, who were involved in the therapy program consisted of a coordinator, two cameramen, and a tester who conducted the independent testing sessions.

The coordinator was a graduate student working on her doctorate, who had previous experience with play therapy groups. Her job entailed in general coordinating the program under the supervision of the director.
She arranged therapy appointments for the clients and therapists, ordered videotapes, requested cameramen when videotaping, etc.

Two psychology graduate students served as cameramen to record the designated ten-minute segments of each of the client's therapy session. The cameramen also reviewed the videotapes with the therapists and with graduate psychology students who were enrolled in play therapy classes.

Another psychology graduate student served as an independent tester. As a statistical measure, independent testing sessions were held before any therapy began, after six sessions of play therapy, and then after six sessions of video therapy. The purpose of these sessions was to attain a measure of behavior under normal conditions and then under stressful conditions. The tester acted as unbiased as possible, displayed no emotions, and participated in little or no conversation with the client.

Procedure of Therapy

The project consisted of twelve fifty-minute sessions of therapy which were divided into two segments. For the first six sessions all four boys and their therapists engaged in individual play therapy. The boys were allowed to talk about anything and do anything in the Activity Room. During each session a specified ten-minute segment of therapy was videotaped from behind the one-way mirror without the boy's knowledge. Videotaping the ten-minute segments of each of the boy's therapy sessions remained constant, so that Tom was videotaped the first ten minutes of the fifty-minute therapy session. Larry, the second ten
minutes of each therapy session. John, the third ten minutes of each therapy session, and Frank, the fourth ten minutes of each therapy session.

During the second six sessions the boys with their therapists reviewed the videotapes that had previously been made of them. Specifically, the seventh session of therapy, the therapist and client together viewed the videotape recorded during the first session; the eighth session they viewed the tape recorded during the second session; the ninth session they viewed the tape recorded during the third session; etc.

After viewing a videotape, the remainder of the therapy session was spent in discussion. The client was asked to discuss or re-enact his observations of himself and to describe his feelings. It was believed that after being confronted with an accurate and realistic recording of one's own behavior, there would be a breakdown of defenses and a dissonance set up between one's distorted self-image and the more accurate one. This in turn would possibly cause the client to shift his self-image in the direction of increased reality.

Method of Collecting Data

Data was collected by two methods. The first method was the independent testing sessions, in which a sample of the client's behavior under normal conditions and under stressful conditions was videotaped. These testing sessions, each lasting twenty minutes, were administered before any therapy had begun, after six sessions of play therapy, and after six sessions
of video therapy. For the first ten minutes of the sessions the client was videotaped in the Activity Room by himself. He was told he could do anything in the room except leave. After ten minutes of solitude, the tester entered the room. He asked the client several questions, such as how he liked school, what he thought about his classmates, what he thought about his brothers, sisters, and parents, etc. Then the tester had the client complete several stressful and provoking tasks. The client was asked to complete the block design and object assembly tests of the Weschler Adult Intelligence Scale until it was accomplished correctly. He was also asked to give ten responses to card five of the Rorschach Diagnostic Test.

These videotapes were then viewed at random by three graduate psychology students. They were asked to rank the three tapes on each of the boys according to behavior showing no improvement, some improvement, and most improvement.

The six ten-minute videotapes of each boy were used not only as a therapy aid for the clients, but also as a means of obtaining objective and precise behavioral data. For statistical purposes six additional ten-minute tapes were recorded during the last ten minutes of the video therapy sessions.

These twelve ten-minute videotapes were then viewed by five graduate psychology students. The students were asked to categorize the boys' behavior into three broad categories: non-verbal expressions, verbal expressions, and play activities. Each of these was then divided into two
The descriptive groups were then given a score of "0" or "1" depending upon whether the specific behavior demonstrated a nondesirable trait (negative behavior) or a desirable trait (positive behavior). It was intended that a t-test be computed to determine a statistically significant increase in positive behavior during the video self-confrontation therapy sessions.
CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Results

To determine whether the overall treatment method (play therapy and video self-confrontation therapy) was effective, samples of the boys' behavior under normal and stressful conditions were videotaped before any therapy, after play therapy, and after video self-confrontation therapy. Three graduate psychology students then ranked these independent testing sessions according to behavior that demonstrated no improvement, some improvement, and most improvement. Table I gives the average ranking by the three students for each boy and the average rank for all four boys.

TABLE I

AVERAGE RANKINGS OF INDEPENDENT TESTING SESSIONS

<table>
<thead>
<tr>
<th>Behavioral Improvement</th>
<th>Tom</th>
<th>Larry</th>
<th>Frank</th>
<th>John</th>
<th>Total Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) None</td>
<td>1.33</td>
<td>1.33</td>
<td>1.33</td>
<td>1.00</td>
<td>1.25</td>
</tr>
<tr>
<td>(2) Some</td>
<td>1.67</td>
<td>1.67</td>
<td>1.67</td>
<td>2.00</td>
<td>1.75</td>
</tr>
<tr>
<td>(3) Most</td>
<td>3.00</td>
<td>3.00</td>
<td>3.00</td>
<td>3.00</td>
<td>3.00</td>
</tr>
</tbody>
</table>
Results of the rankings indicate that the overall treatment plan was effective insofar as the graduate students were able to distinguish the behaviors and rank them significantly. A chi square analysis for k independent samples was computed and reported to be significant far beyond the .001 level, \( p = .049 \), thus indicating that the appropriate behavior assigned to each session is not independent of the testing sessions.

To prove the hypothesis that the video self-confrontation therapy sessions are more effective than the play therapy sessions, five graduate psychology students viewed at random the twelve ten-minute segments of therapy and then scored the observed behavior of each boy according to the definitions of behavior found in the Appendix.

Table II indicates how the five students scored each of the boy's behavior for each session, and the totals. The lowest possible score for each session that could be attained was "0," indicating undesirable traits or negative behavior, and the highest possible score for each session was "6," indicating desirable traits or positive behavior.

Table II illustrates the inconsistency of all four boys' behavior during therapy. It was hypothesized that the video self-confrontation therapy sessions would show a greater increase in positive behavior than did the play therapy sessions; however, the reverse actually occurred. The total score for all four boys obtained during video self-confrontation therapy showed a decrease of 12.4 points in positive behavior from the total score obtained during play therapy.
TABLE II

AVERAGE BEHAVIORAL SCORES OF THE CLIENTS FOR EACH SESSION AND THE TOTALS

<table>
<thead>
<tr>
<th>Play Therapy Sessions</th>
<th>Tom</th>
<th>Larry</th>
<th>Frank</th>
<th>John</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4.0</td>
<td>1.8</td>
<td>3.0</td>
<td>1.6</td>
<td>10.4</td>
</tr>
<tr>
<td>2</td>
<td>2.6</td>
<td>2.6</td>
<td>3.0</td>
<td>1.4</td>
<td>9.6</td>
</tr>
<tr>
<td>3</td>
<td>4.4</td>
<td>2.2</td>
<td>2.4</td>
<td>1.4</td>
<td>10.8</td>
</tr>
<tr>
<td>4</td>
<td>4.4</td>
<td>2.6</td>
<td>2.8</td>
<td>3.8</td>
<td>13.6</td>
</tr>
<tr>
<td>5</td>
<td>3.0</td>
<td>2.0</td>
<td>4.2</td>
<td>1.6</td>
<td>10.8</td>
</tr>
<tr>
<td>6</td>
<td>3.0</td>
<td>2.0</td>
<td>3.6</td>
<td>3.8</td>
<td>12.4</td>
</tr>
<tr>
<td>Total</td>
<td>21.4</td>
<td>13.2</td>
<td>19.0</td>
<td>13.6</td>
<td>67.6</td>
</tr>
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<table>
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<th>Video Sessions</th>
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Discussion

As therapy progresses, patients begin to feel more secure and confident with their therapist and surroundings. Quite often, as this relaxed atmosphere continues, patients are able to reveal more of their problems. Children in play therapy initially demonstrate their problems through aggression and other negative behavior. While the video self-confrontation therapy sessions did not show an increase in positive behavior, it cannot
be concluded that therapy did not progress positively. During the video therapy sessions all four boys seemed to become more open with their therapists, in that they were able to relieve their anxieties and aggressions through appropriate channels in the Activity Room. This increase in negative behavior as therapy continued can therefore be interpreted as an indication of progress toward improvement.

According to the rankings of the independent testing sessions, further support is given to the assumption of positive behavioral change as indicated by the initial increase of negative behavior in therapy. The rankings demonstrated a progressive increase in positive behavior, thus seeming to contradict the results of the behavioral scores obtained during the therapy sessions. However, positive behavioral change would actually be demonstrated in this manner. As therapy progresses, behavior outside of the therapy sessions will continue to improve, while during the sessions negative behavior continues for a period of time and then decreases. Due to these findings, it can further be assumed that the rankings of the independent testing sessions tended to be a better indicator of behavioral change.

Conclusion and Recommendations

The results of the study demonstrate that the overall treatment plan was effective in producing improved behavior. The study did not prove that video self-confrontation therapy alone is a beneficial aid to the treatment of children engaged in play therapy, although improvement was
The idea of children acting out their problems through increased negative but otherwise appropriate behavior in the Activity Room is an indication of positive behavioral change and is demonstrated in this study. Bailey (1970) also observed similar results in his study. However, if the positive behavioral change is to continue, the occurrence of negative behavior in the Activity Room should eventually diminish. Perhaps if this study had been continued, a decline in negative behavior in the therapy sessions would have been noted while positive behavior would have continued. It seems necessary that a future study investigate the factors which cause this increase in negative behavior displayed in the therapy room. What are the effects of the video self-confrontation therapy on this behavior? And does this type of therapy actually aid or hinder the acting out behavior? To be able to answer these questions, a more longitudinal investigation than was made here will be necessary.
APPENDIX

CATEGORIZATION OF BEHAVIOR

I. Nonverbal expressions
   A. Expression of unhappiness and happiness
      1. Unhappiness - cries, frowns, expression of sorrow
      2. Happiness - laughs, smiles, chuckles, giggles, etc.
   B. Expression of anger and expression of no anger
      1. Anger - scowls, clenches fist, grits teeth, stamps foot, etc.
      2. No expressions of anger

II. Verbal expressions
    A. Negative statements about self and positive statements about self
       1. Negative statements - I'm dumb. I'm afraid. I never win. I've been to the principal's office too many times.
       2. Positive statements - I'm good in school. I can do that. I play marbles best. I'll win it back. I'm the fastest runner in the class.
    B. No insightful statements revealing self-understanding and insightful statements revealing self-understanding
1. No insightful statements or poor understanding of behavior - The teacher didn't explain it good enough. It was his fault that I got mad.

2. Insightful statements revealing self-understanding
   When I worried it made me steal. I wasn't loud but I was mean. Sometimes I am a pain. They got me mad, really mad. Sometimes I feel like doing school work but I know I can't.

III. Play Activities

A. Aggressive play and affectional play

1. Aggressive play (expression of anger, hostility, anxiety, or negativism) - Hitting Bobo or puppets with hands, or objects; deflating Bobo; stabbing or cutting objects with knife; beating on boards or shelves with hammer; throwing balls or other things at objects in room; using toy cowboys, soldiers for battles; breaking limits deliberately

2. Affectional play (expression of positive feelings) - hugging, inflating, or repairing Bobo; showing interest in care of room and its contents by repairing toys, cleaning room, etc.

B. Absence of play and dramatic or role play
1. Absence of play or play with noncommittal purpose (expression of confusion, indecision, anxiety or boredom) - time spent standing, sitting, or lying without engaging in a play activity, such as standing in the middle of the floor staring into space

2. Dramatic or role play (expression of feelings or attitudes about self, family, peers, others or situations) - using dolls, soldiers, etc.; talking over telephone to a designated other or an unidentified other; using soldiers, etc. to enact a story or situation.
BIBLIOGRAPHY

Books


Articles


