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INTENSIVE PLAY THERAPY WITH CHILD WITNESSES
OF DOMESTIC VIOLENCE

DISSERTATION

Presented to the Graduate Council of the
University of North Texas in Partial
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

By

Sarina Kot, B.Soc.Sc., M.Ed.

Denton, Texas

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This study was designed to determine the effectiveness of intensive play therapy as a method of intervention for child witnesses of domestic violence. The purpose of this study was to determine the effectiveness of intensive play therapy in: (a) improving the self-concept of child witnesses of domestic violence; (b) reducing internalizing behavior problems, such as withdrawal, somatic complaints, anxiety, and depression, of child witnesses of domestic violence; (c) reducing externalizing behavior problems, such as aggression and delinquency, of child witnesses of domestic violence; (d) reducing overall behavior problems, including internalizing and externalizing behavior problems, and social problems, thought problems, and attention problems, of child witnesses of domestic violence; and (e) improving play behaviors in the areas of affection, contact, physical proximity, self-direction, aggression, mood, play themes, and food nurturing themes.

The experimental group, consisting of 11 child witnesses of domestic violence, received 12 play therapy sessions within two weeks, in addition to the basic shelter services that include three educational or recreational

groups a week. The control group, consisting of 11 child witnesses of domestic violence, received only basic shelter services including educational and recreational groups during the two-week period. Both experimental and control group children participated in pre and post play therapy sessions and were videotaped. All the children completed the Joseph Pre-School and Primary Self-Concept Screening Test. The mothers completed the Child Behavior Checklist.

Analyses of covariance revealed that the child witnesses in the experimental group demonstrated (a) a significant improvement in their self-concept; (b) a significant reduction in their externalizing behavior problems; (c) a significant reduction in their total behavior problems; (d) a significant improvement in the play behaviors of physical proximity and play themes. Insignificant results were found in internalizing behavior problems and the play behaviors of affection, contact, self-direction, aggression, mood, and food nurturing themes.

This study supports intensive play therapy as a viable intervention for treating certain problem areas exhibited by child witnesses of domestic violence.

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CHAPTER I

INTRODUCTION

In the last two decades, domestic violence has gained national recognition as a serious social, economic, and legal problem. Domestic violence was thought to be a rare phenomenon when research on the topic began in the early 1970s. Now it is commonly agreed that violence is a family legacy that cuts across social class, education, and income levels (Lloyd, 1990). In nationally representative surveys conducted a decade apart, more than 25% of the couples studied reported at least one incident of physical aggression occurring during the course of their relationships (Straus & Gelles, 1990; Straus, Gelles, & Steinmetz, 1980). Other studies suggested that at least one in ten women are abused every year by the man with whom they live (MacLeod, 1987). In addition, repeated and severe violence occurs in one in fourteen marriages (Dutton, 1988). An estimated three to four million American households live with this violence every year (MacLeod, 1987).

Many children witnessing the violence between their parents or parent figures blame themselves for the violence. The children's guilt feelings are exacerbated by the fact that arguments about child-rearing practices and children's behavior are major precipitating crises that lead to violent

episodes (Jaffe, Wolfe, & Wilson, 1990).

Children entering domestic violence shelters with their mothers after a violent episode are often confused, afraid, and angry. Children are often misinformed or uninformed about the reason that they were suddenly uprooted from their home, leaving their personal possessions, friends, and school to stay in a shelter. In addition, the children may miss their fathers and do not know if they will see their fathers again (Roberts & Roberts, 1990).

From clinical experience as a director of a domestic violence shelter, deLange (1986) listed the following characteristics of child witnesses of domestic violence: low self-esteem, lack of impulse control, short attention span and inability to control anger, physical aggression and verbal abuse or passivity and withdrawal, and possibly pseudo-maturity. She found that child witnesses are often isolated. In addition, child witnesses struggle with nightmares, bed-wetting, tantrums, biting, kicking, or excessive anger or fear.

Despite the obvious need for intervention, a recent survey of the services provided by shelters found that only 60% of shelters provide counseling for children (Johnson, Crowley, & Sigler, 1992). Therefore, it appears that counseling for children is not one of the primary services provided in family violence intervention programs, either in shelters or non-residential counseling.

The impetus for providing intervention for child

witnesses of domestic violence comes from research as well as direct service experience pointing to the intergenerational transmission of domestic violence. Research findings indicate that male children who witness wife abuse are at a higher risk to become wife-abusers themselves (Hotaling & Sugarman, 1986; Lloyd, 1990). For female children, witnessing parental violence seems to set them up to be powerless and increases their vulnerability to later victimizations (Finkelhor, Hotaling, & Yllo, 1988). Workers in shelters see daughters of women sheltered and counseled 10 years ago coming back to the shelter as battered wives. The daughters, in that case, are repeating the pattern of abusive relationships (MacLeod, 1987). Intervention with children seems crucial in stopping the intergenerational cycle of violence.

Despite the research supporting the intergenerational transmission of family violence, not all children exposed to domestic violence grow up and engage in violent relationships as adults. Knowledge about the protective factors as well as effective treatment approaches is important to guide future intervention.

Play therapy is a promising option in treating child witnesses of domestic violence. Through play children can express, in a safe and natural way, their experiences, thoughts, feelings, and desires. Due to the unstable and transient life situations of violent families, traditional once-a-week play therapy sessions do not seem to meet the

unique needs of children in these families. The time duration that a child stays at a shelter may be as short as a few days, with the longest stay not exceeding four to six weeks. The shelter stay may be the only time the child has an opportunity to receive treatment. Intensive play therapy that collapses the time between sessions seems to more adequately address the unique needs of the child witnesses of domestic violence.

Purpose of the Study

The purpose of this investigation was to determine the effectiveness of intensive play therapy as a method of intervention for child witnesses of domestic violence. Specifically, this study was designed to determine the effectiveness of intensive play therapy in: (a) improving the self-concept of child witnesses of domestic violence; (b) reducing internalizing behavior problems, such as withdrawal, somatic complaints, anxiety, and depression, of child witnesses of domestic violence; (c) reducing externalizing behavior problems, such as aggression and delinquency, of child witnesses of domestic violence; (d) reducing overall behavior problems, including internalizing and externalizing behavior problems, and social problems, thought problems, and attention problems, of child witnesses of domestic violence; and (e) improving play behavior in the areas of affection, contact, physical proximity, self-direction, aggression, mood, play themes, and food nurturing themes.

Synthesis of Related Literature

The following review is a synthesis of theoretical constructs and research related to four major areas: (a) dynamics of domestic violence as related to children; (b) child witnesses of domestic violence; (c) treatment considerations for child witnesses of domestic violence, and (d) play therapy.

Dynamics of Domestic Violence

According to Rosenberg (1987), children in violent homes observed repeated verbal threats of injury, verbal assault on their mother's character, objects hurled across a room, suicide attempts, beatings, threats with and the actual use of a gun or a knife, and homicide. In addition, Rosenberg (1987) pointed out that these children also observe the cyclical nature of their parents' relationship and are often confused when violence alternates with loving periods. This confusion seems to affect children's emotional well-being in a negative way.

Children in violent homes are also at risk of being physically hurt, either accidentally when they are caught in the middle of their parents' fights or when they become the direct target of the parents' anger and frustration. Some parents may rely inappropriately on their children for nurturance, support, and guidance. Others may be emotionally unavailable (Rosenberg, 1987).

The findings of Suh and Abel (1990) supported Rosenberg's findings. They reviewed case files of women and

children who entered a shelter and found that child witnesses of domestic violence are at high risk of physical and emotional abuse.

Moore, Pepler, Mae, and Kates (1989) listed a number of characteristics of violent homes that may jeopardize children's well-being and development. These characteristics include a lack of stability and consistency, poor problem-solving skills of the parents, salient models of aggressively responding to social problems, and the apparent success or approval of aggression as a means of conflict resolution. Children in families with a coexistence of family violence, chemical dependency, and family disruption were found to suffer from mental health problems in the short run and maladaptive behavior, such as difficulty in trusting, lack of assertiveness in the long run (Johnson & Montgomery, 1989).

Since the parents who engage in domestic violence often cannot function as a buffer for the child's overwhelming feelings, the child experiences the father's rage and the mother's fear and helplessness at a similar level experienced by the parents. With denial being used as a common coping strategy in violent homes, the overwhelming feelings of child witnesses are never acknowledged. As a result, intense affective states may be experienced by the child witnesses. These intense affective states may include school phobia, separation anxiety, learning disorders, enuresis, digestive disorders, major depression and peer

difficulties. In addition, these children become "parentified." That is they are the ones who take care of younger siblings and call the police during a violent incident (Hanks, 1992).

Child Witnesses of Domestic Violence

Behavioral problems of children can be divided into the internalizing form, such as anxiety, depression, withdrawal, and somatic complaints; and the externalizing form, such as delinquency and aggression. Studies on the specific relationships between witnessing domestic violence and children's internalizing and externalizing behavior problems present a diverse and sometimes inconsistent picture. Some studies have found children from violent homes evidenced significantly more externalizing behavior than counterparts (Jaffe, Wilson, & Wolfe, 1986; Jaffe, Wolfe, Wilson, & Zak, 1986; Wolfe, Jaffe, Wilson, & Zak, 1985) while other studies found no such distinctions (Hughes, 1988; Jouriles, Barling, & O'Leary, 1987; Wolfe, Zak, Wilson, & Jaffe, 1986). In the area of internalizing problems, some studies reported no group differences between children from violent homes and children from non-violent homes (Hershorn & Rosenbaum, 1985; Jouriles et al., 1987; Wolfe et al., 1986). Co-existing are other studies that found violence-exposed children experienced substantially more internalizing problems (Jaffe et al., 1986; Wolfe et al., 1985). A recent meta-analysis by Depner, Leino, and Chun (1992) indicated a statistically significant

association between witnessing domestic violence and children's behavior problems. These findings seem to contradict the earlier findings of Wolfe et al. (1985) who found that statistically accounting for family stress variables across violent and nonviolent groups reduced the difference in child behavior to nonsignificant levels. Hershorn and Rosenbaum (1985) also found no difference in children's behavior problems between violent and nonviolent groups when families display comparable levels of marital distress.

Fantuzzo and Lindquist (1989) reviewed these studies on child witnesses of domestic violence and identified several methodological issues that may account for these inconsistent findings. First, many of the studies did not distinguish child witnesses from child witnesses who are also victims of child abuse. Significant differences in behavior were found between groups of abused and non-abused child witnesses with abused child witnesses demonstrating a higher level of internalizing and externalizing behavior problems.

Second, the age of the child witness was found to be an important mediating variable. Preschool children are particularly vulnerable to the impact of interparental violence. Preschool children at domestic violence shelters manifested more behavior problems and reported lower levels of self-esteem than 6-12 years-olds.

Third, comparison groups from nonviolent homes were not

carefully matched on socioeconomic, family composition, ethnic, and discord variables. Consequently, failure to control for the impact of class, culture, and resources may present a serious threat to claims that group difference are due to exposure to interparental violence.

Fantuzzo and Lindquist's (1989) final conclusion was that nearly all of the child witnesses that were studied were temporary residents in shelters for battered women. The amount of disruption in the home environment experienced by shelter children needs to be accounted for before concluding that the adjustment problems are related to witnessing domestic violence.

In an attempt to control for some of the above mentioned mediating variables, Fantuzzo, DePaola, Lambert, Martino, Anderson, and Sutton (1991) investigated preschool children exposed to interparental violence by dividing the subjects into four groups: (1) shelter group exposed to verbal and physical conflict; (2) home group exposed to verbal and physical conflict; (3) home group exposed to verbal conflict only; (4) home control group. Findings indicated that children residing at home or in shelters who were exposed to comparable levels of interparental physical and verbal aggression exhibited comparable levels of externalizing behavior problems which were classified in the clinical range and were significantly more severe than those of the non-physically violent comparison groups. The shelter group evidenced a significantly higher level of

internalizing problems than did both the home violence and verbal aggression only groups.

Controlling for the parents' general marital discord, marital aggression was still found to contribute unique variance to the prediction of conduct disorder, personality disorder, inadequacy-immaturity, and clinical level of problematic child behavior (Jouriles, Murphy, & O'Leary, 1989).

Children witnessing their mothers being abused have been found to be less socially adequate than witnesses of sibling abuse. Children who saw abuse directed to their mothers appeared to suffer more emotional turmoil and had a tendency to imitate the violent behavior of their parents (Pfouts, Schopler, & Henley, 1982). Child witnesses of violence against their mothers have also been found to have a higher incidence of aggression toward siblings, parents, and non-family members (Suh & Abel, 1990).

Besides behavioral problems, child witnesses are also found to encounter academic problems. Inconsistent school attendance related to family instability and transience, and inability to concentrate as a result of anxiety, over-tiredness, illness, and other factors related to family crises all affect child witnesses' academic performance in an adverse way (Moore et al., 1989). In addition, child witnesses of domestic violence tend to overestimate their own responsibility for their parents' conflict but underestimate their own ability to control situations in

their everyday lives such as performing at school.

Rosenberg (1987) found that children from violent homes tend to display either passive or aggressive strategies to resolve interpersonal conflicts and are less likely to choose assertive strategies. Assertive strategies involve the ability to stand up for personal rights and the expression of thoughts, feelings, and beliefs in direct, honest, and appropriate ways which do not violate another person's rights. In conflict situations, children from violent homes do not recognize the feelings and perspectives of their peers as readily as do children from non-violent homes. This lack of empathy reduces the possibility of resolving conflicts in an assertive way (Rosenberg, 1987).

Depaola (1989) found a significant correlation between domestic violence and the frequency of the child's negative and hostile social interactions. Mosca (1992) also studied social interactions and the use of adaptive and maladaptive coping strategies by children exposed to domestic violence. Findings indicated that children from violent homes had less social interaction and were less able to utilize adaptive coping skills.

There are evidently long-term psychological and behavioral effects of exposure to witnessing marital violence. College students who had witnessed interparental violence achieved higher mean scores on depression than college students whose parents were satisfactorily married. The "witnessed violence group" also reported significantly

more aggression against non-intimates than did the "parents satisfactorily married group" or a "discord group without physical violence". A trend was also found for the "witnessed violence group" to use more violence in dating relationships (Forsstrom-Cohen, 1989).

One area that has not been addressed by the domestic violence studies reviewed is the possibility of a genetic tendency toward violence. As the child witnesses of domestic violence are oftentimes biological children of the batterers, externalizing behavior problems manifested by the child witnesses could be related to a genetic tendency toward violence. Raine and Dunkin (1990) investigated the interaction of genetic and environmental factors in antisocial behavior. They suggested a modification to the commonly held belief that behavior with a genetic basis cannot be modified. They argued for a better understanding of the genetic basis of behavior to enhance treatment of problem behaviors.

Reports in the literature have highlighted the fact that witnessing domestic violence affects children's behavior. Child witnesses as a group experience more internalizing and externalizing behavior problems. Child witnesses also have increased academic problems and are found to have difficulty in interpersonal conflict resolution.

Treatment Considerations for Child Witnesses of Domestic Violence

Silvern and Kaersvang (1989) hypothesized that traumatization underlies the difficulties experienced by children who witness interparental violence and argued that interventions for these children should be designed to counteract posttraumatic disorders. The goal of the immediate intervention is to prevent long-term pathology by providing support and encouragement to disclose what they have witnessed.

Long term follow-up research has shown the following children's responses to trauma: (a) strongly visualized or otherwise repeatedly perceived memories, such as the ability and tendency to re-see or re-experience the original traumatic stimuli or events; (b) repetitive behaviors, such as reenactments of the traumatic episode through play or through behavioral idiosyncrasies; (c) trauma-specific fears, such as fear of mundane things (food, noise) or specific trauma-related stimuli (the abuser); and (d) changed attitudes about people, aspects of life, and the future, such as the expression of distrust or the belief that one has little control over unpleasant events (Terr, 1991).

Children who witness extreme acts of violence are at risk of developing anxiety, depression, phobia, conduct disorder, and post-traumatic stress disorder. School-age children have been found to exhibit four common

psychological phenomena that appear to serve as methods to limit trauma anxiety in the immediate weeks or months after a violent incident. These phenomena are: (a) denial in fantasy: The child tries to mitigate painful reality by imaginatively reversing the injurious outcome; (b) inhibition of spontaneous thought to avoid reminders of the violent actions; (c) "fixation to the trauma": The child uses incomplete, journalistic recounting of the event to make the harmful occurrence more tolerable through reiteration; (d) preoccupation with fantasies of future harm: The child avoids directly addressing the initial violence by supplanting the memories of the occurrence with new fears (Pynoos & Eth, 1986).

Landsman (1991) investigated the use of defense mechanisms and other emotional-focused coping by child witnesses of domestic violence and their relationship with behavioral adjustment. Findings indicated that boys and girls manifested two distinct patterns. Boys seemed to have better behavioral adjustment when they avoided emotional involvement of the abuse situation and avoided thinking about the abuse situation. In addition, boys who avoided identifying with the aggressor and found positive models to identify with seemed to have better behavioral adjustment. Girls seemed to have better behavioral adjustment when they were able to comfort themselves and did not become overly defensive.

While witnessing domestic violence is related to many

problems manifested by children, some child witnesses manage to function relatively well. Rutter (1987) suggested internal protective factors of positive self-esteem, self-confidence, and a belief in one's own ability to deal with change may influence a child's response to stressful events. Moore et al. (1989) listed social problem-solving skills of interpersonal sensitivity and the effective use of alternative methods to aggression for dealing with social conflicts as other possible protective factors. Additional possible protective factors might be the child's own capacities and behaviors, the mother-child relationship, sibling relationships, and the broader social context of peer interactions (Moore, Pepler, Weinberg, Hammond, Waddell, & Weiser, 1990).

The likelihood that child witnesses will have problems in functioning may depend on both the severity of the violence and the mother's adjustment to the violence (Hughes & Barad, 1983). The mother's concurrent impairment is viewed as a mediating factor affecting the child witnesses (Wolfe et al., 1985).

The protective factors described in this section have implications for treatment of child witnesses which would involve attempts to help these children (1) to develop internal protective factors such as self-esteem; (2) to learn skills such as social problem solving skills; and (3) to utilize external resources of supportive adults.

deLange (1986) listed the following goals for

activities planned for child witnesses of domestic violence: enhance self-esteem, stimulate problem solving and creative play, improve social skills, increase coping mechanisms to better handle anger and frustration, and learn more appropriate ways to gratify needs.

Several specific intervention approaches were described in the literature. Roberts and Roberts (1990) described the use of specially designed coloring books that discuss domestic violence in terms that children can understand. The coloring books are used as a part of an orientation into a shelter with the following objectives: (a) to provide assurances of the child's continued care and safety; (b) to encourage children to identify and express their feelings; (c) to provide information needed for children to understand what is happening in their family; (d) to provide information that will improve the children's ability to adapt to the shelter setting; and (e) to begin to assess the individual child's needs and concerns.

Butterworth and Fulmer (1991) listed group counseling as the most widely used intervention for child witnesses of domestic violence age 8 to 13. Alessi and Hearn (1984) described a six-session treatment program for children ages 8 to 16. Jaffe et al. (1990) described a group counseling program using a structured format of ten sessions covering topics such as labeling and expressing feelings, dealing with anger, safety procedures, the development of social competence and self-concept, and understanding the cycle of

violence and the children's perceived responsibility for parental violence.

While group counseling is used for school-age children who have witnessed violence, the therapeutic use of play is suggested for pre-school children who have witnessed violence. Butterworth and Fulmer (1991) cited Watson (1986) on the use of play for assessment and play therapy for expression of feelings about the trauma.

Treatment involving the family has also been described by various authors. Davis (1991) described conjoint treatment for the mother and the child as an approach aimed at very young children who had witnessed domestic violence. The approach focused on helping the child master the traumatic experience by drawing on the strengths of the mother-child attachment. Frey-Angel (1989) presented a sibling group approach to the treatment of child witnesses which caters to a wide age range. Weidman (1986) described a domestic violence treatment program involving the components of structured cognitive-behavioral groups for men, women, and children, and conjoint family therapy.

Play Therapy

The rationale for using play therapy in treating children is based on developmental considerations. Toys are children's words and play is their symbolic language of self-expression (Axline, 1947; Ginott, 1982). Play bridges the gap between concrete experience and abstract thought. Play is children's attempt to organize their experience.

Children gain a sense of control and learn coping skills through play (Landreth, 1991).

Landreth (1991) discussed the use of the child's natural medium of expression, play, in therapeutic interventions as follows:

Children express themselves more fully and more directly through self-initiated spontaneous play than they do verbally because they are more comfortable with play. For children to "play out" their experiences and feelings is the most natural dynamic and self-healing process in which children can engage. (p.10)

Child witnesses of domestic violence are subject to anxiety-provoking events that are beyond their control and thus may experience a feeling of powerlessness. Play therapy seems to be a viable intervention method to help children deal with this sense of powerlessness. Bettelheim (1987) stated the importance of play as a means for children to control in fantasy what is unmanageable in reality:

It is important that a child be able to conquer reality through play. However, even more crucial to his development is the freedom to transform an event of which he was the passive subject into one in which he is the active instigator and controller. (p. 206)

Despite the theoretical basis for using play therapy to help child witnesses of domestic violence, studies on the effectiveness of play therapy as a treatment modality for child witnesses of domestic violence are non-existent. White

and Allers (1994) reviewed 22 published studies that specifically address play therapy and childhood abuse and neglect. They concluded that evidence of the successful use of play therapy with abuse and neglect remains illusive.

Contrary to the scarce and illusive support from research, practitioners have written extensive clinical descriptions illustrating how play therapy with child witnesses of domestic violence facilitates healing. Webb (1991) presented a case of a four-year-old child witness of parental violence using play therapy and described the play therapy process as symbolic communication and a means for children to explore their feelings associated with witnessing parental violence. Robinson (1991) worked with a child witness of parental violence using play therapy with a focus on the art medium. She described drawing as a means that enables a child to construct an image of the world as the child perceives it. Through making the internal world external by drawing, the child can communicate with the therapist on a safe level. The communication further alleviates loneliness and instills a sense of hope. Malchiodi (1990) described her work with children in battered women's shelters using art as a medium. She stated that children learn ways to relax and reduce tension, ways to express feelings, and active ways to entertain themselves through art therapy. This learning is also believed to transfer to post-shelter life.

The literature on play therapy with abused children is

included here given the similarity of experience by child witnesses and direct victims of abuse. Researchers in this field have reported success in the use of play therapy and have discussed the dynamics of the therapeutic power of play in treating abused children.

Gil (1991) described numerous cases in which she effectively used play therapy with abused children. Allan (1988) described two cases in which spontaneous and directed drawings in play therapy were used and found to be an effective intervention with sexually and physically abused children. He asserted that "painting, drawing, making (in clay) and play enactment are very helpful ways of externalizing these forms of abuse and hence enabling psyche to be healed and move forward" (Allan, 1988, p. 64). A study of play therapy with 25 abused and neglected children showed improvement of all children except one in the areas of behavioral symptom control, social relationships, school performance, and self-esteem after at least one year of weekly play therapy (Mann & McDermott, 1983). In a case study, In and McDermott (1976) reported success in the use of play therapy with a four-year-old girl who had been physically abused. They stated "integration took place only after her (the child client's) life experiences were recreated in play, and mastery and control gained through that play" (p. 292). Marvasti (1994) described the use of play in diagnosis as well as treatment of child victims of incest. Cases were presented to support the use of play

therapy for children to rehearse developmental skills, for mastering them, and to work through conflicts.

The replaying of stressful events is believed to be a self-curative process that children engage in to deal with psychic trauma. Mastery play therapy has been presented as a technical eclectic approach that includes a combination of abreaction, cognitive reappraisal, a supportive relationship, and crisis intervention (Schaefer, 1994).

Play is also viewed as a developmental process for children to move back and forth along a developmental continuum to experience individuation and separation. At the same time, play is viewed as a symbolic process in which children can experiment with imaginary choices that provide a safe distance from real life choices (Cattanach, 1993).

Nicol, Smith, Kay, Hall, Barlow, and Williams (1988) compared the use of a focused casework approach to the whole family and a structured play therapy approach to the child for the treatment of child abuse. Greater improvement was found in the focused casework approach. Reams (1988) studied the efficacy of time-limited play therapy, 15 weeks of individual play therapy, with maltreated preschoolers. Results indicated superiority in the treatment group on the amount of spontaneous isolated play but the finding was not substantiated at a ten week follow-up assessment.

Summary

Findings reported in the literature have highlighted the fact that witnessing domestic violence is related to

children's behavior problems. Child witnesses as a group evidence more internalizing and externalizing behavior problems. Child witnesses also evidence academic problems. In addition, child witnesses are found to be less effective in interpersonal conflict resolution.

Witnessing domestic violence appears to be traumatic to children. However, positive self-esteem, appropriate behavior, social problem solving skills, and a positive mother-child relationship are associated with a lower incidence of behavior and emotional problems and may all act as protective factors. Intervention that focuses on enhancing some of these factors are believed to result in a lower incidence of internalizing and externalizing behavior problems. Play therapy, as an intervention particularly suitable for younger children, may be just such an intervention.

CHAPTER II

PROCEDURES

A pretest-posttest control group design was utilized in this study to measure the effectiveness of intensive play therapy with child witnesses of domestic violence. Volunteer subjects that met specified criteria were selected to participate in the study and assigned to a control group and an experimental group, with only the experimental group receiving the intensive play therapy.

Self-concept of the child subjects was measured by the Joseph Pre-School and Primary Self-Concept Screening Test. A global score indicates the child's self-concept.

The child subjects' behaviors were rated by the mothers using the Child Behavior Checklist. The specific behaviors measured are grouped under Internalizing Behavior Problems and Externalizing Behavior Problems. The total score also includes social problems, thought problems, and attention problems.

The child subjects' play behaviors in the pre and post play therapy sessions were rated by using the Children's Play Session Behavior Rating Scale, a direct observational scale. The behaviors measured include: (a) Affection, (b) Contact, (c) Physical Proximity, (d) Self-Direction, (e) Aggression, (f) Mood, (g) Play Themes, and (h) Food

Nurturing Themes.

Definitions

Affection refers to the child's expressed liking of the therapist or nurturance expressed toward the therapist. The existence of warmth in the child-therapist relationship is also classified as affection. For the purpose of this study, affection was operationally defined as the score on the Affection subscale of the Children's Play Session Behavior Rating Scale.

Aggression is the child's expression of hostility, conflicts, and attempts to hurt or destroy. For the purpose of this study, aggression was operationally defined as the score on the Aggression subscale of the Children's Play Session Behavior Rating Scale.

Child witnesses of domestic violence are defined as children who enter a domestic violence shelter as a result of their parents or parent figures engaging in domestic violence. The child witnesses have watched the violent incidents or are aware of the violence.

Contact describes the child's interactions with the therapist. Contact includes verbal as well as physical interactions. For the purpose of this study, contact was operationally defined as the score on the Contact subscale of the Children's Play Session Behavior Rating Scale.

Domestic violence is defined as the intentional use of force on the part of the husband/male partner to inflict pain on the wife/female partner. The physical battering may

be accompanied by psychological, sexual, and/or property violence (Hanks, 1992).

Externalizing behavior problems refer to delinquent and aggressive behavior (Achenbach, 1991). Externalizing grouping of behavior/emotional problems were also identified by performing second-order factor analysis of the eight 1991 syndrome scales of CBCL. For the purpose of this study, Externalizing Behavior Problems were operationally defined as the score on the Externalizing subscale of the Child Behavior Checklist.

Food nurturing themes belong to a specific kind of play theme considered separately from the other play themes. The child uses play involving food, cooking, or feeding to express nurturance for self or others. For the purpose of this study, food nurturing themes were operationally defined as the score on the Food Nurturing Themes subscale of the Children's Play Session Behavior Rating Scale.

Intensive play therapy involves collapsing the time between play therapy sessions. In contrast to the traditional once-a-week play therapy sessions, intensive play therapy in this study refers to one play therapy session per day, for four to five days a week, over a time period of approximately two weeks.

Internalizing behavior problems include withdrawal, somatic complaints, and anxiety/depression. Internalizing grouping of behavioral/emotional problems were identified by performing second-order factor analysis of the eight 1991

syndrome scales of the Child Behavior Checklist (CBCL) scored separately from each instrument for each sex/age group (Achenbach, 1991). For the purpose of this study, Internalizing Behavior Problems were operationally defined as the score on the Internalizing subscale of the Child Behavior Checklist.

Mood refers to the child's overall emotional state which includes positive moods such as happy, content, excited, etc.; negative moods such as sad, worried, etc.; and no obvious affect observed. For the purpose of this study, mood was operationally defined as the score on the Mood subscale of the Children's Play Session Behavior Rating Scale.

Physical proximity means the physical closeness or distance the child maintains in relation to the therapist. For the purpose of this study, physical proximity was operationally defined as the score on the Physical Proximity subscale of the Children's Play Session Behavior Rating Scale.

Play themes refer to the storyline or the essence of the child's play. In this study, play themes were categorized into nurturing, creative, mechanical, exploratory, and conflictual themes, with the nurturing and creative themes as desirable and conflictual themes as undesirable. For the purpose of this study, the term play themes was operationally defined as the score on the Play Themes subscale of the Children's Play Session Behavior

Rating Scale.

Play therapy is defined as "a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through the child's natural medium of communication, play" (Landreth, 1991, p. 14).

Self-concept is defined as the attitude that a child holds toward himself or herself. Self concept also refers to the extent to which the child values his or her own worth (Joseph, 1978). For the purpose of this study, self-concept was operationally defined as the score on the Joseph Pre-School and Primary Self-Concept Screening Test.

Self-direction refers to the child's expressed ability to independently make decisions and solve problems. For the purpose of this study, self-direction was operationally defined as the score on the Self-Direction subscale of the Children's Play Session Behavior Rating Scale.

Hypotheses

To carry out the purposes of this study, the following hypotheses were formulated:

- 1) Subjects in the intensive play therapy group will attain a significantly higher mean score on self-concept as indicated on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) posttest than will subjects in the control group.

- 2) Subjects in the intensive play therapy group will attain a significantly lower mean score on Internalizing Behavior Problems as indicated on the Child Behavior Checklist (CBCL) posttest completed by the mothers than will subjects in the control group.
- 3) Subjects in the intensive play therapy group will attain a significantly lower mean score on Externalizing Behavior Problems as indicated on the CBCL posttest completed by the mothers than will subjects in the control group.
- 4) Subjects in the intensive play therapy group will attain a significantly lower mean score on Total Behavior Problems as indicated on the CBCL posttest completed by the mothers than will subjects in the control group.
- 5) Subjects in the intensive play therapy group will attain a significantly higher mean score on Affection as indicated on the Children's Play Session Behavior Rating Scale (CPSBRS) posttest than will subjects in the control group.
- 6) Subjects in the intensive play therapy group will attain a significantly higher mean score on Contact as indicated on the CPSBRS posttest than will subjects in the control group.
- 7) Subjects in the intensive play therapy group will attain a significantly higher mean score on Physical Proximity as indicated on the CPSBRS posttest than will subjects in the control group.
- 8) Subjects in the intensive play therapy group will attain a significantly higher mean score on Self-Direction as indicated on the CPSBRS posttest than will subjects in the

control group.

9) Subjects in the intensive play therapy group will attain a significantly lower mean score on Aggression as indicated on the CPSBRS posttest than will subjects in the control group.

10) Subjects in the intensive play therapy group will attain a significantly higher mean score on Mood as indicated on the CPSBRS posttest than will subjects in the control group.

11) Subjects in the intensive play therapy group will attain a significantly higher mean score on Play Themes as indicated on the CPSBRS posttest than will subjects in the control group.

12) Subjects in the intensive play therapy group will attain a significantly higher mean score on Food Nurturing Themes as indicated on the CPSBRS posttest than will subjects in the control group.

Limitations

This study has the following limitations:

1. The number of subjects in both the experimental and control groups was small and not racially balanced.
2. The experimental group and the control group were not living at the shelter at the same time.
3. Mothers who completed the Child Behavior Checklist were aware of the fact that their children received intensive play therapy or not. This knowledge may have biased the mothers' ratings.

4. The Children's Play Session Behavior Rating Scale is a new instrument that was constructed specifically for use in this study rather than a well-established instrument used in previous research.

Instrumentation

Joseph Pre-School and Primary Self-Concept Screening Test

The Joseph Pre-School & Primary Self-Concept Screening Test (JPPSST) was developed by Joseph (1979) to measure children's self-concept. The instrument was originally developed for preschool children and later adapted for upper grade levels. Pictures are used to stimulate responses from the child. First, the child identifies the pictures as pictures of himself or herself. By using the child's descriptions of the activities and feelings surrounding the pictures of self, the scorer rates the child's self-esteem on a global index scale of 0 to 30.

The JPPSST can be used with children ranging in age from three years, six months to nine years, eleven months. The JPPSST does not require verbal or reading skills and can be administered with a minimum of training for the questioner. The relative shortness of the JPPSST is another desirable feature.

In order to check the reliability of the JPPSST, a test-retest sample was taken. With this method, the reliability coefficient was established at .87. The Kuder-Richardson (20) formula was used in estimating the internal

consistency reliability of the JPPSST. Kuder-Richardson (20) coefficients ranged from .59 to .81 with a median correlation of .73. An item analysis was performed with item-discrimination coefficients ranging from .30 to .70 as a function of the particular item and the age level of the sample. All items on the scale obtained correlation coefficients that significantly contribute to the overall test score performance.

Construct validity was addressed by correlating Global Self-Concept Scores with scores derived from two self-concept rating scales that were completed by teachers. The correlation coefficient between the scores of the two tests equaled .51 which was significant at the .01 level of significance (Joseph, 1979).

Child Behavior Checklist

The Child Behavior Checklist (CBCL) was originally developed by Achenbach and Edelbrock (1983). In the current study, the 1991 profile (Achenbach, 1991) was used. The purpose of the CBCL is to record in a standardized format the behaviors and competencies of children as reported by their parents. There are 120 items in CBCL which takes about 15 to 20 minutes to complete. In this study, only the scores on the internalizing behavior problem scale, the externalizing behavior problem scale, and total behavior problems were used.

Reliability has been extensively established for the CBCL. As the syndrome scales were derived from principal

components analyses of the correlations among items, internal consistency was built-in. Cronbach's alpha is .90 for Internalizing Behavior Problems and .93 for Externalizing Behavior Problems for girls age 4 - 11. For boys age 4 - 11, Cronbach's alpha is .89 for Internalizing and .93 for Externalizing Behavior Problems. Cronbach's alpha represents the mean of the correlations between all possible sets of half the items comprising a scale.

Inter-interviewer reliability of item scores was established at .959 for the problem items by comparing scores obtained by three interviewers on 241 matched triads of children. This indicates a very high inter-interviewer reliability in scores obtained for each item relative to scores obtained for each other item.

Test-retest reliability was established at .89 and .93 for Internalizing and Externalizing Behavior Problems respectively. Long-term stability (two years) of scaled scores was established at .70 and .86 for Internalizing and Externalizing behaviors respectively. However, among children receiving mental health services, long-term stability coefficients have been generally lower, with significant decreases in problem scores. Therefore, the long-term stability found in the longitudinal sample does not mean that the parents' CBCL ratings are insensitive to the effects of interventions with children.

Content validity is supported by the ability of nearly all CBCL items to discriminate significantly between

demographically matched referred and non-referred children. Construct validity is supported by numerous correlates of CBCL scales, including significant associations with analogous scales on the Conners (1973) Parent Questionnaire and the Quay-Peterson (1983) Revised Behavior Problem Checklist. Criterion-related validity is supported by the ability of the CBCL's quantitative scale scores to discriminate between referred and non-referred children after demographic effects were partialled out. Clinical cutpoints on the scale scores were also shown to discriminate significantly between demographically matched referred and non-referred children.

Children's Play Session Behavior Rating Scale

The Children's Play Session Behavior Rating Scale (CPSBRS) was developed by the investigator to rate children's play behavior in play therapy sessions. This direct observational instrument measures children's behavior in the following eight dimensions: (a) Affection, (b) Contact, (c) Physical Proximity, (d) Self-Direction, (e) Aggression, (f) Mood, (g) Play Themes, and (h) Food Nurturing Themes.

Videotaped play therapy sessions were rated in 4-minute segments. The ratings range from 1 (low) to 5 (high). Each score on a specific dimension is based on a description of the intensity, duration, and/or frequency of the behavior.

The CPSBRS was developed using a process which included two steps. First, a review of the literature related to

indicators of therapeutic progress in play therapy and direct observational instruments of children's behavior in play therapy was conducted to establish a theoretical perspective on measuring behavioral change by children in play therapy and to identify behavioral dimensions to include in a rating scale. Moustakas (1955) found that normal and disturbed children do not differ in the kinds of negative attitudes they express in play therapy. The difference lies in the frequency and intensity, with disturbed children expressing negative attitudes more frequently and with greater intensity than normal children. Moustakas theorized that feelings expressed by children in play therapy move in the general direction from negative to positive. Axline (1950) postulated that at the end of successful therapy children are taking responsibility for their own feelings and behaviors. Hendricks (1971) and Withee (1975) investigated the process of play therapy by observing and analyzing children's verbal expression, non-verbal expression, and play activities. The categories of play activities by Hendricks (1971) were derived from observations and analysis of children's play therapy sessions and included: (a) exploratory, (b) noncommittal, (c) absence of play, (d) incidental, (e) aggressive, (f) messy-destructive, (g) creative, (h) messy-constructive, (i) dramatic and role play, (j) affectional, (k) relationship, (l) environmental expansion, (m) environmental modification, (n) infantile, (o) absence from room, and (p) removal from

room. Hendricks (1971) found that in later stages of therapy, there is an increase in relationship play and creative play and a reduction in aggressive play.

Guerney and Stover (1971) developed a rating scale to rate children's behavior in play sessions with their parents who were trained in filial therapy. The scale measures five specific behaviors of children in play sessions: (a) aggression, (b) affection, (c) leadership, (d) dependence, and (e) role play.

Howe and Silvern (1981) developed the Play Therapy Observational Instrument to codify children's behavior and measure children's emotional well-being. Perry (1988) adapted Howe and Silvern's instrument to identify adjusted versus maladjusted children on the basis of their behavior in play therapy.

The categories of play behaviors included in the above mentioned observational instruments were reviewed for items that indicate therapeutic progress in children. As these instruments were not constructed specifically to measure progress in play therapy, the items were not directly used to construct the Children's Play Session Behavior Rating Scale. The items were used to establish areas of behaviors commonly found in play therapy sessions. In addition, the dimensions in the scale developed by Guerney and Stover (1971) were used as a blueprint to expand upon for the present scale.

In the Children's Play Session Behavior Rating Scale,

Affection is a dimension adopted from Guerney and Stover (1971). However, since this scale was designed to measure the parent-child relationship, the description of behaviors that indicate affection was modified to more appropriately reflect the therapist-child relationship. In addition to Affection, other relationship dimensions of Contact and Physical Proximity were included. The dimension of Self-Direction was adapted from Guerney and Stover's Leadership and Dependence dimensions. The dimension of Aggression was included in light of the unique nature of the population of child witnesses of domestic violence. The dimensions of Mood and Play Themes were adapted from the Play Therapy Observational Instrument (Howe and Silvern, 1981; Perry, 1988). The inclusion of the dimension of Food Nurturing Themes was an attempt to separate out children's use of food, feeding, and cooking to express nurturing themes.

Specific behavioral descriptions were then provided for each of the eight dimensions and a five point rating scale was developed for each dimension. Two experts in the field of play therapy were consulted to establish content validity of the scale. Garry Landreth, Ed.D., Director of the Center for Play Therapy at the University of North Texas and chair of the Board of Directors of the International Association for Play Therapy, is an authority in the field of play therapy and has published three books on play therapy including Play Therapy: The Art of the Relationship. Lessie Perry, Ph.D., is a member of the Board of Directors of the

International Association for Play Therapy, has conducted research using the Play Therapy Observational Instrument, and has published in the area of diagnostic assessment of children's play therapy behavior. Suggestions from both experts were incorporated before the Children's Play Session Behavior Rating Scale was finalized.

Selection of Subjects

Volunteer subjects were recruited from the child residents of three domestic violence shelters in Denton, Dallas, and Arlington, Texas: Denton County Friends of the Family Shelter, Genesis Women's Shelter, and Arlington Women's Shelter. The domestic violence shelters are temporary residential shelters for battered women and their children. The limit of stay for the residents at the shelters is four to six weeks. Typically, shelter residents stay two to four weeks. Children were selected to participate in this study based on the following criteria: (a) must be a resident at one of the domestic violence shelters involved in this study; (b) must be between the ages of 4 years and 10 years; and (c) must have consent from the mother to participate in this study.

Children were assigned to the experimental and control group depending on the time period they resided at the shelter. Since the shelters are communal living facilities where residents have daily contact with each other, experimental and control group children selected for the study were not living at the shelter at the same time

because this could create a sense of unequal treatment. Children who came to the shelters between September, 1994, and February, 1995, and met the selection criteria were placed in the treatment group. The control group was comprised of children who came to the shelters between March and April, 1995. Since there was no change in personnel, policies, or programs in the shelters during the period of the research, it would be safe to assume that the experimental and control groups received the same basic services.

The investigator met with each mother who had a child or children that met the specified criteria to explain the purpose and requirements of the study, to provide information about confidentiality, and to answer any questions the mother had before she signed the consent form (Appendix A & C). Participation was voluntary.

Of the 40 children who were selected for the study, 22 completed the study and 18 left the shelter before the study was completed. The experimental group was comprised of 11 children, 6 girls and 5 boys ages 4 to 10. There were 11 children in the control group, 7 girls and 4 boys ages 4 to 9. The mean age for the children in the experimental group was 6.9 and in the control group, the mean age was 5.9. The population in the experimental group was 46% Caucasian, 27% Hispanic, and 27% African American. In the control group, 15% of the children were Caucasian, 15% Hispanic, and 70% African American.

Collection of Data

The pre and post play therapy sessions for each child were videotaped and the playrooms in the three different locations were equipped with similar play materials according to the guidelines outlined by Landreth in Play Therapy-The Art of the Relationship (1991).

The child subjects in the Denton County Friends of the Family Shelter were brought to the Child and Family Resource Clinic at the University of North Texas for the videotaping. The playrooms in the clinic are equipped with two-way mirrors and videotaping equipment. The subjects in the Genesis Women's Shelter in Dallas were videotaped in a playroom at the Genesis Outreach Office. This playroom is equipped with video equipment mounted from the ceiling. For the subjects in the Arlington Women's Shelter, videotaping was performed in the shelter playroom where a video camera was set on a tripod inside the playroom.

Children in both the experimental and control groups participated in the videotaped pre play session within a few days after they arrived at the shelter. Following the pre-session, the children in the experimental group received 10 more play therapy sessions in a playroom in the shelter where they resided while the control group children did not receive play therapy. At the end of two weeks or the completion of play therapy, the children in both the experimental and control groups received a post play therapy session which was videotaped in the same playroom with the

same play therapist they met in the pre session. For the experimental group children, the pre-session, the 10 play therapy sessions, and the post session were conducted by the same therapist. For both the experimental and control group children, the post play session was the second time they went to the playroom where videotaping took place.

Although the Child Behavior Checklist (CBCL) is designed to be self-administered, an interviewer was available to read it to the mother if the mother so chose. The availability of an interviewer was particularly important as some mothers at the shelter had difficulty reading. This instrument was completed within three days of a child's arrival into the shelter and prior to the pre play therapy session.

The Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) was administered to the child subjects prior to the beginning of the first videotaped play therapy session. The videotapes of the pre and post play therapy sessions were rated by judges using the Children's Play Session Behavior Rating Scale (CPSBRS). The judges rated the video tapes blind: they were not aware of whether the child was in the experimental or control group or whether the tapes were from a pre or post session.

For the experimental group, after the approximately two weeks intensive play therapy treatment (total of 10 sessions), the CBCL was administered again to the mother. The JPPSST was administered to the child again.

For the control group, after two weeks, the CBCL was administered to the mother again. The JPPSST was administered to the child. A play therapy session was conducted by the same play therapist the child saw two weeks ago and the session was videotaped. The videotapes were kept for future rating.

The instruments and videotapes were number coded to maintain the confidentiality of the participants. The researcher kept a master list with the subjects' names and respective codes in a locked filing cabinet.

Treatment

The children in the treatment group received 12 sessions of play therapy. The play therapy sessions were 45-minute sessions that spanned a period of twelve days to three weeks, depending on availability of the child for scheduling. Having the play therapy sessions in the shelter provided convenience of access which was a crucial factor to prevent drop out and to eliminate an additional burden to the mothers who were already in crisis. The space utilized in the shelter was either a playroom smaller than the playrooms where videotaping was performed, or an office where toys were brought in and set up for the play sessions. In addition to the intensive play therapy, the experimental group children also received three to four educational and recreational group sessions per week. The group sessions included all children in the shelter and focused on family violence awareness, sexual abuse prevention, feelings, and

self-esteem. The group activities involved art and crafts, paper-and-pencil worksheets, and physical activities. For the children in the control group, only group sessions (the same type of groups as those attended by the experimental group children) were provided.

Play therapy was provided by two master's degree level counselors and one doctoral level counselor who had been trained in play therapy. Their training in play therapy included an introductory course in play therapy, an advanced course in play therapy, and a practicum in play therapy. The master's level counselors had completed all their coursework and were enrolled in a field experience class when they provided the intensive play therapy. In addition, the doctoral level counselor had an advanced doctoral practicum and internship in play therapy. She is also a Registered Play Therapist and Supervisor. In addition, the counselors received special training on the issue of domestic violence provided by the staff at the shelter.

Analysis of Data

Following the collection of the pretest and posttest data, the instruments were scored and double checked. The pre and posttest video tapes of the play sessions were not rated until completion of the study to insure that the raters did not know whether they were rating a pre or post session, an experimental group tape or a control group tape. Four doctoral students with advanced course work and training in play therapy blind scored the videotapes over a

two week period. Inter-rater reliability for the four raters was established during two 2-hour training sessions.

Training included discussions and collaborative rating sessions. Inter-rater reliability was also checked midpoint of the scoring process and again at the end of the scoring as suggested in the Manual for Coders (Muehl, 1961).

Kendall's Coefficient of Concordance W was used to calculate inter-rater reliability and the resulting reliability coefficients are presented in Table 1.

Table 1

Inter-rater reliability coefficients of concordance for coding of the Children's Play Session Behavior Rating Scale

	Pre-coding	Midpoint	Post
W	0.830	0.916	0.929

The data were keyed into the computer and analyzed by the researcher using SPSS for MS Windows Release 6.0 (Norusis, 1994). An analysis of covariance (ANCOVA) was computed to test the significance of the difference between the experimental group and the control group on the adjusted posttest means for each hypothesis. In each case the posttest specified in each of the hypotheses was used as the dependent variable and the pretest as the covariant. ANCOVA was used to adjust the group means on the posttest on the basis of the pretest, thus statistically equating the control and experimental groups. Significance of difference

between means was tested at the .05 level. On the basis of the ANCOVA, the hypotheses were either retained or rejected.

CHAPTER III

RESULTS AND DISCUSSION

This chapter presents the results of the analysis of the data for each hypothesis tested in this study. Included also is a discussion of the results, implications, and recommendations for further research.

Results

The results of this study are presented in the order the hypotheses were tested. Analyses of covariance were performed on all hypotheses and a level of significance of .05 was established as the criterion for either retaining or rejecting the hypotheses.

Hypothesis 1

Subjects in the intensive play therapy (experimental) group will attain a significantly higher mean score on self-concept as indicated on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) posttest than will subjects in the control group.

Table 2 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 3 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 2

Mean scores for the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

	<u>Experimental (n=11)</u>		<u>Control (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	22.818	27.000	24.818	22.909
<u>SD</u>	3.790	2.793	4.020	4.277
Total cases =	22			

Note. An increase in the mean score indicates an increase in self-concept.

Table 3

Analysis of covariance data for the mean scores on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio
Main effects	166.381	1	166.381	48.956***
Covariates	196.336	1	196.336	57.770
Error	64.573	19	3.399	
Total cases =	22			

***p < .001

Table 3 shows the F ratio for the main effects was significant to the <.001 level indicating a significant increase in the experimental group's self-concept as measured by the JPPSST. On the basis of these data, hypothesis 1 was retained.

Hypothesis 2

Subjects in the intensive play therapy group will attain a significantly lower mean score on Internalizing Behavior Problems as indicated on the Child Behavior Checklist (CBCL) posttest completed by the mothers than will subjects in the control group.

Table 4 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 5 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 4

Mean scores on the Child Behavior Checklist (CBCL) subscale:
Internalizing Behavior Problems

	<u>Experimental (n=11)</u>		<u>Control (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	6.000	4.364	9.818	10.000
<u>SD</u>	4.171	3.529	5.154	5.710
Total cases =	22			

Note. A decrease in the mean score indicates a decrease in internalizing behavior problems.

Table 5

Analysis of covariance data for the mean scores on CBCL subscale: Internalizing Behavior Problems

Source of Variation	Sum of Squares	df	Mean Square	F Ratio
Main effects	25.198	1	25.198	3.978
Covariates	330.184	1	330.184	52.122
Error	120.361	19	6.335	
Total cases =	22			

Table 5 shows the F ratio for the main effects was not significant to the $<.05$ level indicating that there was not a significant difference between the experimental group and the control group's internalizing behavior problems as indicated on the CBCL completed by the mothers. On the basis of these data, hypothesis 2 was rejected.

Hypothesis 3

Subjects in the intensive play therapy group will attain a significantly lower mean score on Externalizing Behavior Problems as indicted on the CBCL posttest completed by the mothers than will subjects in the control group.

Table 6 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 7 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 6

Mean scores on the CBCL subscale: Externalizing Behavior Problems

	<u>Experimental (n=11)</u>		<u>Control (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	12.364	10.273	18.727	20.091
SD	9.584	9.111	7.417	6.848
Total cases =	22			

Note. A decrease in the mean score indicates a decrease in externalizing behavior problems.

Table 7

Analysis of covariance data for the mean scores on the CBCL subscale: Externalizing Behavior Problems

Source of Variation	Sum of Squares	df	Mean Square	F Ratio
Main effects	146.169	1	146.169	4.388*
Covariates	666.210	1	666.210	20.001
Error	632.881	19	33.310	
Total cases =	22			

*p = .05

Table 7 shows the F ratio for the main effects was significant to the .05 level indicating a significant decrease in the experimental group's externalizing behavioral problems as indicated on the CBCL completed by the mothers. On the basis of these data, hypothesis 3 was retained.

Hypothesis 4

Subjects in the intensive play therapy group will attain a significantly lower mean score on the Total Behavior Problems as indicated on the CBCL posttest completed by the mothers than will subjects in the control group.

Table 8 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 9 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 8

Mean scores on the CBCL subscale : Total Behavior Problems

	<u>Experimental (n=11)</u>		<u>Control (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	28.636	21.182	42.909	45.546
<u>SD</u>	19.876	16.654	15.169	15.896
Total cases =	22			

Note. A decrease in the mean score indicates a decrease in total behavior problems.

Table 9

Analysis of covariance data for the mean scores on the CBCL subscale: Total Behavior Problems

Source of Variation	Sum of Squares	df	Mean Square	F Ratio
Main effects	853.195	1	853.195	9.562**
Covariates	3605.017	1	3605.017	40.402
Error	1695.347	19	89.229	
Total cases =	22			

**p < .01

Table 9 shows the F ratio for the main effects was significant to the <.01 level indicating a significant decrease in the experimental group's total behavior problems indicated on the CBCL completed by the mothers. On the basis of these data, hypothesis 4 was retained.

Hypothesis 5

Subjects in the intensive play therapy group will attain a significantly higher mean score on Affection as indicated on the Children's Play Session Behavior Rating Scale (CPSBRS) posttest than will subjects in the control group.

Table 10 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 11 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 10

Mean scores on the Children's Play Session Behavior Rating Scale (CPSBRS) subscale: Affection

	<u>Experimental (n=11)</u>		<u>Control (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	2.391	2.489	2.310	2.185
<u>SD</u>	0.409	0.751	0.575	0.580
Total cases =	22			

Note. An increase in the mean score indicates an increase in the expression of affection toward the therapist as observed in the play therapy session.

Table 11

Analysis of covariance data for the mean scores on the Children's Play Session Behavior Rating Scale (CPSBRS) subscale: Affection

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u> Ratio
Main effects	0.347	1	0.347	0.953
Covariates	2.249	1	2.249	6.175
Error	6.920	19	0.364	
Total cases =	22			

Table 11 shows the F ratio for the main effects was not significant to the $<.05$ level indicating that there was no significant difference between the experimental and control groups' posttest scores on the Affection subscale of the

CPSBRS. On the basis of these data, hypothesis 5 was rejected.

Hypothesis 6

Subjects in the intensive play therapy group will attain a significantly higher mean score on Contact as indicated on the CPSBRS posttest than will subjects in the control group.

Table 12 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 13 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 12

Mean scores on the CPSBRS subscale: Contact

	<u>Experimental (n=11)</u>		<u>Control (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	3.288	2.822	2.706	2.830
<u>SD</u>	1.046	1.056	1.188	1.163
Total cases =	22			

Note. An increase in the mean score indicates an increase in the contact with the therapist as observed in the play therapy session.

Table 13

Analysis of covariance data for the mean scores on the
CPSBRS Subscale: Contact

Source of Variation	Sum of Squares	df	Mean Square	F Ratio
Main effects	0.326	1	0.326	0.305
Covariates	4.405	1	4.405	4.128
Error	20.273	19	1.067	
Total cases =	22			

Table 13 shows the F ratio for the main effects was not significant to the $<.05$ level indicating that there was no significant difference between the experimental and control groups' Posttest scores on the Contact subscale of the CPSBRS. On the basis of these data, hypothesis 6 was rejected.

Hypothesis 7

Subjects in the intensive play therapy group will attain a significantly higher mean score on Physical Proximity as indicated on the CPSBRS posttest than will subjects in the control group.

Table 14 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 15 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 14

Mean scores for the CPSBRS subscale: Physical Proximity

	<u>Experimental (n=11)</u>		<u>Control (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	1.960	2.701	2.094	1.912
SD	0.786	0.674	1.154	0.850
Total cases =	22			

Note. An increase in the mean score indicates an increase in physical proximity between the child and the therapist as observed in the play therapy session.

Table 15

Analysis of covariance data for the mean scores on the CPSBRS subscale: Physical Proximity

Source of Variation	Sum of Squares	df	Mean Square	F Ratio
Main effects	4.081	1	4.081	13.561**
Covariates	6.047	1	6.047	20.094
Error	5.717	19	0.301	
Total cases =	22			

**p < .01

Table 15 shows the F ratio for the main effects was significant to the <.01 level indicating a significant increase in the experimental group's physical proximity as indicated on the CPSBRS. On the basis of these data, hypothesis 7 was retained.

Hypothesis 8

Subjects in the intensive play therapy group will

attain a significantly higher mean score on Self-Direction as indicated on the CPSBRS posttest than will subjects in the control group.

Table 16 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 17 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 16

Mean scores for the CPSBRS subscale: Self-Direction

	<u>Experimental (n=11)</u>		<u>Control (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	4.476	4.891	4.372	4.826
<u>SD</u>	0.582	0.181	0.558	0.383
Total cases =	22			

Note. An increase in the mean score indicates an increase in the child's self-direction as observed in the play therapy session.

Table 17

Analysis of covariance data for the mean scores on the CPSBRS subscale: Self-Direction

Source of Variation	Sum of Squares	df	Mean Square	F Ratio
Main effects	0.017	1	0.017	0.187
Covariates	0.042	1	0.042	0.452
Error	1.752	19	0.092	
Total cases =	22			

Table 17 shows the F ratio for the main effects was not significant to the $<.05$ level indicating that there was no significant difference between the experimental and control groups' posttest scores on the Self-Direction subscale of the CPSBRS. On the basis of these data, hypothesis 8 was rejected.

Hypothesis 9

Subjects in the intensive play therapy group will attain a significantly lower mean score on Aggression as indicated on the CPSBRS posttest than will subjects in the control group.

Table 18 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 19 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 18

Mean scores for the CPSBRS subscale: Aggression

	<u>Experimental (n=11)</u>		<u>Control (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	2.144	1.785	1.627	1.758
<u>SD</u>	1.331	0.969	0.593	0.775
Total cases =	22			

Note. A decrease in the mean score indicates a decrease in the aggression expressed by the child as observed in the play therapy session.

Table 19

Analysis of covariance data for the mean scores on the
CPSBRS subscale: Aggression

Source of Variation	Sum of Squares	df	Mean Square	F Ratio
Main effects	0.550	1	0.550	1.912
Covariates	9.942	1	9.942	34.562
Error	5.465	19	0.288	
Total cases =	22			

Table 19 shows the F ratio for the main effects was not significant to the $<.05$ level indicating that there was no significant difference between the experimental and control groups' posttest scores on the Aggression subscale of the CPSBRS. On the basis of these data, hypothesis 9 was rejected.

Hypothesis 10

Subjects in the intensive play therapy group will attain a significantly higher mean score on Mood as indicated on the CPSBRS posttest than will subjects in the control group.

Table 20 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 21 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 20

Mean total scores for the CPSBRS subscale: Mood

	<u>Experimental (n=11)</u>		<u>Control (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	3.234	3.806	2.969	3.157
<u>SD</u>	0.902	0.753	0.938	0.980
Total cases =	22			

Note. An increase in the mean score indicates an increase in positive mood expressed by the child as observed in the play therapy session.

Table 21

Analysis of covariance data for the mean scores on the
CPSBRS subscale: Mood

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u> Ratio
Main effects	2.140	1	2.140	2.678
Covariates	0.072	1	0.072	0.090
Error	15.187	19	0.799	
Total cases =	22			

Table 21 shows the F ratio for the main effects was not significant to the $<.05$ level indicating that there was no significant difference between the experimental and control groups' posttest scores on the Mood subscale of the CPSBRS. On the basis of these data, hypothesis 10 was rejected.

Hypothesis 11

Subjects in the intensive play therapy group will attain a significantly higher mean total score on Play Themes as indicated on the CPSBRS posttest than will subjects in the control group.

Table 22 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 23 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 22

Mean scores for the CPSBRS subscale: Play Themes

	<u>Experimental (n=11)</u>		<u>Control (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	3.376	3.599	3.590	3.127
<u>SD</u>	1.112	0.970	0.665	0.521
Total cases =	22			

Note. An increase in the mean score indicates an increase in positive play themes expressed by the child as observed in the play therapy session.

Table 23

Analysis of covariance data for the mean scores on the
CPSBRS subscale: Play Themes

Source of Variation	Sum of Squares	df	Mean Square	F Ratio
Main effects	2.131	1	2.131	12.182**
Covariates	8.808	1	8.808	50.346
Error	3.324	19	0.175	
Total cases =	22			

**p < .01

Table 23 shows the F ratio for the main effects was significant to the <.01 level indicating a significant increase in the experimental group's posttest scores on the Play Themes subscale of the CPSBRS. On the basis of these data, hypothesis 11 was retained.

Hypothesis 12

Subjects in the intensive play therapy group will attain a significantly higher mean total score on Food Nurturing Themes as indicated on the CPSBRS posttest than will subjects in the control group.

Table 24 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 25 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 24

Mean scores for the CPSBRS subscale: Food Nurturing Themes

	<u>Experimental (n=11)</u>		<u>Control (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	1.229	1.094	1.479	1.196
<u>SD</u>	0.295	0.164	0.719	0.356
Total cases =	22			

Note. An increase in the mean score indicates an increase in food nurturing themes expressed by the child as observed in the play therapy session.

Table 25

Analysis of covariance data for the mean scores on the CPSBRS subscale: Food Nurturing Themes

Source of Variation	Sum of Squares	df	Mean Square	F Ratio
Main effects	0.028	1	0.028	0.365
Covariates	0.084	1	0.084	1.090
Error	1.457	19	0.077	
Total cases =	22			

Table 25 shows the F ratio for the main effects was not significant to the $<.05$ level indicating that there was no significant difference between the experimental and control groups' posttest scores on the Food Nurturing Themes subscale of the CPSBRS. On the basis of these data, hypothesis 12 was rejected.

Discussion

The results of this study point to the effectiveness of intensive play therapy in certain areas with child witnesses of domestic violence. Significant results were found on 5 of the 12 hypotheses. The meaning of these results is discussed below.

Self-Concept

The experimental group children showed a significant increase ($p < .001$) in self-concept as indicated by the Joseph Pre-School and Primary Self-Concept Screening Test. Parents' comments and therapists' observations also supported this result. One mother of an experimental group child said, "My child seems happier. He used to blame himself for everything that went wrong. Now he is able to look at things as they are. He seems more confident."

The play therapists also commented on how the experimental group children became more self-assured in their play. One therapist described a four-year-old girl's progress in therapy:

Cindy first came into the playroom with both excitement and fears. She was excited about the wide range of toys available to her but was afraid of the spiders, alligator, snake, and other wild animals. Cindy purposely stayed away from the scary animals. As several play sessions went by, and Cindy re-enacted her scary escape from home after the violent episode, she approached the scary animals again. She gradually moved from looking at them and touching them to picking the

animals up. At the last two sessions, she picked up the scary animals and told them one by one, in an assured voice, "I am not afraid of you" and proceeded to throw them onto the floor.

At the end of the intensive play therapy, another six-year-old girl in the experimental group was reported to have communicated to the therapist in the following way: "When I grow up and get married, I will not let my husband beat me up. I will go away. I will also learn Karate so that I can protect myself." This same child also expressed some doubts about her newly gained confidence. She said, "But what if I forget (Karate)." However, this child reassured herself and communicated hope and self-confidence by saying, "I will learn it (Karate) again."

Self-concept is at the core of a child's social-emotional development (Joseph, 1979). Improvement in self-concept is particularly beneficial to child witnesses of domestic violence. Children in violent homes frequently blame themselves for the conflicts between their parents (Jaffe et al., 1990). Children with a better self-concept are less likely to perceive the parental violence as their fault. A positive self-concept is also viewed as a protective factor against child witnesses' development of problematic behaviors (Rutter, 1987). It is also believed that children with a better self-concept are less likely to repeat the cycle of violence in their adulthood.

Behavior Problems

Subjects in the experimental group demonstrated fewer

behavior problems (Tables 4 - 9) at the time of the posttest as measured by the Child Behavior Checklist (CBCL). The most significant change was found in the total behavior problems (significance: $p = <.01$) which encompasses the ratings by the mothers on all the items. The total score includes the scores on all eight factors on the CBCL: (a) withdrawn, (b) somatic complaints, (c) anxious/depressed, (d) social problems, (e) thought problems, (f) attention problems, (g) delinquent behavior, and (h) aggressive behavior. Having a significantly lower mean for total behavior problems at posttest indicated a reduction of overall behavior problems perceived by the mothers.

There was also a significant ($p = 0.05$) reduction in externalizing behavior problems for the experimental group at posttest. Children in the experimental group were perceived by their mothers as less aggressive and as manifesting less delinquent behaviors such as lying, cheating, and swearing. This decrease in behavior problems as perceived by the mothers is particularly noteworthy. Previous research findings have indicated the tendency of mothers in domestic violence situations to over-report behavioral concerns of their children (Wissow, Wilson, Roter, Larson, & Berman, 1992). The significant change in the mothers' perception of the experimental group children's behavior suggests that the children had shown improvements in their behavior, either at the level as reported by the mothers or at an even higher level.

Although mothers of children in the experimental group

reported a reduction in internalizing behavior problems after the intensive play therapy, the difference between the experimental and control groups at posttest approached but did not achieve significance ($p = 0.061$). Overall, mothers of children in the experimental group reported that their children demonstrated less withdrawal, somatic complaints, anxiety, or depression. In addition, the experimental group mothers gave verbal reports to the therapists about specific benefits of intensive play therapy such as reducing the nightmares experienced by the children. Nightmares are common concerns of mothers in domestic violence shelters. One mother was very concerned about her four-year-old daughter's nightmares. The mother reported, "My child has nightmares of her father killing her and her friends." After approximately five play therapy sessions, this same mother reported, "My child's nightmares are gone. The play sessions have a big calming effect on my little girl. I don't know how to describe it. When my child comes out of a play session, it's like me after taking a bubble bath." The other children in the experimental group also had fewer or no nightmares shortly after the beginning of the intensive play therapy.

The therapists also noticed changes in the experimental group children in the area of internalizing problems. One therapist said:

When five-year-old David came into the playroom for the first few sessions, he was hypersensitive to noise.

When the slightest outside noise was heard, he would be

frightened and stop his activities to ask about the noise. He asked if it was his father coming to the shelter. He was nervous and feeling unsafe. After several play therapy sessions, David began to express intense aggression through fantasy play involving biting, shooting, hitting, and killing. He was sweating and exhausted after the aggressive acts. He seemed empowered after these aggressive play expressions. His hypersensitivity to noise disappeared and he was overall calmer and more content.

Another child in the experimental group was described by her therapist as developing self-nurturing strategies through play therapy and in turn reduced her somatic complaints and sad affect:

Nine-year-old Kim first came in looking sad and complaining about not feeling well, having aches of one kind or another. She typically would paint and tell the therapist a story about her picture. Her stories were full of themes of loneliness, helplessness, danger, and death. In the sixth session, she discovered that it was very comfortable to curl up in front of the space heater to enjoy the warm air blowing on her skin. She developed this self-nurturing activity of setting up a place with baby blankets and a pillow or stuffed animals right in front of the space heater and then laying down to rest. She would ask me to keep time and tell her when five minutes had gone by. She then proceeded to close her eyes and just enjoy her cozy

place. Kim repeated this activity every session for four sessions. She seemed relaxed and content after the "rest." Her somatic complaints ceased and her pictures and stories began to show hope and happiness.

The therapists' verbal reports indicated more positive changes in the area of internalizing behavior problems than the mothers' reports as indicated on the CBCL. One possible explanation is that mothers tend to notice changes in externalizing behavior problems more easily than changes in internalizing behavior problems. Externalizing behavior problems by nature demand the mothers' intervention and a reduction of problems is immediately felt by the mothers. The mothers in this study were in a state of crisis and might have been less sensitive to the children's internalizing behavior problems of withdrawal, anxiety, depression, and somatic complaints. The interpretation of the insignificant difference at posttest between the experimental and control groups in the area of internalizing behavior problems should take into consideration the possible insensitivity of the mothers to changes in the children's internalizing behavior problems and the small sample size.

The children's improvement in behavior as perceived by the mothers can have an added impact of enhancing the parent-child relationship. These mothers are usually under a lot of stress in this transition of leaving a violent relationship and are usually not emotionally available to the children in addition to being easily aggravated by the

children's misbehavior. Having one less stressor of children's misbehavior usually frees up some of the mothers' energy that can be invested in supporting the children's adjustment to the crisis of leaving home to come to the shelter. The children receiving therapy indirectly provided support for the mothers and in turn promoted the mothers' parenting.

The relationship between witnessing violence and the development of internalizing and externalizing behavior problems has been widely studied (Fantuzzo et al., 1991; Hershorn & Rosenbaum, 1985; Hughes, 1988; Jaffe, Wilson, et al., 1986; Jaffe, Wolfe, et al., 1986; Jouriles et al., 1987; Wolfe et al., 1985; Wolfe et al., 1986). Findings suggested that child witnesses of domestic violence evidenced a higher level of internalizing and externalizing behavior problems. Thus, a reduction in internalizing and externalizing problems indicates successful treatment. The current results of the experimental group's significantly lower posttest externalizing behavior problem score points to the effectiveness of intensive play therapy.

Another observation worth noting was the consistent pattern in the control group with an increase in behavior problems as perceived by the mothers at posttest. The drastic change of moving to a shelter is related to deterioration of children's behaviors (Fantuzzo & Lindquist, 1989). This pattern suggests that the basic shelter services of food, accommodation, recreation, psycho-educational groups for children, and counseling for mothers may not be

sufficient for impacting change in the children's behavior problems within a two-week period.

Play Therapy Behaviors

The Children's Play Session Behavior Rating Scale (CPSBRS) was used to measure play therapy behaviors. The scale included eight areas: Affection, Contact, Physical Proximity, Self-Direction, Aggression, Mood, Play Themes, and Food Nurturing Themes. Significant changes were found in two out of the eight areas (Table 10 - Table 25).

A significant change ($p < 0.01$) was observed in the area of physical proximity. On a scale of 1 to 5, the children in the experimental group showed an increase of 0.74 points ($SD = 0.67$). This change indicated the experimental group children's increased sense of security and comfort in the relationship with the therapist. The therapists all commented on how the children in the experimental group, as the therapy progressed, moved to play closer to the therapist or asked the therapist to come closer to see the play activities. This physical inclusion indicated the experimental group children's active attempt to build a relationship and develop trust with a nurturing adult. One limitation to this interpretation is the fact that the control group children did not have the same amount of contact with the therapist as compared to the experimental group children. The increased physical proximity might be due to the familiarity with the therapist.

In the area of play themes, the experimental group

children also improved significantly ($p < 0.01$) at the posttest over the control group children. Improvement in the score on play themes indicated an increase in nurturing and creative play themes and a reduction in conflictual play themes. Since play is the child's language, this significant change in play theme indicated that the children made a shift in what they communicated to the therapist, from conflict-ridden themes to creative, constructive, and nurturing themes. One therapist described her five-year-old client's changing play theme as the therapy progressed:

In the first few sessions, a predominant theme expressed by Jim was killing and death. The soldiers would all die due to one attack or another. He also engaged in the pretend play of people trying to break in and shooting a poisonous snake at the door. Toward the end of the intensive play therapy treatment, Jim shifted to spending a lot of time in using the art and craft supplies to create pictures or other art products. The fear of potential danger was no longer present in his play. The creative part of his play seemed to be most important to him by the end of the therapy.

In the areas of affection, contact, self-direction, aggression, mood, and food nurturing themes, the difference between the experimental and control group children at posttest was not significant. These are important behavior areas and are discussed separately in the following paragraphs.

The affection dimension measures the expression of liking or nurturance toward the therapist. An increase in the expression of affection would indicate the establishment of a close relationship between the child and the therapist. There was a slight increase in the expression of affection toward the therapist by the experimental group children at the post session while the control group showed a slight decrease in the expression of affection toward the therapist at the post session. The difference was not significant at the 0.05 level.

In the area of contact, children's self-initiated verbal or physical interaction with the therapist was measured. The experimental group children showed less verbal and physical interaction with the therapist by the post session while the control group children increased interaction with the therapist. Again, the difference was not significant. The reduced interaction in the experimental group is consistent with the therapists' experience that the children in the experimental group focused more on their own play rather than keeping the therapists informed by giving a verbal running account of activities or physically involving the therapist. A possible interpretation is that the children in the experimental group experienced an increased sense of security in the relationship with the therapist and had less need to interact with the therapist.

In the area of self-direction, both the experimental and control groups scored high in the pre session (Table 16). There was no significant difference between the

posttest means of the experimental and the control groups. The initial high scores suggest that these child witnesses of domestic violence may not depend on adults for directions. This is consistent with the description by Hanks (1992) and deLange (1986) that children from violent homes tend to be pseudo-mature and "parentified." Due to the unavailability of the parents, the child witnesses have to rely on their own abilities to deal with the world. As indicated by the results, intensive play therapy does not seem to promote nor does intensive play therapy discourage the originally high self-direction expressed in the child witnesses' play therapy sessions.

In the area of aggression, there was a reduction of aggression expressed by the experimental group in the post play therapy sessions but the change was not significant at the 0.05 level. The observation of the therapists throughout the play therapy process with the experimental group children revealed a change in the expression of aggression in quality rather than in quantity. An example is a child who expressed a lot of aggression in the beginning sessions with sound effects and reports of death. The child was intensely involved in the play activity of shooting and killing. Toward the end of the intensive play therapy, the sound effects and people dying as a result of the aggressive play had disappeared. The child had changed to expressing aggression through short periods of punching the Bobo (the punching bag).

The scores on aggression on the CPSBRS which were

derived from children's behavior in play therapy and the scores on externalizing behavior problems (which include aggression) on the CBCL which were observations by mothers in a natural setting were compared. Children in the experimental group displayed significantly less ($p = 0.05$) externalizing behavior problems as indicated on the CBCL by the time of the posttest. The results from the CPSBRS indicated change but not at a significant level.

Interpreting these result together, the experimental group children, by the end of the intensive play therapy, may be less aggressive in their natural setting than in the play therapy sessions. This is an interesting point to note in regard to applying the learning from therapy to daily lives. It seems that children in the experimental group at the time of the post session, had gained a better control of their aggressive behaviors outside the play therapy sessions. However, they still utilized the play therapy sessions to work out issues of aggression.

In the area of Mood, the experimental group's posttest mean score increased indicating a more positive mood expressed by the children in the post play session. However, the difference between the experimental and control group was not significant. The interpretation of the results in this area should take into account the comments by the raters. During raters' meetings for training and to establish inter-rater reliability, the raters repeatedly commented on the limitation of the videotapes in identifying the child's mood. As the videotapes covered the whole play

room without the use of closeups, facial expressions were not always visible to the raters. This limitation posed by the use of videotapes without closeups compromised the accuracy of the ratings and in turn the conclusion drawn from the results.

Food nurturing theme was separated out from play theme as a separate area to test. No significant difference was found. Children in both groups scored low (1.2 and 1.5 for experimental and control groups respectively) in the pre session and lower in the post session. Children in both groups did not use food as symbolic expressions of nurturance as had been expected.

Recommendations

Based on the results of this study, the following recommendations are offered:

1. The utilization of intensive play therapy is a viable intervention for child witnesses of domestic violence, especially when the therapeutic goals include improving self-concept and decreasing externalizing behavior problems.
2. A follow-up study to investigate the long term effect of intensive play therapy with child witnesses of domestic violence is needed.
3. Further research utilizing intensive play therapy with other populations such as children in hospitals is needed.
4. Further research is needed to modify the Children's Play Session Behavior rating Scale.

Concluding Remarks

This study has demonstrated the promising effectiveness of intensive play therapy as an intervention for child witnesses of domestic violence. This intervention can serve as treatment for problematic behaviors and as prevention to preclude the development of problematic behaviors. Intensive play therapy can be used to deal with the traumatic aspects of witnessing interparental violence. The short time duration required for completing the intensive play therapy fits particularly well with the unstable and transient life situations of the families suffering from domestic violence.

APPENDIX A
PARENTAL INFORMATION AND CONSENT FORM
FOR EXPERIMENTAL GROUP

PLAY THERAPY - RESEARCH INFORMATION FOR PARENTS

You and your child are invited to participate in a study to determine the effectiveness of Play Therapy with children who have witnessed domestic violence. Participation in this study is voluntary. You and/or your child may choose to withdraw at any time. You will be asked to complete one questionnaire before and after the play therapy for your child. Your child will be asked to participate in a 45-minute videotaped play session with the investigator before and after the play therapy.

Play therapy is a therapeutic approach used for working with young children that utilizes selected play materials. The trained counselor helps the child to express feelings, thoughts, experiences, and behaviors through the child's natural medium of communication, play.

Your child will receive 45-minute sessions of play therapy each day for two weeks for a total of 12 sessions of play therapy. The counselors have been trained in play therapy and have received special training on the issue of domestic violence.

The benefits of the intensive play therapy can be 1) improving your child's self-esteem, 2) reducing behavioral problems, and 3) improvement in problem solving skills. There is no personal risk or discomfort directly involved with this study. You will be asked to give permission for your child to participate in play sessions and to be videotaped two times. There may be times after the play sessions when your child may behave a little differently (more quiet or more active). The counselor for your child will be available to help you understand what is going on with your child and give you ideas about responding to your child.

The information you provide when you answer the questionnaire will be kept confidential. Your name and your child's name will not be disclosed in any publication or discussion of this material. Information obtained from the questionnaires will be recorded with a code number. Only the investigator, Sarina Kot, will have a list of the participants' names. At the end of this study the list of participants' names will be destroyed. The video taped play sessions of your child will be viewed only by graduate research assistants. The research assistants will have no knowledge of participants' names and they will abide by the same confidentiality standard.

If you agree to participate, please fill out and sign the consent form on the back of this page. For further information please contact Sarina Kot at (817) 565-2066 (work) or (817) 381-0947 (home). Thank you very much for your time, cooperation and your participation.

Sincerely,

Sarina Kot

PLAY THERAPY Informed Consent

You are making a decision whether or not to participate in this study. You should not sign until you understand all the information presented on the front of this form and until all your questions about the research have been answered to your satisfaction. You understand that participation is voluntary and you and/or your child may choose to withdraw at any time during the study. Your signature indicates that you meet all the requirements for participation as explained by Sarina Kot and have decided to participate, having read the information on the front of this form.

Signature of Parent
Date

Name of Child	Age
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Signature of Witness	Date
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Signature of Investigator _____ Date _____

APPENDIX B
RESEARCH INFORMATION FOR
EXPERIMENTAL GROUP CHILDREN

PLAY THERAPY - RESEARCH INFORMATION FOR CHILDREN

(To be read to child subjects age four to 10. The underlined part will be omitted for children age four to five due to their shorter attention span and limited abstract reasoning ability. Questions will be allowed and responded to immediately during the reading of this statement.)

I am a counselor for children. I spend time with children in the playroom and help them with their problems. I am studying about some better ways to help children and would like for you to help. You can help me by playing in the playroom with a counselor for 45 minutes everyday, not counting Saturdays and Sundays, for two weeks.

In the playroom, you can play with the toys, draw pictures, talk to the counselor, and do other things that you like to do. What you say or do in the playroom is private. The counselor will not tell your mother or other people about what you say or do in the playroom. The counselor will only break this rule if he or she thinks that you are not safe and need to be protected. However, if you like, you can tell your mother or other people about what you do in the playroom.

Before you start seeing your counselor in the playroom, I will invite you to come to a different playroom and make a video-tape of you playing in the playroom. At the end, I will invite you to come to the playroom again to make another video-tape. The video-tapes will be watched by some other counselors who are helping me. They will not tell other people about how you play in the playroom. They are just helping me to figure out the best way to be helpful to children.

I have talked to your mother and she told me that it would be alright with her that you help me with this study. She allows you to go to the playroom with the counselor. I would like to check if it is alright with you. It is up to you to decide. You can choose to help by going to the playroom for 12 times with your counselor and be videotaped for two times; or you can choose not to do this. Tell me which you would choose. (Allow child to respond and confirm his or her response.) Also, I would like you to know that you can change your mind any time and you can tell your mother that you do not want to go to the playroom any more.

If you have other questions later, you can always ask me. If you do not see me when you have a question, you can ask your mother to call me. I will call you back or come to talk to you. (Give child a business card of the investigator.)

Thank you for your help.

APPENDIX C
PARENTAL INFORMATION AND CONSENT FORM
FOR CONTROL GROUP

PLAY THERAPY - RESEARCH INFORMATION FOR PARENTS

You and your child are invited to participate in a study to determine the effectiveness of Play Therapy with children who have witnessed domestic violence. Participation in this study is voluntary. You and/or your child may choose to withdraw at any time. You will be asked to complete one questionnaire before and after a two-week period. Your child will be asked to participate in a 45-minute videotaped play session with the investigator before and after the two-week period.

Play therapy is a therapeutic approach used for working with young children that utilizes selected play materials. The trained counselor helps the child to express feelings, thoughts, experiences, and behaviors through the child's natural medium of communication, play.

The information you provide when you answer the questionnaire will be kept confidential. Your name and your child's name will not be disclosed in any publication or discussion of this material. Information obtained from the questionnaires will be recorded with a code number. Only the investigator, Sarina Kot, will have a list of the participants' names. At the end of this study the list of participants' names will be destroyed. The video taped play sessions of your child will be viewed only by graduate research assistants. The research assistants will have no knowledge of participants' names and they will abide by the same confidentiality standard.

If you agree to participate, please fill out and sign the consent form on the back of this page. For further information please contact Sarina Kot at (817) 565-2066 (work) or (817) 381-0947 (home). Thank you very much for your time, cooperation and your participation.

Sincerely,

Sarina Kot

**PLAY THERAPY
Informed Consent**

You are making a decision whether or not to participate in this study. You should not sign until you understand all the information presented on the front of this form and until all your questions about the research have been answered to your satisfaction. You understand that participation is voluntary and you and/or your child may choose to withdraw at any time during the study. Your signature indicates that you meet all the requirements for participation as explained by Sarina Kot and have decided to participate, having read the information on the front of this form.

Signature of Parent Date

Name of Child Age

Signature of Witness Date

Signature of Investigator Date

APPENDIX D
CHILDREN'S PLAY SESSION BEHAVIOR RATING SCALE

CHILDREN'S PLAY SESSION BEHAVIOR RATING SCALE

AFFECTION

1. Somewhat distant or hostile toward the therapist.
2. Absence of affection.
3. Content and warmth in being with the therapist or coming to the playroom.
4. Communicate liking or nurturance to therapist **once**: "You are nice.", preparing food for the therapist, paint a picture to give to the therapist, give toys to the therapist (You can have this one), lean against the therapist.
5. Communicate liking or nurturance to therapist **more than once**: "You are nice.", preparing food for the therapist, paint a picture to give to the therapist, give toys to the therapist (You can have this one), lean against the therapist.

CONTACT

1. * **Hiding** activities from the therapist on purpose (usually using the back to block the therapist's view). Do not score when hiding is a game.
* Completely **unresponsive** (verbally and non-verbally) to therapist's comment (Do not score when child is intensely involved in the play and thus unresponsive).
* **No** visible contact.
2. * **Clue** the therapist in by making a few statements of intent or activities. Somewhat verbally active in play.
* **Brief** contact in the context of play: give therapist things to hold. Do not score glancing at the therapist.
3. Spend **half of the time** being in contact with the therapist in ways described in 2.
Contact in the context of play may involve doctoring the therapist.
4. For the **majority of time**, interact with the therapist verbally or physically. Examples: "Watch me", "I am the policeman", ask the therapist to hold the doll.
5. * For the **whole time**, interact with the therapist verbally or physically. Examples: give a verbally account, handcuffing, doctoring.
* **Involving** the therapist in a game or in a fantasy role play.
* Ask the therapist to **physically move** closer to play or watch.

PHYSICAL PROXIMITY

Close proximity is defined as within a 3 feet radius in a standard playroom. Reduce to a 2 feet in a smaller playroom.

1. * Spend the whole time far away from the therapist.
* Move toys to play further away from the therapist.
* Choose toys and activities that are in the far corner of the room.
2. Spend the majority of time far away from the therapist, move into closer proximity of the therapist briefly.
3. Spend part of the time away from the therapist and part of the time close to the therapist.
4. Stay close to the therapist for the majority of time.
5. * Stay close to the therapist for the majority of time.
* When the play involves going to another part of the room that is away from the therapist, child may go away from the therapist **very briefly** but child must turn around to face the therapist or intentionally approaches to show the therapist something.

SELF-DIRECTION

1. Stand or sit in front of the therapist waiting for instructions.
2. * Ask for **permission** and require a **directional permission** (Yes, you can play/paint, etc.) before proceeding with planned activities. Usually demonstrated by several exchanges between the therapist and child after the therapist returns responsibility to child and child not proceeding with the previously verbalized intent. Child does not proceed with the original intent. Child may eventually proceed to do the activity with constant checking of the therapist's approval.
* Ask for **help** without first trying to solve the problem: Take a finger paint container to the therapist with the intent of having the therapist open the container; "Open this (lid)"; "Take this (clothes) off." When the therapist does not solve the problem, child gives up the original intent.
3. * Ask for **permission** (verbally or non-verbally by looking at the therapist) and wait for the therapist to respond before proceeding. Once therapist responds, child proceeds with plan.
* Ask for **help** and would work with the therapist to solve the problem.
* Ask for **ideas or instruction**: "Where shall I put this?"
4. Ask for help only after making an attempt to do things on his/her own.
* Ask for permission and then proceed with own plan even before therapist can have time to respond.
"Can I paint?" and then proceed with own plan even before therapist can have time to respond.
* Ask for ideas or instruction once or twice.
5. * Planned, self-assured way of going about the activities.
* Child does not request help or permission, takes responsibility to solve problems for self. Child may solicit the therapist's help when the request is realistic. Child has tried and made some effort in solving the problem. Child takes responsibility in seeing that the task is completed.

AGGRESSION

1. Absence of aggression.
2. Some aggressive play, less than half of the time.
3. * Engage in high level aggressive play for about half of the time (two minutes).
* Engage in low level aggression for half to whole time: exploring guns and other weapons, playing cops and robbers, setting up toy soldiers, carrying weapons around for protection. **No intense expression** of aggression.
4. High level aggressive play for the majority of time.
5. * Aggressive play for the **whole time**: hitting Bobo, toy soldiers fighting, puppets fighting, shooting with guns, run a car against the bricks to knock them over, making threatening noises.
* Predominance of aggression with **intensity**: forceful and involved, and/or with hostility.
* Anger toward the **therapist** - threats, accusations, cursing, attempts to hit, disparaging remarks, tell therapist to shut up.
* **Destroy** or attempts to destroy things in the playroom.
* Breaking **limits** set by the therapist.

MOOD

When child's facial expression cannot be seen clearly, use the child's general demeanor and other clues such as therapist's comment to determine mood.

1. * Negative mood for the whole time: anxious, sad, angry, frustrated, worried, afraid.
* Negative self-statements. Criticism toward own activities.

2. * Negative mood for the majority of time.
* No obvious affect observed, child may seem unsure, guarded, somewhat agitated.
3. * Demonstrating positive mood for part of the time and negative mood for part of the time, or no obvious affect for part of the time.
4. Positive mood for the majority of time.
5. Positive mood for the whole time: happy, content, excited, proud of self, free, spontaneous.

PLAY THEMES

1. Predominance of **conflictual** themes: dinosaurs fighting, fighting or running away from bad guys or bad situations, dress up to be an aggressor and making angry noises, give verbal account of happenings (real or imaginary) that involve conflicts: I can't find my cat. There are people trying to break in. The poisonous snake is at the door. To get a score of 1, there must be the existence of fear, hurt, danger, intense worry or sadness in the story line.
2. * Conflictual themes for the majority of time, some exploratory play, and/or mechanical activities.
* If conflictual themes are predominant, the conflicts achieve resolution or partial resolution.
3. * Some conflictual themes.
* **Exploratory** play.
* Repetitive and somewhat **mechanical** activities, without a plan for mastery or a purpose of self-soothing (do not score sifting sand if it is soothing).
Examples: counting money, measuring sand.
4. * Spend a majority of time in **nurturing** themes: tucking the baby in, carrying the baby, doctoring to make somebody well.
* Spend a majority of time in **creative** or constructive themes: making some art or craft, dress up to be a "friendly" character (angel, ballerina, Indian), music making, hammering with a plan and purpose.
5. Spend the whole time in nurturing, creative, and/or constructive play themes.

FOOD NURTURING THEMES

1. Child does not engage in cooking or feeding or any other food related play.
2. * Play involves food for some of the time.
* Play involves being hungry and eating to satisfy the hunger: Have the wild animals eat sand and make comments about them being hungry. The eating may involve non-aggressive eating of other animals.
3. Play involves food for about half of the time.
4. Elaborate (time and intensity) play involving food: preparing food for self or the therapist, feeding the baby. Child looks content or nurturing in the play.
5. Spend the whole time in play involving food.

CHILDREN'S PLAY SESSION BEHAVIOR RATING SCALE **Rating Form**

Rater's Initials _____

Video tape # _____

DIRECTIONS FOR SCORING: A rating is made every 4 minute interval for 10 intervals

(Lowest score = 1; Highest score = 5)

Affection

Average Score

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Contact

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Physical Proximity

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Self-Direction

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Aggression

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Mood

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Play Themes

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Food Nurturing Themes

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