A COMPARATIVE ANALYSIS OF INTENSIVE INDIVIDUAL PLAY THERAPY
AND INTENSIVE SIBLING GROUP PLAY THERAPY WITH
CHILD WITNESSES OF DOMESTIC VIOLENCE

DISSERTATION

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

For the Degree of

DOCTOR OF PHILOSOPHY

By

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This study was designed to determine the effectiveness of intensive sibling group 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; and (d) reducing overall behavior problems of child witnesses of domestic violence. A second objective of this study was to compare the effectiveness of intensive sibling group play therapy and intensive individual play therapy on the above identified dimensions.

The experimental group, consisted of 10 child witnesses of domestic violence and received 12 forty-five minute sibling group play therapy sessions within a two week period, in addition to shelter services. The comparison group, utilized from the 1995 Kot study, consisted of 11 child witnesses of domestic violence and received 12 forty-five minute intensive individual play therapy sessions within a two week period, in addition to basic shelter services. Finally, the control group, also from the Kot study, consisted of 11 child witnesses of domestic violence and received no treatment intervention, however, they did received basic shelter services.
An Analysis of Covariance revealed significant findings in 6 of the 10 hypotheses examining the effectiveness of intensive sibling group play therapy versus the wait list control group. Specifically, child witnesses of domestic violence in the experimental group exhibited: (a) a significant improvement in their self concept; (b) a significant reduction in total behavior problems; (c) a significant reduction in externalizing behavior problems; (d) a significant reduction in internalizing behavior problems; (e) a significant reduction in aggression; and; (f) a significant reduction in anxiety and depression. Intensive sibling group play therapy was found to be equally as effective as intensive individual play therapy with child witnesses of domestic violence.
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CHAPTER I

INTRODUCTION

The last two decades have marked a dramatic increase in public awareness of domestic violence and more specifically its impact on the children who witness spousal abuse. Early literature reveals that violence within the home was considered a discussion topic shrouded by secrecy due to the belief that events occurring within the home were private (Carlson, 1984). By the late 1970's, the silence was broken and domestic violence had become recognized as a growing societal concern. Children who witnessed violence, however, received little attention other than a perfunctory acknowledgment that they were among an at risk population (Hughes & Barad, 1983).

A review of recent literature suggests that family violence has become widespread and is increasingly evident in today's societal attitudes and values systems (Arroyo & Eth, 1995; Butterworth & Fulmer, 1991; Hansen, Conaway, & Christopher, 1990; Gelles & Straus, 1988). Current estimates of domestic violence indicate that between 3 million to 4 million American households live with domestic violence each year, with only a small portion of these families seeking assistance at battered women's shelters (Jaffe, Wolfe & Wilson, 1990). Of those that make a decision to go to a shelter, concern for the children's safety and well being is listed as the primary catalyst prompting women to leave a violent partner (Henderson, 1990; Hilton, 1992; Syers-McNairyu, 1990).

Comprehensive evaluations of shelter populations indicate that at least 70% of battered
women seeking safety have children who accompany them. It is estimated that 3.3 million children in the United States between the ages of 3 and 17 are exposed to parental violence each year (Jaffe, Wolfe & Wilson, 1990). This estimate is considered to be an excessively conservative figure due to the large number of existing cases that go unreported.

When families arrive at battered women's shelters, they are in crisis. The children who witness spousal abuse are at an increased risk for developing numerous adjustment difficulties. "Their vulnerability may be the result of several interrelated factors, including their exposure to violent role models, experiencing discord that accompanies wife abuse, the lack of physically and emotionally available caregivers, and/or fear that their mothers or they may be physically injured" (Jaffe, Wolfe, & Wilson, 1990, p. 55). Despite the acknowledgment that child witnesses of domestic violence are in urgent need of support services upon entering shelters, Johnson, Crowley, and Sigler (1992) estimate that only 60% of battered women's shelters offer counseling for children.

The implications of the lack of therapeutic attention are becoming increasingly clear to clinicians who work with children that have witnessed domestic violence. Lewis, Shanok, Pincus, and Glaser (1979) found that 79% of violent children in psychiatric institutions reported witnessing extreme violence between their parents. According to Kalmuss (1984), adults who witnessed parental violence as children were more likely to engage in severe marital violence as adults. These findings are consistent with the theory of intergenerational transmission of violence. This theory hypothesizes that children who
are raised in violent homes and learn violent behavior patterns are more likely to engage in violent behaviors as adults. This linear relationship has drastic implications for child witnesses of domestic violence. However, only recently have research efforts been directed toward investigating appropriate treatment interventions and more clearly delineating effective preventative measures specific to children involved in family violence (Tutty & Wagar, 1994).

Given the long range implications of the theory of intergenerational transmission, it is important to investigate therapeutic procedures aimed at providing child witnesses of domestic violence with interventions which emphasize trusting and healthy peer relationships, as well as positive adult relationships. According to Layzer, Goodson, and DeLange (1986), shelters attempting to accomplish the above objectives most commonly recommend play therapy and group therapy for child witnesses of domestic violence. In general, group therapy offered within shelters is aimed at assisting school aged children, while play therapy is most frequently identified for very young children (Layzer, 1986). Much of the literature focused on group therapy with child witnesses of domestic violence refers to structured educational groups which provided children with information regarding abuse and protective behaviors (Jaffe, Wolfe & Wilson, 1990). While educational groups highlight the need for children to learn to become empowered, such groups lack two crucial qualities: utilization of an expressive mode that can be accessed by children of all ages and verbal abilities; and utilization of relationships and social skills to negotiate problematic issues which are occurring in the moment.
Individual play therapy has been found to have positive results in working with child witnesses of domestic violence. Kot (1995) reported that child witnesses of domestic violence who received intensive individual play therapy showed a significant improvement in self-concept and showed a reduction of externalizing behavior. She further took into account that the average length of stay at a battered women’s shelter is one week, with the longest stay being four to six weeks. Since it is important to intervene during this time frame, Kot developed an intensive play therapy model, which collapsed weekly sessions into a two week, daily treatment model to further enhance the effectiveness of treatment with child witnesses of domestic violence.

Although Kot’s intensive individual play therapy model demonstrated positive results, the intensive play therapy intervention has the potential to achieve even greater results by incorporating the benefits of group therapy and the established bond between siblings with Kot’s daily play therapy treatment design to achieve a more dynamic treatment intervention. By combining these elements, children have the opportunity to address social and emotional concerns while working through family dynamics within the group process. Therefore, intensive sibling play therapy seems to be a reasonable alternative taking into account social and emotional needs of children and a limited duration of treatment opportunity.

Purpose of the Study

The purpose of this study was to determine the effectiveness of intensive sibling group play therapy as an intervention for child witnesses of domestic violence.
Specifically, this study was designed to determine the effectiveness of intensive sibling group 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; and (d) reducing overall behavior problems of child witnesses of domestic violence. A second objective of this study was to compare the effectiveness of intensive sibling group play therapy with intensive individual play therapy on the above identified dimensions.

Synthesis of Related Literature

The following is a review of literature related to child witnesses of domestic violence. This review will focus on related areas: (a) dynamics of domestic violence; (b) child witnesses of domestic violence; (c) treatment interventions and considerations; (d) group therapy; and (e) group play therapy.

Dynamics of Domestic Violence

The environment in which children who witnesses domestic violence are being raised is marked by violence and chaos. Moore, Pepler, Mae, and Kates (1989) identified a number of variables associated with violent homes which may jeopardize the child’s well-being, safety and development. These characteristics include: a lack of stability and consistency in parenting, poor problem solving skills demonstrated by parents, and the apparent approval and sanctioning of aggressive behavior as a method of resolving
personal difficulties. According to Campbell and Lewandowski (1997), factors that may impact children who live in a violent environment include:

- ongoing marital conflict, underlying family dysfunction, maternal depression resulting in reduced social support and nurturance, living with secrecy,
- dislocations and relocations as the mother leaves the home to seek safety and then returns, economic and social disadvantage, and interactions with the police and the court system (p. 360).

According to McClosky, Figueredo, and Koss (1995), the specific parental interactions witnessed by children who live in violent homes included: repeated beatings, mental degradation, assault with guns and knives, threats of suicide and homicide, and destruction of property. Further complicating the impact that these incidents have on children, is the fact that violent outbursts are typically followed by loving parental exchanges, which at best present a confusing picture to the children. The cyclical nature of parental violence leaves children feeling frustrated, out of control, confused, and unable to predict the occurrence of violent outbursts. Additionally, this cycle creates negative and conflictual attitudes regarding intimate relationships and acceptable expressive behavior (Rosenberg & Rossman, 1990). The underlying message regarding intimacy negatively impacts the child's developing sense of security and trust in the world as being a safe place (Campbell & Lewandowski, 1997).

Many women continue the abusive cycle because they are coping with symptoms of Battered Women's Syndrome, which is characterized by an increased sense of
helplessness and hopelessness about terminating the violent relationship. These women typically manifest an extremely poor sense of self-worth which is fostered by the batterer. Eventually, the severity of the abuse is minimized and accepted by the battered woman, causing the lethality of the abuse to be underestimated or even denied. This dynamic jeopardizes children’s safety and often negates any effort put forth to protect the family as a whole. As a direct result of this pattern, children often develop primitive methods of self protection and cognitively rationalize that they are deserving of the violence. Many child witnesses also develop ineffective coping skills such as: learned helplessness, exaggerated aggressive tendencies, and extreme withdrawal (Carlson, 1984).

One of the most powerful dynamics created by batterers, which helps to preserve the abusive relationship, is that of isolation and secrecy. Generally, the families of batterers are controlled by intimidation and coercion, with alcohol being present in almost half of the violent episodes thus directly increasing the risk of physical harm to the children in the home (Johnson & Montgomery, 1990). Increased parental aggression resulting from the use of alcohol further scares and confuses the children who witness these events. An intense level of fear and secrecy are often continued long after the children have been removed from the violent environment (Jaffe, Wolfe, & Wilson, 1990).

Jaffe, Wolfe, and Wilson, (1990) stated that spousal “victimization has direct implications for a mother’s effectiveness as a parent. The battered women’s role as a parent is radically demeaned through their victimization, because the dysfunction and
disorganization offers little nurturance, support, structure, or supervision for children” (p. 23). Holden and Richie (1991) cited degree of maternal stress as the most powerful predictor of children’s behavioral difficulties. This finding has far reaching implications for children when one takes into consideration the level of stress resulting from victimization within an abusive spousal relationship.

Finally, secondary stressors may complicate environmental dynamics if the family is forced to seek protection within a shelter. Disclosure of family secrets, repeated questioning, testifying in court in the presence of the abuser and potential foster placement are among the numerous additional stressors (Campbell & Lewandowski, 1997).

**Child Witnesses of Domestic Violence**

The effects of witnessing domestic violence on children’s behavior and overall adjustment are heavily documented in the literature. Children who witness domestic violence have been found to demonstrate more externalizing behavioral problems (aggressiveness, hyperactivity, and conduct problems), more internalizing behavioral problems (anxiety, social withdrawal and suicidal ideation), total behavior problems (school problems, excessive screaming, clinging behaviors, and less social competence) and somatic complaints (headaches, bed wetting, disturbed sleeping, failure to thrive, vomiting, and diarrhea). Child witnesses of domestic violence also tend to show more symptoms of depression, temperamental problems, less empathy, and lower verbal, cognitive, and motor abilities (Campbell & Lewandowski, 1997; Fantuzzo et al., 1991;
The immediate short-term effects of children witnessing domestic violence often include psychic trauma, which can be all encompassing and debilitating. Many mental health professionals conceptualize the formation of psychic trauma in child witnesses of domestic violence as being a direct repercussion of witnessing events that involve: a high degree of threat to personal safety of the child or a loved one; and that create feelings of intense fear and helplessness (Erel, Marolin & John, 1998; Frick-Helms, 1997). In many cases, the magnitude and nature of the stressful events observed by child witnesses of domestic violence are recognized as significant enough to warrant a diagnosis of Posttraumatic Stress Disorder.

Terr (1991) has conceptualized traumatic reactions as consisting of two types, Type I and Type II. Type I consists of a severe reaction to a single event that is perceived by the person as overwhelming. Type II is a more severe reaction and it is described as response to repeated exposure to traumatic events. Growth and developmental progress may be compromised by prolonged and severe post-traumatic reactions, with the greatest developmental deficit being in fine motor development and language skills. According to Arroyo and Eth (1995), developmental delays may be caused by lower cognitive skills or they may be due to chaotic lifestyles which include decreased school attendance, and acquisition of survival skills that are incompatible with learning.
It is often difficult to predict how children will respond to witnessing domestic violence due to difficulty in accurately assessing additional environmental disturbances that may be present in the child’s life. The Cumulative Stressors Hypothesis suggests that child adjustment problems are compounded, not by the presence of any one familial stressor in isolation, but by the interactions of the accumulation of familial stressors. Children that are exposed to cumulative stress factors such as low-income status, inter-parental violence, and shelter residence may have a more extreme reaction to parental violence and may have more difficulty with emotional adjustment in the long term (Rutter, 1987).

Emery (1989) has proposed the Aversion Theory to explain why children adopt negative behavioral patterns and why they have difficulty altering these patterns while still within the family unit. According to Emery (1989) there is a sequence of interpersonal events which serve to develop and maintain negative behavioral patterns as a reaction to parental conflict. Initially, conflict serves as an aversive event which distresses the child. Next, the child emotionally reacts in order to alleviate distress. And finally, the child maintains these specific behavioral patterns in order to serve a function for the family and for the child.

It is important to note that all children do not respond in the same way to witnessing domestic violence. Pynoos and Eth (1986) noted a number of factors which influence the child’s reaction to domestic violence: proximity to the violent incident, duration of the experiences, extent of the violent behavior, the number and the nature of
the threats and injuries that occurred during the violent episode, the relationship to the
perpetrator and to the victim, use of physical force, and the degree of brutality. There are
also protective factors which have been identified by Garmezy (1983) as positively
impacting children’s ability to cope: (a) ability to adjust to new situations; (b) positive
relationships with mother or siblings and; (c ) social support outside of the family.

A significant positive protective factor identified by Goldsmith (1992) is the
existence of a sibling relationship which can serve as a primary buffer from the long term
emotional, behavioral and relational effects of domestic violence. Mutual sibling support
has such a protective affect because siblings confirm one another’s reality, defend one
another, and create an atmosphere of fun in an otherwise stressful environment.

According to Caya and Liem (1998), children in high conflict homes who
reported high levels of sibling support also reported higher levels of self-esteem and
showed more competence in social relationships than did children who did not have the
support of a positive sibling relationship. Caya and Leim also suggested that sibling
support has both a direct effect on psychological adjustment and a buffering effect in high
conflict homes because siblings often serve as a confidant who shares an unspoken bond.
Additionally, siblings offer an outlet for expression that is not available in only child
homes or in relationships with peers. The ability to seek out the sibling during parental
discord, the consistent comfort provided by discussion and distraction, and knowing that
they are not alone during times of family stress are protective factors available to siblings
in high conflict homes.
Similarly, as cited by Caya and Liem (1998), Kempton (1991) found that adolescents from high conflict divorced families who did not have a sibling showed more externalizing behaviors than did adolescents who did have an involved sibling. Children from disharmonious families who had the companionship of a sibling exhibited a level of dysfunction similar to children from harmonious family environments and, conversely, children without a close sibling relationship showed more dysfunction. Jenkins (1992) concluded that close sibling relationships mitigate some of the negative effects associates with highly stressful life events. While some researchers stress the nature and degree of the sibling relationship, Jenkins indicated that the mere presence of a sibling is associated with well being, regardless of the nature and the quality of the relationship.

Caya and Liem (1998) emphasized that siblings are not entirely spared from the devastating impact of parental violence. They proposed three hypotheses that categorize nurturing and conflictual tendencies among sibling relationships. The first hypothesis suggests that in the absence of a strong parental relationship, siblings have the opportunity to develop a stronger sibling bond. This relationship is seen as a supportive and nurturing buffer to the chaos occurring within the violent home. A second, alternative view, argues that the sibling relationship in high conflict homes is characterized by increased conflict due to the need to compete for parental attention. Children who become involved in this type of sibling interaction are exposed to increase psychosocial harm due to a sibling relationship that has the potential to be the most violent relationship in the family unit. The third hypothesis, incorporates both views and
suggests that both heightened conflict and increased sibling ties are represented in the context of parental strife. This relationship has both a supportive quality and an abusive quality which has the potential to lead to unpredictable sibling interactions. One possible explanation for the increase in both positive and negative sibling interactions is offered by Hetherington (1988) who found that sibling caretaking increases as parental availability decreases. This increase in sibling contact accounts for the increase in both conflict as well as nurturing interactions. Hetherington argued that the increased opportunity for social learning, despite the conflictual interactions, may be helpful to these children in the long term.

Leavitt, Gardener, Gallagher and Schamess (1998) suggested that impaired social skills are often represented within the sibling relationship and are can be representative of familial distress present within the home. The impairment in sibling interactions have the potential to lead to negative emotional and social complications for each child involved. Children who have experienced severe trauma relate to one another in one of four distinct interactional patterns. First, the absent sibling relationship is characterized by siblings who fail to initiate any meaningful attachment. Second, the adult lockout sibling relationship develops when siblings develop a bond with one another that serves as a substitute or as a barrier to parent-child attachment. Often this type of sibling relationship is developed as a buffer against parental aggression. Third, the half and half sibling relationship is characterized by interactions representative of the primary parental relationship. Typically, these children reenact the difficulties that were seen in their
family of origin. Parental conflict and non-nurturing caregiving often result in increased sibling violence. And finally, the trauma shield sibling relationship, is characterized by siblings who live in a violent context and resort to using each other as a shield from psychic trauma. Those individuals that react in this manner may take on the role of victim-aggressor or they may adopt shared defenses and blurred boundaries resulting in a fused relationship. Each of these sibling relationships is an adaptation to problematic parent-child relationships and interferes with individual development. Leavitt et al. suggested that interventions should vary in approach to accommodate the specific needs of the siblings.

Sternberg, Lanb, Greenbaum, Cicchetti, Dawud, Cortes, Krisping, and Loey (1993) indicated that the effects of witnessing violence are unrelated to sibling support and to other protective factors. Instead, adjustment of children exposed to violent family conditions can be tied directly to the magnitude and nature of the in home violence. Hughes (1988) suggested that children who both witnessed domestic violence and were physically abused are faced with more severe emotional and behavioral complications.

Similarly, families who are forced to leave home due to the severity of violence exhibit more intense emotional and behavioral reactions due to the added stress of having to enter a strange, new environment. These children are considered to be in an active phase of crisis. They experience acute feelings of separation, loss, anger, fear, and emotional pain upon their arrival at the shelter (Alessi & Hearn, 1984; Carlson, 1984; Jaffe, Wolfe, & Wilson, 1990; Layzer, Goodson, & DeLange, 1986). In an effort to
decrease feelings of helplessness, child witnesses of domestic violence, like many trauma survivors, blame themselves for what happened in an attempt to restore control and predictability (Terr, 1991). Additionally, many children feel responsible for having to leave their homes, which is compounded by feelings of guilt, lowered self-esteem and a lowered perception of self competence (Campbell & Lewandowski, 1997).

Children in shelters often have inadequate problem solving skills. Placement in overcrowded conditions often causes them to utilize hitting as their first method of resolving difficulties. Aggression is a central feature exhibited by child witnesses of domestic violence and is often characterized by physical outbursts directed toward peers, adults, animals and inanimate objects. The aggression is often coupled with the use of abusive language and the attribution of mistakes to other people and to inanimate objects (Alessi & Hearn, 1984).

Additionally, many difficulties in resolving conflict may arise from the fact that children from violent homes have difficulty identifying with or recognizing others feelings (Rosenberg, 1987). Social relationships of child witnesses of domestic violence are impaired both within the family and among peers. Children from families with several children also face extreme difficulties in managing aggressive behaviors. This dynamic between siblings seems to be a direct reflection of the amount of violence witnesses by the sibling group. The more they have witnessed or experienced verbal abuse and physical violence, the greater the use of verbal and physical violence against their sibling (Hai-Yahai & Dawaud-Nousi, 1998).
Often child witnesses of domestic violence attempt to compensate for poor social skills by engaging in adaptive personal styles. The most commonly noted adaptive personal styles are immature and regressive behaviors or overly mature behaviors. Parentified children are raised with the expectation that the child must play the adult role within the household (Alessi & Hearn, 1984). These characteristics make child witnesses of domestic violence well suited for group play therapy due to the social climate offered within the group intervention.

**Treatment Interventions and Considerations**

Many current mental health researchers conceptualize the psychological effects of witnessing domestic violence within the traumatic response framework (Attala, Bauza, Pratt, & Veiera, 1995; Campbell & Lewandowski, 1997). According to Attala, Bauza, Pratt, and Veira (1995) the Posttraumatic Stress Disorder Theory is utilized to explain pathogenic processes within the family framework which have been disturbed by continuos violence episodes. This theory rests on the notion that children respond to family violence as they would to any other traumatic event. A stress reaction is noted throughout the family system, with children's behaviors being reflective of extreme difficulties in coping.

Terr (1991) has identified the following children's responses to trauma: (a) recurrent and intrusive distressing visual recollections of the event; (b) repetitive behaviors, such as repeated reenactment of the distressing episode during play; (c) trauma-specific fears or avoidance of stimuli associated with the trauma; (d) a diminished
interest in activities, people, activities or the future. Terr (1991) suggested that in order to address long-term pathology, immediate treatment goals should include intensive emotional support and encouragement for children to disclose what they have witnessed.

Silvern and Kaersvang (1989) similarly suggested that children who witness extreme violence are reacting to traumatic stress and recommend that treatment interventions be aimed at counteracting posttraumatic reactions, thereby preventing long-term pathologies. They listed social support and encouragement to disclose traumatic events as effective intervention mechanisms.

A second consideration in treating child witnesses of domestic violence is that families entering shelters for protection from domestic violence are in crisis, with the primary concern being safety. When initially arriving at the shelter, children may present as confused and frightened. Recognition and report of abuse often sets into motion a variety of legal and protective measures that are confusing and stressful to the child (Rosenbeg & Rossman, 1990). Most children are disheartened by the unpredictability and length of legal procedures, however, it is imperative that professionals working with this population be prepared to help the child to cope with these procedures. Additionally, children who have witnessed domestic violence may be called upon to testify in courts. This is an additional stressor often exacerbating issues being addressed in counseling (Gil, 1991).

Therapeutic interventions geared towards stabilizing the family are essential to the creation of an atmosphere of trust needed to enhance later treatment interventions.
Rosenberg and Rossman (1990) listed immediate crisis intervention goals as: assuring the children that they and their mothers are safe and secondly, conveying support and an expectation that the crisis will be appropriately managed. As the child stabilizes to some degree, additional crisis intervention goals may be added, which may include: focused problem solving, self-esteem building, and the development of improved coping strategies which can be addressed in any therapeutic counseling intervention.

Once the children have become familiar with the surroundings, those children who have witnessed extreme violence may exhibit a variety of healthy and/or disturbed coping behaviors in an attempt to manage painful memories. Treatment interventions may be positively or negatively impacted by the child’s use of coping strategies. Pynoos and Eth (1986) identified specific coping mechanisms which serve to limit trauma anxiety after a violent episode. These phenomena are: (a) mitigation of painful reality by fantasizing about reversing injurious outcomes; (b) inhibition of thoughts in an attempt to avoid reminders of the violent event; (c) “fixation to the trauma”, the child engages in repetitious recounting of the episode in an attempt to understand and become desensitized to the painful event; and (d) preoccupation with future harm.

Jaffe, Wolfe, and Wilson (1990) cited several factors which appear to influence adjustment of children residing in shelters. Among these factors are: age, gender, the amount of violence witnessed, whether the child was a victim as well as a witness, and the stability and severity of the mother’s mental health. Additionally, Rutter (1987) identified positive self-esteem, self-confidence, and a belief in one’s own ability to cope
with change as factors which positively effect children's ability to manage stressful events. These factors greatly impact the nature and duration of treatment required (Alessi & Hern, 1984; Fantuzzo & Lindquist, 1989; Hughes, 1988; Rosenberg & Rossman, 1990; Wolfe & Jaffe, 1991).

An additional treatment consideration to account for is the fact that children adjust to witnessing domestic violence according to the social reality that the child creates based on their interpretation of the violent event. Pre-school and elementary school children may create a social reality which incorporates passive aggressive behavioral patterns. Externalized behavior is seen as normative with this age group because developmentally, the violence can only be addressed and assimilated in a concrete and tangible manner. Many shelter interventions focus on moving away from traditional approaches of addressing negative behaviors and, instead, focus interventions geared toward a social-constructivist approach. These approaches incorporate activities such as story telling or narratives which allow the child to create a new social reality for their behavior (Markward, 1997).

Other recommended treatment strategies focus on improving social skills in an attempt to prevent violent methods of problem solving in later life. These treatment objectives focus on applying principles of social learning theory to working with excessively aggressive siblings. This intervention strategy is aimed at ending the cycle of violence by developing new interactional patterns between children from the same family. Role modeling, practicing new behaviors, receiving feedback and reinforcement,
improving communication skills and developing productive problem solving mechanisms are listed as treatment objectives (HajYahai & Dawud-Nouri, 1998).

deLange (1986) identified the following general treatment objectives for child witnesses of domestic violence: self-esteem enhancement, increased problem solving skills, improved social skills, anger management, and impulse control focusing on delayed gratification. Treatment interventions that have been found to be productive with child witnesses of domestic violence include: individual therapy (Ammerman & Hersen, 1990), educational interventions (Jaffe, Wolfe & Wilson, 1990), family therapy (Gil, 1991), group therapy (Butterworth & Fulmer, 1991), and play therapy (Kot, 1995; Layzer, Goodson & DeLange, 1986).

Individual talk therapy for child witnesses of domestic violence is an intervention strategy which has the capacity to target unique needs of children who have witnessed domestic violence. This intervention, however, is recommended primarily for children eight years and older, who present with severe pathology. In a shelter, many children need to be reached and there are often a limited number of qualified professionals available to assist. Therefore, other treatment options may be a more appealing treatment choice (Ammerman and Hersen, 1990).

Jaffe, Wolfe, and Wilson (1990) have effectively applied structured educational group interventions to working with child witnesses of domestic violence. Issues addressed are central to the cognitive understanding of the violence within the home and are primarily focused on helping children between 8 and 14 years of age. Goals include
learning to identify and express feelings, anger management, social skills, understanding the cycle of violence, and responsibility for violence.

Ammerman and Hersen (1990), list family therapy as the most effective method of intervening with violent family styles. Therapeutic sessions focus on the interactional styles of various family members with interventions targeting functional realignment of relationships. Alternative family therapy models view family violence from a systems perspective and treat the family as a unit. Gil (1994) has identified a specific type of family intervention which relies on the use of play. This technique caters to a wide range and it incorporates an understanding of family dynamics with the age appropriate use of toys to assist the entire family in effective communication.

Group Therapy

Within the past decade, group therapy has received increased empirical attention which has caused group interventions to be hailed as the treatment of choice when working with child witnesses of domestic violence (Alessi & Hearn, 1984; Hughes, 1988; Ragg & Webb, 1992; Wilson, Cameron, Jaffe, & Wolfe, 1989). However, the vast majority of group interventions reported in the literature are highly structured with specific goals and cognitively oriented educational activities and do not fit the definition of group therapy (Peled, Jaffe, Edleson, 1995).

Theoretically, however, groups that focus on group process and personal insight are especially appropriate for child witnesses of domestic violence. Yalom (1970) has identified ten curative factors inherent in group therapy. These factors are as follows: (a)
the imparting of information; (b) the instillation of hope, which allows children to feel they have control over their lives; (c) universality, which helps children to realize that other children have experienced similar situations; (d) altruism, which provides children with a non-threatening opportunity to give and receive; (e) corrective recapitulation of the primary family group, which allows children to work through family dynamics within the group system; (f) development of socialization techniques; (g) imitative behavior, which provides children with positive therapeutic adult role models; (h) interpersonal learning; (i) group cohesiveness; and (j) catharsis.

Jaffe, Wilson and Wolfe (1986) observed an increase in self-esteem and improved attitudes about violence after child witnesses of domestic violence participated in an educationally based group therapy program. Objectives of the eight session intervention were: identifying and expressing feelings, anger management, social skills, understanding the cycle of violence and responsibility for violence. Parents comments at the conclusion of the group intervention indicated that they also perceived a positive behavioral change in their children. In a second study, Jaffe, Wilson, and Wolfe (1988) established a wait list control group and concluded that those who participated in educational groups showed improved overall adjustment and improved school behavior and school performance.

Grusznski, Brink, and Edleson (1988) reported similar results in a study of 371 child witnesses of domestic violence who participated in a support group. These children also improved self-esteem, demonstrated that the abuse was not their fault and showed
improved problem solving skills and anger management skills. Peled and Davis (1995) found that child witnesses of domestic violence who participated in group therapy while residing in a battered women's shelter were able to break the secret, could define abuse, distinguish among forms of abuse, and state that the abuse was not their fault.

Frey-Angel (1989) reported unique benefits with sibling group therapy with child witnesses of domestic violence. This intervention rests on the notion that siblings typically experienced similarly traumatic events within the family of origin, which has resulted in extremely trusting and bonded relationships. Additionally, Frey-Angel suggests that siblings are more comfortable in acknowledging and reaffirming loving and non-threatening relationships, which allows the children to experience deeper therapeutic exploration and catharsis.

**Group Play Therapy**

Since group therapy typically relies on the use of advanced communication skills and an in-depth awareness of emotional motivations, this mode of treatment often surpasses the developmental abilities of younger children. While group therapy is highly effective with school-aged children who have witnessed domestic violence, the use of play is recommended for younger children who have witnessed domestic violence (Butterworth & Fulmer, 1991). Tutty and Wagar (1994) explained that group play therapy is the preferred treatment alternative with child witnesses of domestic violence.

However, due to "insufficient child-focused therapists and resources to offer play therapy to the majority of those who may benefit" (p. 92) many agencies are forced to embrace
alternative group interventions, despite the fact that they are perceived as less therapeutic. As a rule, however, it is generally recognized that groups for younger children must be structured differently from groups for older children because developmentally, younger children are less likely to have the ability to articulate and to express their concerns utilizing adult terms.

Developmentally, play is considered the natural vehicle of expression for young children. Toys are the children’s words and play is their symbolic language, through play, children can express experiences that can not be easily conveyed to adults due to immature verbal development. (Axline, 1947; Ginott, 1982; Landreth, 1991; & Schaefer, 1994). More specifically, play serves to bridge the gap between concrete experience and abstract thought. In early years of development, the activity of play is one of the most important ways that children learn to organize their experiences and to express feelings without fear of rejection (Landreth, 1993).

Child witnesses of domestic violence often feel powerless and vulnerable to environmental circumstances. Through play therapy, children can easily access feelings associated with personal control and they can more easily internalize coping skills (Landreth, 1991). Additionally, play serves 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 a passive subject into one in which he is an active instigator and controller
(Bettelheim, p. 206, 1987)

It is through the playing out of troublesome events that the child is able to conquer personal fears and to make sense of that which is overwhelming and unpredictable.

Play also serves to protect the child who has limited ego strength by providing the child with the opportunity to work through external difficulties without having to identify and label the painful incident as his or her own. This process allows children to work through extremely traumatic events without being further challenged to communicate these confusing events to adults (Terr, 1990). This is particularly important to child witnesses of domestic violence who have been taught to maintain the secret of the family violence. Play allows the child to begin to work through issues at a slower pace, revealing the personal aspect of the play at a later time. By establishing a therapeutic environment in a slow and controlled manner, the child can begin to feel respected and understood; thereby dealing with threatening feelings and moving toward internal health (Axline, 1947).

Although individual play therapy has the potential to address numerous emotional and behavioral concerns, group play therapy combines the therapeutic elements of group therapy and the unique communication style used in individual play therapy to provide a foundation for an extremely dynamic intervention. Ginott (1958) cited numerous advantages of group play therapy in working with children who have social adjustment difficulties. First, within the group play therapy arena, children are provided with
opportunities for multilateral relationships that are unavailable to them in individual play therapy. Group play therapy allows children to identify with the therapist and with other members of the play group. Secondly, group play therapy provides two media of catharsis, play and verbalization. This allows the child to utilize the method with which they feel most comfortable. Third, group play therapy provides children with vicarious catharsis. As one child explores an issue, the other children can benefit from the events that take place by indirectly experiencing the outcome. Fourth, group play therapy is representative of a miniature society in which children can test out new patterns of behavior. This arena also provides motivation and support for change. Finally, children are exposed to a new quality of intimate relationships. They learn that they can get close without being hurt or rejected (Ginott, 1958). An additional benefit of group play therapy is the reduction repetitious play that may be caused by traumatic reenactment (Terr, 1991). The collaboration of several children provides the opportunity to jointly utilize resources to establish a therapeutic and progressive expression of troubling situations (Slavson, 1968). This has direct implications for work with child witnesses of domestic violence, as repetitious play is a common behavior among children who have been traumatized by violent parental interactions.

In addition to the theoretical rationale for utilizing group play therapy with child witnesses of domestic violence, there is a growing body of literature that has demonstrated the positive effects of group play therapy with the general population of children. Empirical research specific to sibling group play therapy with child witnesses
of domestic violence, however, continues to remain limited. Literature on play therapy with populations who share experiences similar to those endured by child witnesses of domestic violence is included here to establish a broad scope of the application and established outcome for children who enter treatment with related issues.

Often child witnesses of domestic violence are deprived of attention and neglected by one or both parents. Belle, Lyne and Kolvin (1989) reported significant results with deprived children between the ages of 5 and 6 by applying a combination of developmental play therapy and non-directive play therapy techniques. Immediate effects in social play, constructive play, imitative play, aggressive and regressive play were noted. However, gains obtained during the first several sessions were not significantly maintained by termination of treatment.

Family displacement is another dynamic which is often an ultimate result of extreme parental violence. Hunter (1993) conducted research focusing on sibling play therapy with homeless children in crisis. These children utilized the play therapy experience to manage family crises as they arose, to resolve conflicts, to express difficult feelings, to make sense of their unpredictable world, and to master developmental tasks. Due to residence in a shelter environment and unstable living conditions, this research has significant relevance to the potential outcome of sibling play therapy with child witnesses of domestic violence.

Additionally, parental loss due to family deterioration is often a complicating issue faced by child witnesses of domestic violence. Saravay (1991) found short-term
sibling group play therapy to be an effective intervention with two pre-school brothers following a sudden parental death. Progress as a result of this intervention included: a decrease in nocturnal awakening, complete relief from nightmares, a reduction in the intensity of the expression of anger, an increase in positive peer relations, and an increase in autonomous daily functioning. Further, it was noted that as the brothers participated in treatment, each sibling served as a catalyst and a sounding board for the other, with each reflecting the other's experience.

Leavitt, Morrison, Gardner, and Gallagher (1996) studied the effects of sibling group play therapy as an intervention with cumulatively traumatized siblings between 7 and 12 years of age, who were dealing with issues of parental loss due to AIDS. This study included 10 children from four families who participated in weekly, eighty-minute sessions involving free play, snack time and 10 minutes of transitional time which was incorporated to help the children to regain structure before returning to school activities. Results showed that siblings behaved as an auxiliary ego function for one another and that the presence of a sibling in the aftermath of a traumatic event served as a protection from re-traumatization. The benefits of sibling support in group play therapy were effective in helping the children to stabilize enough to deal with the stress associated with familial AIDS. This study has added to the understanding of the potential effects of play therapy with child witnesses of domestic violence due to the coexisting issues of parental loss and the dynamic of secrecy as well as stigmatization that are often associated with both AIDS and domestic violence.
Perez (1987) conducted a research study comparing individual and group play therapy with 55 sexually abused children between the ages of 4 and 9. The children received group play therapy or individual play therapy for 60 minutes, one time weekly for 12 sessions. Results indicated that play therapy was beneficial to sexually abused children regardless of age, gender, type of abuse or current living situation. Self-concept and self-mastery both showed a significant increase at posttesting for both group play therapy and individual play therapy interventions. Further, group play therapy and individual play therapy were found to be equally successful in assisting sexually abused children. Perez, however, identified positive advantages of group play therapy. Group was found to offer the children a sense of universality, reduced feelings of isolation, and created a positive pseudofamily in which abuse did not occur. Due to the similarities in therapeutic issues such as: dysfunctional family dynamics, family secrecy, and traumatic reactions, this research imparts valuable information regarding the potential effectiveness of group and individual play therapy with child witnesses of domestic violence.

Hofman and Rogers (1991) utilized intensive play therapy in working with traumatized children who have been displaced from their homes due to an earthquake. The groups met on a daily basis for 4 days for 4-6 hours and included children between the ages of 2 and 12. Each day, the groups engaged in structured play activities which encouraged the children to utilize art supplies, spontaneous dialogue, and toys to express their initial fears related to their trauma. The children's reactions to the group play therapy interventions varied with the level of trauma experienced by the child and with
the level of pre-existing intrapersonal adjustment. Positive outcomes included increased sense of control, mastery over the crisis, decreased anxiety, and an understanding of the traumatic episode.

Tutty and Wagar (1994) explored creative play groups with child witnesses of domestic violence which focused on theatrical expression of emotions, a unique method of allowing children to express concerns without having to rely on verbalizations. The therapists perceived the children to show improvements in problem solving and feelings of universality after participation in the creative drama groups.

Further, Malchiodi (1990) described encouraging behavioral changes in working with children residing in a battered women’s shelter utilizing art as the primary medium of expression. Case examples demonstrated that these children were able to internalize relaxation strategies, express feelings in a non-verbal, yet productive manner, and positively enhance self-esteem without a need for external reinforcement.

Davies (1991) documented a detailed review of an intervention technique with twelve male toddlers who had witnessed parental violence. The intervention utilized attachment theory as a theoretical framework to evaluate children’s play behavior. Information was gathered from the child’s play behavior served as a guide for training the mother in appropriate responses to her child’s play interactions. The mother then used these play responses to engage her child in play and to formulate a clearer understanding of her child’s concerns. This model is similar in concept to that of filial therapy. Davies concluded that this intervention helped to foster an enhanced mother-child bond.
Fredrick-Helms (1997) implemented a client-centered individual play therapy intervention with 24 child witnessed of domestic violence. Treatment duration and number of sessions depended on each family’s length of stay at the shelter. Many of the children demonstrated symptoms associated with Post Traumatic Stress Disorder and were identified as highly aggressive when they began play therapy sessions. Detailed case studies supported play therapy as being a beneficial intervention because it allowed “children to reenact the traumatic event, remember and feel the feelings that accompanied the event and restructure it in such a way as to provide meaning for the event” (p.86). Fredrick-Helms concluded that children who had the opportunity to engage in individual play therapy for longer periods of time, demonstrated more satisfactory and powerful resolutions of emotional turmoil.

Webb (1991) reviewed a play therapy treatment regimen with a 4 year-old boy who had multiple traumatic insults specific to domestic violence. This particular review detailed long term treatment due to the child’s severe reaction to multiple family crises. Webb provided a detailed case explanation of the effective use of play therapy to assist in the reduction of aggressive outburst and emotional crises. Early treatment interventions focused on allowing the child to reenact and play out his experience, while later treatment interventions involved behavior modification techniques.

Resources specifically pertaining to the topic of intensive play therapy as an intervention with child witnesses of domestic violence are nearly non-existent. However, Kot (1995) conducted a study designed to determine the effectiveness of intensive
individual play therapy with child witnesses of domestic violence versus a wait list control group. Children between the ages of 4 and 9 participated in 45-minute individual play therapy sessions on a daily basis, for twelve consecutive days. Kot found that child witnesses of domestic violence showed significant improvement in self-concept, a reduction of externalizing behavioral problems, improvement in behavior problems over all, and a showed a significant improvement in play proximity.

**Summary**

In summary, child witnesses of domestic violence have been exposed to extreme violence and the short term and long term effects are clearly documented. Group therapy with this population has become increasingly identified as the treatment of choice due to the social and familial components that are readily accessible through this intervention. When families enter domestic violence shelters, time is limited and treatment interventions should be designed to have the maximum potential within the time period in which they reside in the shelter. Intensive sibling group play therapy offers an alternative for child witnesses of domestic violence which has the potential to serve as intervention for the immediate crisis, as well as a preventative measure against intergenerational transmission of violence.
CHAPTER II

METHODS AND PROCEDURES

This chapter presents the methods and procedures for the data collected in this study. Also included are the definition of terms, hypotheses, limitations of the study, instruments utilized for collection of data, a discussion of the data collection and treatment and an explanation of the data analysis procedures.

Definition of Terms

Aggression was defined as the initiation of a hostile act against another person. It is often an expression of inner turmoil, anger, and frustration. Behaviorally, aggression is exhibited by the child’s decision to attempt to destroy objects or to hurt another. For the purposes of this study, aggression was operationally defined as the score on the Aggression subscale of the Child Behavior Checklist.

Anxious/Depressed was defined as a psychological condition characterized by low mood, sadness, feelings of loneliness, nervousness, guilt and fear. For the purposes of this study, anxious/depressed was operationally defined as the score on the Anxious/Depressed subscale of the Child Behavior Checklist.

Child witness of domestic violence was defined as children who enter a domestic violence shelter as a result of repeatedly witnessing severe acts of emotional and physical abuse directed at their mother by her intimate partner.
Delinquent behavior refers to behaviors that are associated with violation of legal or ethical standards. Some of these behaviors include: setting fires, lying, running away, stealing, and truancy. For the purposes of this study delinquent behavior was operationally defined as the score on the Delinquent Behavior subscale of the Child Behavior Checklist.

Domestic violence refers to physical, emotional, and psychological abuse of a woman by her intimate partner, which is specifically intended to cause injury or to maintain power and control.

Externalizing behavior problems refers to behaviors which are outward manifestations of inner conflict. These behaviors can include: aggression, hyperactivity, conduct problems. For the purposes of this study externalizing behavior problems was operationally defined by the cluster of behaviors identified as the Externalizing Behavior subscale on the Child Behavior Checklist.

Intensive individual play therapy involves collapsing the time between play sessions in order to provide maximum benefit to transient children. Each child participated in individual play therapy, once a day, six days per week, for two weeks.

Intensive sibling group play therapy involves the collapsing of group play therapy sessions in order to provide maximum benefit to transient children. For the purposes of this study each child participated in a sibling group play therapy session once a day, six days per week, for two weeks.
Internalizing behavior problems are a cluster of behavioral characteristics which are symptomatic of an attempt to cope with internal difficulties. Most often emotions are prevented from being expressed and they are instead directed internally. Behavioral characteristics include: withdrawal, anxiety, depression and suicidal ideation. For the purposes of this study, internalizing behavior problems was operationally defined as the score on the Internalizing Behaviors subscale Child Behavior Checklist.

Play therapy was 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 environment 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 refers to the underlying attitude and belief that a child holds about his or her self worth. 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.

Sibling Group Play Therapy refers to the use of play therapy principles to implement social, emotional and behavior changes. It is a psychological and social process in which children are able to process interpersonal change through peer interaction and interaction with a play therapist. Each child has the opportunity to utilize toys to play out issues which are of concern. Group membership consisted of two siblings, each from the same family, who had been screened and selected as participants.
Somatic Complaints are physical symptoms of underlying emotional distress. For the purposes of this study, somatic complaints was operationally defined as the score on the Somatic Complaint subscale on the Child Behavior Checklist.

Withdrawn was defined as socially detached and unresponsive. For the Purposes of this study, withdrawn was operationally defined as the score on the Withdrawn subscale of the Child Behavior Checklist.

Hypotheses

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

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

2) Subjects in the intensive sibling group play therapy treatment group will attain a significantly higher mean score on self-concept as indicated by the JPPSST posttest than will subjects in the control group.

3) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Total Behavior Problems subscale on the CBCL than will subjects in the intensive individual play therapy group.

4) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Total Behavior Problems subscale on the CBCL than will subjects in the control group.
5) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Externalizing Behaviors subscale of the Child Behavior Checklist (CBCL) posttest than will subjects in the intensive individual play therapy group.

5a) Subjects in the intensive sibling group play therapy group will attain a significantly lower mean score on the Aggressive Behaviors subscale of the CBCL posttest than will subjects in the intensive individual play therapy group.

5b) Subjects in the intensive sibling group play therapy group will attain a significantly lower mean score on the Delinquent Behaviors subscale of the CBCL posttest than will subjects in the intensive individual play therapy group.

5c) Subjects in the intensive sibling group play therapy group will attain a significantly lower mean score on the Attention Problems subscale of the CBCL posttest than will subjects in the intensive individual play therapy group.

6) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Externalizing Behaviors subscale of the CBCL posttest than will subjects in the control group.

6a) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Aggressive Behaviors subscale of the CBCL posttest than will subjects in the control group.
6b) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Delinquent Behaviors subscale of the CBCL posttest than will subjects in the control group.

6c) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Attention Problems subscale of the CBCL posttest than will subjects in the control group.

7) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Internalizing Behavior Problems subscale on the CBCL posttest than will subjects in the intensive individual play therapy group.

7a) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Withdrawn Behavior subscale of the CBCL posttest than will subjects in the intensive individual play therapy group.

7b) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Somatic Complaints subscale of the CBCL posttest than will subjects in the intensive individual play therapy.

7c) Subjects in the intensive sibling group play therapy treatment group will receive a significantly lower mean score on the Anxious/Depressed subscale of the CBCL posttest than will subjects in the intensive individual play therapy.

8) Subjects in the intensive sibling group play therapy category will attain a significantly lower mean score on Internalizing Behaviors subscale of the CBCL posttest than will subjects in the control group.
8a) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Withdrawn subscale of the CBCL posttest than will subjects in the control group.

8b) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Somatic Complaints subscale of the CBCL posttest than will subjects in the control group.

8c) Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Anxious/Depressed subscale of the CBCL posttest than will subjects in the control group.

Limitations

This study has the following limitations:

1. Subject selection was limited to volunteers from the Dallas, Texas area and this produced small experimental, comparison and control groups which were not ethnically matched samples.

2. This study relied on volunteer sampling. Due to the nature of the population and the purpose of this study, random selection was not possible.

3. Subjects in the intensive sibling group play therapy group were selected three years after children were selected for the intensive individual play therapy group and for the control group.
4. Mothers who completed the Child Behavior Checklist were aware of whether their children received intensive therapy or not. This knowledge may have biased the mothers' ratings.

Instruments

**Joseph Pre-School and Primary Self-Concept Screening Test**

The Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) was developed by Joseph (1979). This test was first developed to measure the self-concept of pre-school children, however, Joseph modified the testing mechanism to meet the needs of upper level children as well. Both testing measures will be utilized for the purposes of this study. Testing procedures involve the child's identification of a picture which they view to be most similar to themselves. By using pictures accompanied by descriptions of activities and the feelings surrounding those activities, the test administrator rates the child's self-esteem on a global index of 0 to 30.

The JPPSST can be used with children ranging in age from three years, six months to nine years, eleven months. This testing protocol does not require reading ability nor does it require a high level of administrator training. The thirty item test is a desirable quality for this test due to the short attention span of young children.

A test-retest sample established a reliability coefficient of .87. The Kuder-Richardson (20) formula established the internal consistency reliability to be between .59 to .81 with a median correlation coefficient of .73. All test items have been shown to significantly contribute to the overall test score performance.
Construct validity is established at a .51 significance for the .01 level of confidence by correlating the Global Self Concept Scores of the JPPSST with scores from the Self Concept Judgment Scale (Joseph, 1979).

**Child Behavior Checklist**

The Child Behavior Checklist (CBCL) is a well established and recognized instrument for the identification of behavior and emotional difficulties in children from the ages of 4 to 18. It consists of 120 items which require a fifth grade reading level to complete and it take approximately 20 minutes to completed. It is categorized as a self administered test and it involves rating the existence of behavioral symptoms from 0 to 2, with 0 indicating that the behavior is not true for this child and 2 indicating that the behavior is often seen in this child. This checklist was designed to record in a standardized format behavioral symptoms and competencies of children as it is perceived by their parents or surrogates. It was originally developed by Achenbach and Edelbrock in 1986, however for the purposes of this study the 1991 profile, which was revised by Achenbach, will be utilized. Additionally, this study will primarily focus on Internalizing and Externalizing Domains of the behavior scales. Two sources, the mother and a shelter case worker, will be relied upon to complete this checklist because it relies heavily on the informant's perception and judgment of the child's behavior.

Reliability of the CBCL is well established, as it was assessed utilizing several different measures including internal consistency, interrater and test re-test methods. Internal consistency was demonstrated by Cronbach's alpha. For girls between the ages
of 4 and 11, Cronbach's alpha is .90 for Internalizing behavior problems and .93 for Externalizing behavior problems. For boys between the ages of 4 and 11, Cronbach's alpha is .89 for Internalizing behavior problems and .93 for Externalizing behavior problems.

Inter-interviewer reliability of item scores was established at .959. Intraclass correlations from three matched samples of children showed a high level of reliability between raters, indicating that scores obtained for each item are relative to scores obtained for each other item.

Test-retest reliability was established at .89 for Internalizing behavior problems and .93 for Externalizing behavior problems. Scaled scores were evaluated after two years to establish long-term stability, which was calculated as being .70 for Internalizing behaviors and at .93 for Externalizing behaviors. A general downward trend was found among children's scores who were receiving mental health treatment which indicates that this scale remains sensitive to minor changes due to intervention.

Content validity of the CBCL is also well established. All 120 items were significantly associated with clinical status at the .01 level of significance. Criterion related validity was supported by the ability to effectively recriminate between referred and non-referred children.

Selection of Subjects

Volunteer subjects were recruited from battered women's shelters in a large metroplex population area. The limit for the stay in these shelters was four to six weeks.
Families that resided in the long term residential programs at these shelters were excluded from this study. Children who accompanied their mother's to these shelters were provided with the option to participate in this study on a volunteer basis, with the full consent of their legal guardian. The children were required to meet the following criterion in order to be eligible for participation: (a) must be between the ages of 4-10; (b) must have the full consent of the legal guardian; (c) must agree to participate in twelve sessions of sibling group play therapy; (d) must be a resident of one of the domestic violence shelters involved in this study; (e) those assigned to intensive sibling group play therapy must have a sibling who is concurrently residing in the shelter; and; (f) siblings must be no more than three years apart in age to be assigned to the intensive sibling group treatment.

Children were assigned to a therapeutic group within three days of entering the domestic violence shelter. Since data collected for the intensive sibling group play therapy intervention was compared with results from a previously existing study conducted by Kot (1995), group contamination was not an issue. Children who received intensive individual play therapy and those who participated in the control group were members of the study analyzed in *Intensive Play Therapy with Child Witnesses of Domestic Violence* (Kot, 1995). More specifically, children who came to the shelters between September, 1994, and February 1995, and met the selection criterion were placed in the intensive individual play therapy group. These subjects were identified as the comparison group for the purposes of this study. The control group was comprised of
children who came to the shelter between March and April, 1995. Children who participated in the intensive sibling group play therapy treatment entered the shelter between September, 1998 and December, 1998. These subjects were identified as the experimental group for the purposes of this study. After an interview of shelter personnel, a comparison of the child intake profiles from 1994 and 1998, a review of each domestic violence shelter, and a comparison of shelter services and program management, it was concluded that these subjects received the same services, they were exposed to similar shelter dynamics, and that the children are representative of the same cohort.

Each mother who had a child that met the specified criterion received a full explanation of the purpose and requirements of the study and an opportunity to ask any questions pertaining to the intervention. Informed consent and research information was reviewed in detail with each mother. Participation was voluntary.

Ten children volunteered for the experimental group, 6 girls and 4 boys ages 4 to 9. These children received intensive sibling group play therapy. The comparison group was comprised of 11 children, 6 girls and 5 boys ages 4 to 10. These children received intensive individual play therapy in the Kot study. There were also 11 children in the control group, 7 girls and 4 boys ages 4 to 9. These children remained on a waiting list for Kot’s study and they received no intervention. The mean age for the children in the experimental group was 6.2, the mean age for the comparison group was 6.9 and in mean age in the control group was 5.9. The population in the experimental group was 60%
Caucasian, 20% Hispanic, and 20% African American. The population in the comparison
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.
Of the 40 children who volunteered for the Kot study, (the comparison group and the
control group) 22 completed the study and 18 left the shelter before the study was
completed. Of the 20 children that volunteered for intensive sibling play therapy (the
experimental group) 10 completed the study and 10 left the shelter before the study was
completed.

Collection of Data

A pretest- posttest, control group, comparison group design was used to carry out
the objectives of this study. All parameters outlined by Kot (1995) were closely matched
in the collection of data in order to achieve comparable and generalizable results.
Initially, parents received a full explanation of the procedures and any risks involved in
participating in this study. After they signed consent forms, each guardian was asked to
complete the Child Behavior Checklist (CBCL) prior to beginning any treatment with
their children and within three days of arrival at the shelter. Although the CBCL is a self-
administered inventory, the examiner was available to read it to the mother if the mother
so desired. The availability of the examiner was particularly important to some mothers
in the shelter due to difficulties in successfully reading the material on the inventory.
This instrument was completed within three days of admittance to the shelter and prior to
any treatment.
Prior to receiving any play therapy treatment, each child who participated in the experimental group, comparison group and the control group was administered the Joseph Pre-School or Primary School Self-Concept Screening Test (JPPSST). The children were administered the test which coordinated with their age and gender. All of the children had the directions and the questions read to them aloud by the person administering the test.

For the experimental and comparison groups, the JPPSST was re-administered the children after completion of the twelfth play therapy session. Additionally, the mothers were asked to complete the CBCL considering the behaviors that were witnessed only within the previous two weeks. After two weeks, the children in the wait list control group were re-administered the JPPSST and the mothers were re-administered the CBCL.

Treatment

The children who participated in intensive individual play therapy and intensive sibling group play therapy received 12 sessions of play therapy. The play therapy sessions were 45-minutes in length and spanned a period of twelve days. Principles of child centered play therapy were applied to all treatment interventions during this study. These sessions took place at the shelter where the children were residing. Each playroom was similarly equipped with play materials as outlined by Landreth (1991). In addition to the intensive play therapy intervention, all three groups also received three to four educational and recreational group sessions per week. These sessions focused on family violence awareness, sexual abuse prevention, feelings, and self-esteem. The group
activities included arts and crafts, paper and pencil worksheets, and outdoor activities. The children in the control group received no other intervention.

Play therapy was provided by two master's degree level counselors and three doctoral level counselors who had been specifically trained in play therapy. Their training included an introductory course in play therapy, an advanced course in play therapy, a course in filial therapy and a practicum in play therapy. The master's level counselors had completed all of the required course work required for their degree and they were enrolled in a field experience class when they provided the intensive treatment. Additionally, the three doctoral level counselors had participated in an advanced doctoral practicum and a doctoral internship focusing on play therapy.

Analysis of Data

Scores obtained from the CBCL and the JPPSST pretests and posttests from the experimental group were analyzed and compared to the CBCL and JPPSST pretest and posttest scores obtained by Kot (1995). In order to determine whether intensive sibling group play therapy, intensive individual play therapy or no treatment was the most effective intervention with child witnesses of domestic violence; variations in the CBCL and JPPSST pretests and posttest results from the intensive sibling group play therapy treatment design were compared with variations in the CBCL and JPPSST pretests and posttest from the intensive individual play therapy design and a wait list control group.

Specifically, the following data was utilized from the Kot (1995) study for comparative analysis: the total mean score on the JPPSST, the CBCL Withdrawn
subscale score, the CBCL Somatic Complaints subscale score, the CBCL Anxious/Depressed subscale score, the CBCL Delinquent Behavior subscale score, the CBCL Aggressive Behavior subscale score, the CBCL total Internalizing Behavior Problems mean score, the CBCL total Externalizing Behaviors mean score and the CBCL Total Behavior Problems subscale score.

Following the collection of pretest and posttest data, the instruments were computer scored and hand scored to be double checked. The data were keyed into a computer and analyzed by the researcher using SPSS for Windows. An Analysis of Covariance (ANCOVA) was computed to test the significance of the differences between experimental group, comparison group and control group. 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 means on the posttest on the basis of the pretest, thus statistically equating the experimental, comparison and control groups. Significant differences between the means were 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 data for each hypothesis tested in this study. Also included is a discussion of the results, implications, and recommendations for future 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 a criterion for either retaining or rejecting the hypotheses.

Hypothesis 1

Subjects in the intensive sibling group play therapy treatment group will attain a significantly higher mean score on self-concept as indicated by the Joseph Preschool and Primary Self-Concept Screening Test (JPPSSST) posttest than will subjects in the intensive individual play therapy group.

Table 1 presents the pre and posttest means and standard deviations for the experimental and comparison groups. Table 2 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups’ posttest mean scores.
Table 1

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

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group n = 10</th>
<th>Comparison Group n = 11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>22.4000</td>
<td>26.0000</td>
</tr>
<tr>
<td>SD</td>
<td>3.978</td>
<td>2.494</td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

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

Table 2

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

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>3.351</td>
<td>1</td>
<td>3.351</td>
<td>.870</td>
<td>.363</td>
</tr>
<tr>
<td>Covariates</td>
<td>64.663</td>
<td>1</td>
<td>64.663</td>
<td>16.787</td>
<td>.001</td>
</tr>
<tr>
<td>Error</td>
<td>69.337</td>
<td>18</td>
<td>3.852</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the comparison group's self-concept as measured by the JPPSST. On the basis of this data, hypothesis 1 was rejected.
Hypothesis 2

Subjects in the intensive sibling group play therapy treatment group will attain a significantly higher mean score on self-concept as indicated by the JPPSST posttest than will subjects in the control group.

Table 3 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 4 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 3

Mean scores of the experimental and control groups on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Control Group (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>22.4000</td>
<td>26.0000</td>
</tr>
<tr>
<td>SD</td>
<td>3.978</td>
<td>2.494</td>
</tr>
<tr>
<td>Total cases</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

Note. An increase in the mean score indicates an increase in self-concept.
Table 4

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

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>106.014</td>
<td>1</td>
<td>106.014</td>
<td>18.906</td>
<td>.000***</td>
</tr>
<tr>
<td>Covariates</td>
<td>137.979</td>
<td>1</td>
<td>137.979</td>
<td>24.607</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>100.0931</td>
<td>18</td>
<td>5.607</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***p < .001

Table 4 shows the $F$ ratio for the main effects was significant to the < .001 level indicating an increase in the experimental group's self-concept as measured by the JPPSST. On the basis of this data, hypothesis 2 was retained.

**Hypothesis 3**

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Total Behavior Problems subscale on the CBCL than will subjects in the intensive individual play therapy group.

Table 5 presents the pre and posttest means and standard deviations for the experimental and comparison groups. Table 6 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups' posttest mean scores.
Table 5

Mean scores of the experimental and comparison groups on the Child Behavior Checklist (CBCL) subscale: Total Behavior Problems

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Comparison Group (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>56.2000</td>
<td>35.1000</td>
</tr>
<tr>
<td>SD</td>
<td>33.119</td>
<td>22.427</td>
</tr>
<tr>
<td>Total cases =</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Table 6

Analysis of covariance data of the experimental and comparison groups for the Child Behavior Checklist (CBCL) subscale: Total Behavior Problems

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>d/f</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>7.393</td>
<td>1</td>
<td>7.393</td>
<td>.043</td>
<td>.837</td>
</tr>
<tr>
<td>Covariates</td>
<td>4240.087</td>
<td>1</td>
<td>4240.087</td>
<td>24.938</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>3060.449</td>
<td>18</td>
<td>170.025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the comparison group's total behavior problems as measured by the CBCL. On the basis of this data, hypothesis 3 was rejected.
Hypothesis 4

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Total Behavior Problems subscale than will subjects in the control group.

Table 7 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 8 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 7

Mean scores of the experimental and control groups on the Child Behavior Checklist (CBCL) subscale: Total Behavior Problems

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Control Group (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>56.2000</td>
<td>35.1000</td>
</tr>
<tr>
<td>SD</td>
<td>33.119</td>
<td>22.427</td>
</tr>
<tr>
<td>Total cases =</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates a decrease in total behavior problems.
Table 8

Analysis of covariance of the experimental and control groups for the CBCL subscale: Total Behavior Problems

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>1676.235</td>
<td>1</td>
<td>1676.235</td>
<td>11.671</td>
<td>.003**</td>
</tr>
<tr>
<td>Covariates</td>
<td>4468.331</td>
<td>1</td>
<td>4468.331</td>
<td>31.111</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>2585.297</td>
<td>18</td>
<td>143.628</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**p < .01

Table 8 shows the F ratio for the main effects was significant to the < .01 level indicating a decrease in the experimental group’s total behavior problems as measured by the CBCL. On the basis of this data, hypothesis 4 was retained.

Hypothesis 5

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Externalizing Behaviors subscale of the Child Behavior Checklist (CBCL) posttest than will subjects in the intensive individual play therapy group.

Table 9 presents the pre and posttest means and standard deviations for the experimental and comparison groups. Table 10 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups’ posttest mean scores.
Table 9

Mean scores of the experimental and comparison groups on the Child Behavior Checklist (CBCL) subscale: Externalizing Behavior Problems

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Comparison Group (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>18.5000</td>
<td>13.2000</td>
</tr>
<tr>
<td>SD</td>
<td>14.676</td>
<td>8.829</td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

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

Table 10

Analysis of covariance data of the experimental and comparison groups for the mean scores on the CBCL subscale: Externalizing Behavior Problems

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>1.217</td>
<td>1</td>
<td>1.217</td>
<td>.034</td>
<td>.855</td>
</tr>
<tr>
<td>Covariates</td>
<td>890.338</td>
<td>1</td>
<td>890.338</td>
<td>24.984</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>641.444</td>
<td>18</td>
<td>35.636</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 10 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental
group and the comparison group’s externalizing behavior problems as measured by the CBCL. On the basis of this data, hypothesis 5 was rejected.

**Hypothesis 5a**

Subjects in the intensive sibling group play therapy group will attain a significantly lower mean score on the Aggressive Behaviors subscale of the CBCL posttest than will subjects in the intensive individual play therapy group.

Table 11 presents the pre and posttest means and standard deviations for the experimental and comparison groups. Table 12 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups’ posttest mean scores.

Table 11

Mean scores of the experimental and comparison groups on the CBCL subscale: Aggressive Behaviors

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Comparison Group (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>14.7000</td>
<td>11.3000</td>
</tr>
<tr>
<td>SD</td>
<td>10.833</td>
<td>8.097</td>
</tr>
<tr>
<td>Total cases</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates a decrease in aggressive behaviors.
Table 12 shows the $F$ ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the comparison group's aggressive behavior problems as measured by the CBCL. On the basis of this data, hypothesis 5a was rejected.

**Hypothesis 5b**

Subjects in the intensive sibling group play therapy group will attain a significantly lower mean score on the Delinquent Behaviors subscale of the CBCL posttest than will subjects in the intensive individual play therapy group.

Table 13 presents the pre and posttest means and standard deviations for the experimental and comparison groups. Table 14 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups' posttest mean scores.
Table 13

Mean scores of the experimental and comparison groups on the CBCL subscale: Delinquent Behaviors

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th></th>
<th>Comparison Group (n = 11)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>5.9000</td>
<td>1.9000</td>
<td>2.000</td>
<td>1.2727</td>
</tr>
<tr>
<td>SD</td>
<td>9.267</td>
<td>1.101</td>
<td>1.949</td>
<td>1.272</td>
</tr>
<tr>
<td>Total cases =</td>
<td></td>
<td></td>
<td></td>
<td>21</td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates a decrease in delinquent behaviors.

Table 14

Analysis of covariance data of the experimental and comparison groups for the mean scores on the CBCL subscale: Delinquent Behaviors

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>1.093</td>
<td>1</td>
<td>1.093</td>
<td>.759</td>
<td>.395</td>
</tr>
<tr>
<td>Covariates</td>
<td>1.177</td>
<td>1</td>
<td>1.177</td>
<td>.818</td>
<td>.378</td>
</tr>
<tr>
<td>Error</td>
<td>25.904</td>
<td>18</td>
<td>1.439</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td></td>
<td>21</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 14 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the comparison group’s delinquent behaviors as measured by the CBCL. On the basis of this data, hypothesis 5b was rejected.
Hypothesis 5c

Subjects in the intensive sibling group play therapy group will attain a significantly lower mean score on the Attention Problems subscale of the CBCL posttest than will subjects in the intensive individual play therapy group.

Table 15 presents the pre and posttest means and standard deviations for the experimental and comparison groups. Table 16 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups' posttest mean scores.

Table 15

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Comparison Group (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>4.6000</td>
<td>3.8000</td>
</tr>
<tr>
<td>SD</td>
<td>3.204</td>
<td>2.300</td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

*Note. A decrease in the mean score indicates a decrease in attention problems.*
Table 16

Analysis of covariance data of the experimental and comparison groups for the mean scores on the CBCL subscale: Attention Problems

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>7.421</td>
<td>1</td>
<td>7.421</td>
<td>3.217</td>
<td>.090</td>
</tr>
<tr>
<td>Covariates</td>
<td>76.986</td>
<td>1</td>
<td>76.986</td>
<td>33.373</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>41.523</td>
<td>18</td>
<td>2.307</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 16 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the comparison group's attention problems as measured by the CBCL. On the basis of this data, hypothesis 5c was rejected.

Hypothesis 6

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on Externalizing Behaviors subscale of the CBCL posttest than will subjects in the control group.

Table 17 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 18 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.
Table 17

Mean scores of the experimental and control groups on the Child Behavior Checklist (CBCL) subscale: Externalizing Behavior Problems

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Control Group (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>18.5000</td>
<td>13.2000</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>14.676</td>
<td>8.829</td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

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

Table 18

Analysis of covariance data of the experimental and control groups for the mean scores on the CBCL subscale: Externalizing Behavior Problems

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>239.169</td>
<td>1</td>
<td>239.169</td>
<td>13.725</td>
<td>.002**</td>
</tr>
<tr>
<td>Covariates</td>
<td>856.838</td>
<td>1</td>
<td>856.838</td>
<td>49.170</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>313.671</td>
<td>18</td>
<td>17.426</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**p > .01
Table 18 shows the F ratio for the main effects was significant to the < .01 level indicating decrease in the experimental group’s externalizing problems as measured by the CBCL. On the basis of these data, hypothesis 6 was retained.

**Hypothesis 6a**

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Aggressive Behaviors subscale of the CBCL posttest than will subjects in the control group.

Table 19 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 20 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups’ posttest mean scores.

Table 19

**Mean scores of the experimental and control on the CBCL subscale: Aggressive Behaviors**

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Control Group (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>14.7000</td>
<td>11.3000</td>
</tr>
<tr>
<td>SD</td>
<td>10.833</td>
<td>8.097</td>
</tr>
<tr>
<td>Total cases =</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

**Note.** A decrease in the mean score indicates a decrease in the aggressive behavior.
Table 20

Analysis of covariance data of the experimental and control groups for the mean scores on the CBCL subscale: Aggressive Behavior

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>141.295</td>
<td>1</td>
<td>141.295</td>
<td>11.058</td>
<td>.004**</td>
</tr>
<tr>
<td>Covariates</td>
<td>734.988</td>
<td>1</td>
<td>734.988</td>
<td>57.524</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>217.212</td>
<td>17</td>
<td>12.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**p < .01

Table 20 shows the F ratio for the main effects was significant to the < .01 level indicating decrease in the experimental group's aggressive behavior as measured by the CBCL. On the basis of this data, hypothesis 6a was retained.

Hypothesis 6b

Subjects in the sibling group play therapy treatment group will attain a significantly lower mean score on the Delinquent Behaviors subscale of the CBCL posttest than will subjects in the control group.

Table 21 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 22 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.
Table 21

Mean scores of the experimental and control groups on the CBCL subscale: Delinquent Behaviors

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Control Group (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>5.9000</td>
<td>1.9000</td>
</tr>
<tr>
<td>SD</td>
<td>9.267</td>
<td>1.101</td>
</tr>
<tr>
<td>Total cases =</td>
<td></td>
<td>20</td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates a decrease in delinquent behaviors.

Table 22

Analysis of covariance data of the experimental and control for the mean scores on the CBCL subscale: Delinquent Behaviors

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>d/</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>.825</td>
<td>1</td>
<td>.825</td>
<td>.599</td>
<td>.450</td>
</tr>
<tr>
<td>Covariates</td>
<td>1.097</td>
<td>1</td>
<td>1.097</td>
<td>.797</td>
<td>.384</td>
</tr>
<tr>
<td>Error</td>
<td>23.403</td>
<td>17</td>
<td>1.377</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 22 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the comparison group’s delinquent behavior as measured by the CBCL. On the basis of this data, hypothesis 6b was rejected.
Hypothesis 6c

Subjects in the sibling group play therapy treatment group will attain a significantly lower mean score on the Attention Problems subscale of the CBCL posttest than will subjects in the control group.

Table 23 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 24 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 23

Mean scores of the experimental and control groups on the CBCL subscale: Attention Problems

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Control Group (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>4.6000</td>
<td>3.8000</td>
</tr>
<tr>
<td>SD</td>
<td>3.204</td>
<td>2.300</td>
</tr>
<tr>
<td>Total cases =</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates a decrease in attention problems.
Table 24

Analysis of covariance data of the experimental and control groups for the mean scores on the CBCL subscale: Attention Problems

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>2.453</td>
<td>1</td>
<td>2.453</td>
<td>.862</td>
<td>.366</td>
</tr>
<tr>
<td>Covariates</td>
<td>100.138</td>
<td>1</td>
<td>100.138</td>
<td>35.200</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>48.362</td>
<td>17</td>
<td>2.845</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20</td>
</tr>
</tbody>
</table>

Table 24 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the comparison group's attention problems as measured by the CBCL. On the basis of this data, hypothesis 6c was rejected.

Hypothesis 7

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on Internalizing Behavior Problems subscale on the CBCL posttest than will subjects in the intensive individual play therapy group.

Table 25 presents the pre and posttest means and standard deviations for the experimental and comparison groups. Table 26 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups' posttest mean scores.
Table 25

Mean scores of the experimental and comparison groups on the CBCL subscale: Internalizing Behavior Problems

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Comparison Group (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>17.7000</td>
<td>10.8000</td>
</tr>
<tr>
<td>SD</td>
<td>12.275</td>
<td>9.578</td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates a decrease in internalizing behaviors.

Table 26

Analysis of covariance data of the experimental and comparison groups for the mean scores on the CBCL subscale: Internalizing Behaviors

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>2.694</td>
<td>1</td>
<td>2.694</td>
<td>.137</td>
<td>.715</td>
</tr>
<tr>
<td>Covariates</td>
<td>596.555</td>
<td>1</td>
<td>596.555</td>
<td>30.368</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>353.590</td>
<td>18</td>
<td>19.644</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 26 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the comparison group’s internalizing behavior problems as measured by the CBCL. On the basis of this data, hypothesis 7 was rejected.
Hypothesis 7a

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Withdrawn Behavior subscale of the CBCL posttest than will subjects in the intensive individual play therapy group.

Table 27 presents the pre and posttest means and standard deviations for the experimental and comparison groups. Table 28 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups' posttest mean scores.

Table 27

Mean scores of the experimental and comparison groups on the CBCL subscale: Withdrawn Behavior

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Comparison Group (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>5.3000</td>
<td>3.1000</td>
</tr>
<tr>
<td>SD</td>
<td>4.111</td>
<td>2.283</td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates a decrease in withdrawn behavior.
Table 28

Analysis of covariance data of the experimental and comparison groups for the mean scores on the CBCL subscale: Withdrawn Behavior

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>3.015</td>
<td>1</td>
<td>3.015</td>
<td>1.058</td>
<td>.317</td>
</tr>
<tr>
<td>Covariates</td>
<td>10.157</td>
<td>1</td>
<td>10.157</td>
<td>3.565</td>
<td>.075</td>
</tr>
<tr>
<td>Error</td>
<td>51.289</td>
<td>18</td>
<td>2.849</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 28 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the comparison group’s withdrawn behaviors as measured by the CBCL. On the basis of this data, hypothesis 7a was rejected.

Hypothesis 7b

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Somatic Complaints subscale of the CBCL posttest- than will subjects in the intensive individual play therapy group.

Table 29 presents the pre and posttest means and standard deviations for the experimental and comparison groups. Table 30 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups’ posttest mean scores.
Table 29

Mean scores of the experimental and comparison groups on the CBCL subscale: Somatic Complaints

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Comparison Group (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>3.9000</td>
<td>1.8000</td>
</tr>
<tr>
<td>SD</td>
<td>3.315</td>
<td>2.781</td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates a decrease in somatic complaints.

Table 30

Analysis of covariance data of the experimental and comparison groups for the mean scores on the CBCL subscale: Somatic Complaints

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>1.264</td>
<td>1</td>
<td>1.264</td>
<td>.710</td>
<td>.411</td>
</tr>
<tr>
<td>Covariates</td>
<td>57.720</td>
<td>1</td>
<td>57.720</td>
<td>32.405</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>32.062</td>
<td>18</td>
<td>1.781</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 30 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the comparison group’s somatic complaints as measured by the CBCL. On the basis of this data, hypothesis 7b was rejected.
Hypothesis 7c

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Anxious/Depressed subscale of the CBCL posttest than will subjects in the intensive individual play therapy group.

Table 31 presents the pre and posttest means and standard deviations for the experimental and comparison groups. Table 32 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups' posttest mean scores.

Table 31

**Mean score of the experimental and comparison groups on the CBCL subscale: Anxious/Depressed**

<table>
<thead>
<tr>
<th></th>
<th><strong>Experimental Group (n = 10)</strong></th>
<th></th>
<th><strong>Comparison Group (n = 11)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
<td>Pretest</td>
</tr>
<tr>
<td>Mean</td>
<td>9.5000</td>
<td>6.3000</td>
<td>2.700</td>
</tr>
<tr>
<td>SD</td>
<td>6.294</td>
<td>5.438</td>
<td>2.700</td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* A decrease in the mean indicates a decrease in anxious and depressed feelings.
Table 32

Analysis of covariance data of the experimental and comparison groups for the mean scores on the CBCL subscale: Anxious/Depressed

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>1.452</td>
<td>1</td>
<td>1.452</td>
<td>.200</td>
<td>.660</td>
</tr>
<tr>
<td>Covariates</td>
<td>191.880</td>
<td>1</td>
<td>26.376</td>
<td>26.376</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>130.947</td>
<td>18</td>
<td>7.275</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total cases = 21

Table 32 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the comparison group’s feelings of anxiety and depression as measured by the CBCL. On the basis of this data, hypothesis 7c was rejected.

Hypothesis 8

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Internalizing Behaviors subscale of the CBCL posttest than will subjects in the control group.

Table 33 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 34 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups’ posttest mean scores.
Table 33

Mean scores of the experimental and control groups on the CBCL subscale: Internalizing Behaviors

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Control Group (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>17.7000</td>
<td>10.8000</td>
</tr>
<tr>
<td>SD</td>
<td>12.275</td>
<td>9.578</td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean scores indicates a decrease in internalizing behaviors.

Table 34

Analysis of covariance data of the experimental and control groups for the mean scores the CBCL subscale: Internalizing Behaviors

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>89.460</td>
<td>1</td>
<td>89.460</td>
<td>4.085</td>
<td>.058*</td>
</tr>
<tr>
<td>Covariates</td>
<td>757.392</td>
<td>1</td>
<td>757.392</td>
<td>34.583</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>394.208</td>
<td>18</td>
<td>21.900</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05
Table 34 shows the F ratio for the main effects was significant to the < .05 level indicating a decrease in the experimental group's internalizing behaviors as measured by the CBCL. On the basis of this data, hypothesis 8 was retained.

Hypothesis 8a

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Withdrawn Behavior subscale of the CBCL posttest than will subjects in the control group.

Table 35 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 36 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 35

Mean scores of the experimental and control groups on the CBCL subscale: Withdrawn Behavior

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Control Group (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>5.3000</td>
<td>3.1000</td>
</tr>
<tr>
<td>SD</td>
<td>4.111</td>
<td>2.283</td>
</tr>
<tr>
<td>Total cases =</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates a decrease in withdrawn behavior.
Table 36

Analysis of covariance data of the experimental and control groups for the mean scores on the CBCL subscale: Withdrawn Behavior

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>3.264</td>
<td>1</td>
<td>3.264</td>
<td>.848</td>
<td>.370</td>
</tr>
<tr>
<td>Covariates</td>
<td>24.385</td>
<td>1</td>
<td>24.385</td>
<td>6.337</td>
<td>.022</td>
</tr>
<tr>
<td>Error</td>
<td>65.415</td>
<td>17</td>
<td>3.848</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 36 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the control group's withdrawn behaviors as measured by the CBCL. On the basis of this data, hypothesis 8a was rejected.

Hypothesis 8b

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Somatic Complaints subscale of the CBCL posttest than will subjects in the control group.

Table 37 presents the pre and posttest means and standard deviations for the experimental and comparison groups. Table 38 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.
Table 37  

Mean scores of the experimental and control groups on the CBCL subscale: Somatic Complaints  

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>.533</td>
<td>1</td>
<td>.533</td>
<td>.262</td>
<td>.615</td>
</tr>
<tr>
<td>Covariates</td>
<td>41.073</td>
<td>1</td>
<td>41.073</td>
<td>20.165</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>34.627</td>
<td>17</td>
<td>2.037</td>
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</tr>
</tbody>
</table>

Total cases = 20  

Note. A decrease in the mean scores indicates a decrease in somatic complaints.  

Table 38  

Analysis of covariance data of the experimental and control groups for the mean scores on the CBCL subscale: Somatic Complaints  

Table 38 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the control group’s somatic complaints as measured by the CBCL. On the basis of this data, hypothesis 8b was rejected.
Hypothesis 8c

Subjects in the intensive sibling group play therapy treatment group will attain a significantly lower mean score on the Anxious/Depressed subscale of the CBCL posttest than will subjects in the control group.

Table 39 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 40 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 39

Mean scores of the experimental and control groups on the CBCL subscale: Anxious/Depressed

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group (n = 10)</th>
<th>Control Group (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>9.5000</td>
<td>6.3000</td>
</tr>
<tr>
<td>SD</td>
<td>6.294</td>
<td>5.438</td>
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<tr>
<td>Total cases =</td>
<td>20</td>
<td></td>
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</tbody>
</table>

Note. A decrease in the mean scores indicates a decrease in anxiety and depression.
Table 40

Analysis of covariance data of the experimental and control groups for the mean scores on the CBCL subscale: Anxious/Depressed

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>38.758</td>
<td>1</td>
<td>38.758</td>
<td>5.040</td>
<td>.038*</td>
</tr>
<tr>
<td>Covariates</td>
<td>386.273</td>
<td>1</td>
<td>386.273</td>
<td>50.232</td>
<td>.000</td>
</tr>
<tr>
<td>Error</td>
<td>130.727</td>
<td>17</td>
<td>7.690</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td></td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05

Table 40 shows the F ratio for the main effects was significant to the < .05 level indicating a decrease in the experimental group's anxiety and depression as measured by the CBCL. On the basis of this data, hypothesis 8c was retained.

Discussion

The results from this study point to the effectiveness of intensive sibling group play therapy in a variety of areas with child witnesses of domestic violence. Significant results were found in 6 out of 10 hypotheses related to intensive sibling group play therapy versus the control group. Additionally, as indicated by the lack of significant difference between the experimental group versus the comparison group, intensive sibling group play therapy has been shown to be equally as effective as intensive individual play therapy. The meaning of these results will be discussed below.
Self-Concept

The experimental group showed a significant increase ($p > .001$) in self-concept as indicated by the Joseph Pre-School and Primary Self-Concept Screening Test. These findings are extremely robust and therefore imply a high degree of generalizability to the larger population. Additionally, these findings carry particular meaning given the fact that children in the control group showed a significant decline in self-concept without any therapeutic intervention. The implications of continued poor self-concept are central to long term social and interpersonal difficulties for child witnesses of domestic violence.

Children with low self-esteem or negative self-concept see themselves as bad, worthless or unlovable. They feel unable to impact positively on their environments and they have difficulty formulating satisfying interpersonal relationships (McGregor & Johnson, D., p.3, 1993).

These symptoms alone may serve to exacerbate difficulties experienced by child witnesses of domestic violence. Additionally, positive self-concept is listed as a protective factor associated with improved ability to cope with parental violence. Children with a high self-concept are less likely to internalize personal blame for family violence and they are better equip to seek out social support when feeling vulnerable (Jasinski & Williams, 1998).

Many other research studies have also found positive changes in self-concept with play therapy as an intervention (Axline, 1955; Kot,1995; Malchiodi,1990; Perez, 1987). Consistently positive results can be explained in a number of ways. DeMaria and
Cowden (1992) argued that a child's self-concept is a learned perceptual system involving environmental feedback which influences the child's behavior. This is extremely important in terms of child witnesses of domestic violence due to the frequent negative messages that are conveyed in violent homes. DeMaria and Cowden further suggested that changes in self-concept can not be made directly. Instead, change in self-concept must be impacted through the child's experiences, activities and environmental reactions. By actively engaging in activities, play therapy allows the child to experience himself or herself in a variety of new ways, thus creating new beliefs about one's own potentials and abilities. This implies that child witnesses of domestic violence have the potential to alter self-concept by engaging in play activities in the playroom that challenge messages conveyed within their family of origin. For example, one child poignantly summarized this point by stating "My daddy says girls are suppose to clean the house and have babies but I'm gonna' be a doctor." This was a challenge to her existing belief system and broadened her perception of what she was potentially capable of doing.

An additional explanation of the positive changes in self-concept seen in this study can be understood by reviewing Purkey's (1970) beliefs about the constantly developing self-concept. He suggested that self-concept is a function of the expectations and beliefs held by caretakers that become internalized as self worth. In terms of this definition, those who participated in sibling group play therapy, within a nurturing context, had the experience of being valued, respected, and honored and thus change their self-perception. Children from violent homes often lack exposure to adults that convey
positive messages to them and about them. The growth promoting environment offered in the play therapy room may provide new opportunities for child witnesses of domestic violence to develop an improved self-concept.

Axline (1947, 1950, 1955) found significant changes in self-concept throughout her work with a variety of populations and she described changes in the self-concept in terms of self-discovery. She suggested that self-discovery is the vehicle by which children gain a sense of positive self worth, and can be enhanced by experiencing the self in different relationships. The end product of self-respect, Axline argued, is achieved through a cooperative effort to gain self-understanding. She further indicated that group play therapy provides children with a number of avenues to challenge existing belief systems, and to re-examine their own concepts. This implies that by engaging in the group context, child witnesses of domestic violence had the potential to explore who they were in terms of positive relationships.

Behavior Problems

Subjects in the experimental group demonstrated a significant (p < .05) decrease in total behavior problems at the time of posttesting as measured by the Child Behavior Checklist (CBCL). Having a significantly lower mean score for Total Behavior Problems at the time of posttesting indicated a reduction of overall problems perceived by the mothers. The CBCL score of Total Behavior Problems is reflective of the rating of the mothers on all of the items on the CBCL. The total score encompasses the scores on all eight subscales of the CBCL: (a) withdrawn, (b) somatic complaints,
anxious/depressed, (d) social problems, (e) thought problems, (f) attention problems, (g) delinquent behavior, and (h) aggressive behavior. Therefore, these results suggest that children were perceived by their mothers as showing an increase in overall well being and an increase in total emotional adjustment. Shelter staff confirmed these perception with reports that "the children who participated in the study exhibited more behavioral control and exhibited more emotional predictability".

Results specific to improved total behavioral difficulties, as perceived by the children's mothers, are particularly noteworthy because mothers who are experiencing significant distress have a tendency to judge their children using excessively harsh standards. This judgmental attitude toward their children may be a reflection of a greater sensitivity to their children's negative behaviors due to personal distress (Hughes & Barad, 1983). This implies that any positive change noted by the mothers has a potential to be an underestimation of the actual behavior change exhibited by the child. Therefore, the findings may represent a lower degree of change than was actually represented by the children in this study.

A final consideration that may be a factor in the overall behavioral improvement in child witnesses of domestic violence is the change in environment from the family home to the shelter. It is widely excepted that residing in a violent home causes emotional distress severe enough to result in a broad spectrum of negative behaviors exhibited by the children in these homes (Fantuzzo & Lindquist, 1989; Hughes, Vargo & Skinner, 1991; Jaffe, Wolfe, Wilson, 1990; Jaffe, Wolfe Wilson & Zak, 1986). Once the
mother and the children move to the shelter, they are no longer being exposed to an extreme degree of violent activity. The change in living conditions and environmental stressors may have a positive effect on emotional and behavioral adjustment of the children. However, it should be noted that the control group in this study showed an increase in Total Behavior Problems as measured by the Child Behavior Checklist posttest scores. This suggests that even though environmental change may be a factor in overall adjustment, residence in the shelter, alone, is not a salient enough factor to account for the significant degree of change observed in the children who received intensive individual play therapy and intensive sibling group play therapy interventions. Therefore, participation in play therapy may aid in the secure transition from the home to the shelter which, in turn, results in a reduction of total behavior problems.

There was also a significant (p < .01) reduction in externalizing behaviors for the experimental group at the time of posttesting as measured by the CBCL. Children were perceived by their mothers as exhibiting less aggression and less delinquent behaviors such as lying, cheating and swearing. A decrease in Externalizing Behaviors is representative of a total reduction on the CBCL subscales of Aggression and Delinquency.

More specifically, subjects in the experimental group demonstrated a significant (p < .01) reduction in the area of aggressive behavior at the time of posttesting as measured by the CBCL. A significant score on this subscale indicates that there was a significant reduction, as perceived by the children’s mothers, in the child’s expression of
hostility and conflict which is often characterized by attempts to hurt others and destroy property.

There are several explanations for the dramatic decrease in aggression for the experimental group. Pynoos and Eth (1986) state that the expression of aggression in fantasy tends to decrease tension in traumatized children. This implies that the level of aggression in child witness of domestic violence may be a function of the level of interpersonal distress that the child is experiencing. A decrease in aggressive behaviors may be indicative an internal resolution and a decrease in distress experienced by the child who received treatment. It should be noted that children in the control group showed an increase in aggressive behavior which may be explained by the absence of an effective outlet for feelings of tension. Frick-Helms (1997) has documented that aggressive behaviors erupt when children assume responsibility, feel guilty and believe that they are deserving of punishment for the traumatic event. According to this explanation, as the child works through these issues in the playroom the aggressive behaviors a child exhibits decreases.

The family environment is perceived as the key factor to understanding the etiology and maintenance of aggressive behavior. The idea of intergenerational transmission of violent familial behavior underscores the need for positive interventions which incorporate siblings or other family members who have the opportunity to develop and practice new ways of behaving while in the safe environment of the therapy room. An improvement in the relational style of siblings, with a decrease in aggression being a
central component, has far reaching implications in terms of breaking the cycle of violence.

Addressing the issue of family aggression, and more specifically sibling aggression, is inherent in working with child witnesses of domestic violence. In an attempt to address highly aggressive siblings, clinicians may want to consider the possibility of addressing aggression within a group context. Although group screening procedures typically call for restrictions on group membership due to a history of aggressive behavior, the results from this study imply that even extremely aggressive siblings have the potential to show a drastic reduction in the expression of hostility after placement in sibling group play therapy. The children in this study, who tended to show aggressive behaviors, quickly learned more productive patterns of interacting. Carlin and Armstrong (1968) also found similar results in working with extremely aggressive children in group play therapy. They found that by returning responsibility and by providing an opportunity for social learning, the children were able to experience positive social interactions. Additionally, Hai-Yahai and Dawaud-Nousi (1998) found similar results after providing group therapy to children from high conflict families. Adolescents in these groups who tended to display aggressive behavior showed a reduction in aggression due to principles of the social learning and peer feedback.

In this research project, an extremely aggressive dyad volunteered for sibling group play therapy services. Initial sibling interactions included frequent hitting, kicking, scratching and biting, which often appeared to be unprovoked. The unpredictability of
these interactions was reflective of the children's family life prior to entering the shelter. Upon termination of play therapy, these children showed a significant decrease in aggressive behavior. Attacks, which were initially impulsive and second nature, were more restrained and alternative methods of resolving conflicts began to be implemented. These children experienced for, possibly the first time, what it felt like to have a positive resolution to a disagreement. This in turn created a great deal of pride and self respect.

In addition to therapist observations, mothers also reported positive behavioral changes in sibling interaction outside of the therapy time. At the end of the twelve sessions, one mother reported overhearing her younger daughter verbally and physically annoying her older daughter in the back seat of the car while driving to school. The older daughter was clearly annoyed with the younger child and perceived her interactions to be an extreme nuisance. However, rather than engaging in the typical response of hitting her, the older daughter stated “I know you just want my attention, you can just tell me to play with you.” The mother reported that this type of interaction was representative of entirely new behavior and was characteristic of an overall trend in decreased aggressive sibling interactions.

Subjects in the experimental group also demonstrated a significant (p < .05) decrease in internalizing behaviors problems as measured by the CBCL at posttest. This indicates that mothers perceived their children as exhibiting fewer behavior problems associated with withdrawal, somatic complaints, and anxiety/depression. A possible explanation of this phenomenon could be couched in terms of the sibling interaction
available to the children in the social context of sibling group play therapy. In the sibling group play therapy context, the focus shifts from intrapersonal to interpersonal patterns of communication. Often child witnesses of domestic violence have not had the opportunity to engage in healthy patterns of interaction in a nontreating environment. Although individual play therapy might eventually produce similar results, the sibling group play therapy approach has the potential to bring about more direct and faster results because interpersonal issues can be defined immediately and work within the sessions. Additionally, material obtained during the play sessions could be easily applied to interactions outside of the sessions due to the ongoing nature of the sibling relationship (Barlow, Strother, & Landreth, 1986).

This dynamic was readily observed by one of the therapists during intensive sibling group play therapy with two female siblings. Initial behavioral assessments revealed that the older child tended to cope with emotional distress by isolating and withdrawing. The younger of the two appeared to manage anxiety with behavior that was impulsive and aggressive. In the initial sibling play therapy group sessions the older child reacted as though she was overwhelmed by her sister's behaviors. She often retreated behind the easel to color or hold a teddy bear, while her sister raced around the room exploring every detail of the play equipment. Within four sessions, the withdrawn child had established her corner of the room and had portioned off a section that she labeled as “her house”. Additionally she stated that “no one was allowed to visit”. As sibling group play therapy sessions continued, the older child became more willing and
able to tolerate the increased activity of her sister. This was indicated by her increased openness to having visitors in her "home". Initially, visitors were only allowed to knock on the door and speak with her for limited periods of time. By the end of the twelfth session, the older child celebrated her new found freedom and confidence by having an elaborate party at her "house". Not only did she invite the therapist and her sister, but she also invited all of the stuffed animals and dolls.

Posttesting further revealed that subjects in the sibling group play therapy group demonstrated a significant (p < .05) decrease in anxious and depressed feelings as measured by the CBCL at posttest. This means that children who participated in sibling group play therapy decreased behavior associated with feelings of sadness, feelings of loneliness, nervousness, guilt and fear. This is particularly important for child witnesses of domestic violence because often these children are burdened by feelings of guilt associated with feeling responsible for violence within the home. Additionally, children who are living in the shelter are faced with anxiety, grief and sadness associated with being forced to leave their home, belongings and often even their friends. A decrease in these anxious and depressed feelings implies a feeling of stability and a resolution to many of the precipitating events that caused the uncomfortable feelings.

These characteristics were also observed by the therapists during the process of intensive sibling play therapy. Often initial play therapy sessions were marked by play behaviors characteristic of increased arousal and a high level anxiety. More specifically, many of the children were preoccupied with safety and self preservation which is
believed to be representative of high levels of anxiety pertaining to safety from the perpetrator. Play themes typically revolved around shielding oneself from harm and gaining mastery and control over an otherwise frightening situation. Additionally, a theme that was consistent throughout all of the sibling group play therapy sessions was that of a symbolic reassurance of safety. Most of the children engaged in elaborate play with weapons and shields or they established secret, protected hiding places for themselves and for the toys that were representative of themselves. According to Frick-Helms (1997), these types of play behaviors allow children to restructure their reality so as to experience control and psychological safety, thereby decreasing high levels of anxiety.

One specific example of anxiety reducing protective play in this study involved the creation of a super durable magnetic tank with special protective powers by one of the children. The metallic tank had the ability to withstand any amount of violent attacks from dinosaurs, magical-destructive demons and it could even withstand nuclear bombs. In addition to the protective powers of this tank was a secret hiding place under ten tons of sand on the side of a mountain in the dessert. No one was allowed to know were the tank went to rest every night. However, on a daily basis the metallic tank retrieved all of the solders that were honored members of it’s force (his brother) and retreated to the secret hiding place. This play served to reduce the overwhelming anxiety that this child was experiencing. Additionally, the play created a feeling a safety and control during feelings of intense vulnerability and fear.
Other children did not initially exhibit the ego strength needed to manage the high
degree of depression brought on by family violence. In one particular case, shelter staff
members contacted the therapist with concern of potentially suicidal behavior exhibited
by one of the children getting ready to begin sibling group play therapy. Throughout
daily play therapy sessions, this child showed a dramatic improvement in affect and
showed an increase in ego strength as well. Improvement in his mood and ability to cope
was represented by a picture that he painted of "his house" every day in sibling group
play therapy. During initial sessions, the child's house was black and falling down. It
was raining in the picture and a lightening bolt had caught the house on fire. With each
session, the house began to take on a brighter representation. By the middle of the
intensive sibling play therapy sessions, the house was an orangish-brown, it had a tree
next to it and it was raining. By the final session, this child painted a brightly colored
house with a tree and a rainbow in the sky. It was still drizzling "to water the tree" and
the mood of the picture was certainly one of hope. His mother reported that he "was less
tearful and that he appeared to be much happier." In this particular case, daily treatment
was not only indicated but it is perceived to have more rapidly resolved a severe level of
depression.

Comparisons Between Intensive Individual Play Therapy and Intensive Sibling Group
Play Therapy

Although there were no significant differences between intensive sibling group
play therapy and intensive individual play therapy, there were several statistical trends
worth noting. Given a larger sample size, these trends may have shown more statistical power. As indicated by the change in pretest and posttest scores on the CBCL, children who participated in intensive sibling group play therapy showed more positive change than the children who participated in intensive individual play therapy on the following subscales: Total Behavior Problems, Internalizing Behaviors, Externalizing Behaviors, Anxious/Depressed, Aggressive Behavior, Delinquent Behaviors, Somatic Complaints, Social Problems, and Withdrawn Behavior. Intensive individual play therapy showed more positive change than intensive sibling group play therapy on the Attention Problems subscale of the CBCL at posttest.

The implications associated with these trends are far reaching and may be helpful to clinicians as they are attempting to determine the most beneficial intervention for their clients. Overall, intensive sibling group play therapy has the potential to be more helpful with issues related to emotional and social difficulties, while intensive individual play therapy has the potential to be most helpful with attention and concentration difficulties. Children who experience difficulties with attention and concentration may show more positive changes in individual play therapy because a second person serves as a distracter in sibling group play therapy. Children who are attempting to improve focusing skills may need the opportunity to receive one on one attention from the therapist. Once these skills have been developed, group play therapy may then become a tool for further enhancing and testing concentration skills.
Aside from statistical trends, advantages of sibling group play therapy were noted by this researcher. First, the sibling groups created a pseudofamily where the children were able to create positive family interactions without having to rely on generalizability from the group environment to the family environment. The children in the intensive sibling group play therapy group were able to actually experience a new family dynamic within the session, where as the children that participated in intensive individual play therapy only had access to a positive relationship between the therapist and the child. Although the therapist-child relationship is often a healing one, the child must internalize experiences from this relationship and generalize it to the family. Within the context of sibling group play therapy, the therapist often serves as a representation of the parent figure. During the play therapy sessions, the child is able to experience acceptance and nurturing, thereby restructuring the child's perception of the parental role. This relationship becomes a powerful tool for therapeutic change in the children.

Second, sibling group play therapy decreased feelings of isolation and secrecy established in the home environment. Intensive sibling group play therapy provided the children with an open forum where they could begin to openly express what occurred within the family. Although, individual play therapy addresses this issue by helping the child to feel safe with the therapist, it does not directly assist any members of the family in becoming more open about the family violence. Individual play therapy leaves the child with the difficult task of risking expression of "taboo topics" without the safety of the therapeutic environment. In sibling group play therapy the therapist is available to
mediate between potentially harmful interchanges and to protect the nurturing environment of the playroom when the children risk expression.

Third, siblings have a pre-existing relationship that expedites the therapeutic process. Children who participated in intensive sibling group play therapy were able to immediately explore difficult issues because of a shared bond and because of a mutual understanding of what had occurred. In individual play therapy or in non-sibling group play therapy, the child lacks the advantage of having a partner that they can rely on having an assumed knowledge of previous events.

Fourth, aggressive feelings and behaviors were humanized in sibling group play therapy. In individual play therapy, the children are not faced with solving interpersonal conflicts. This dynamic in sibling group play therapy has the potential to more easily tap into feelings and behaviors associated with person to person aggression. Siblings that have witnessed aggression have the opportunity to explore reactions to aggression as well as reactions to more productive ways of interacting.

The Therapeutic Process

The findings in this study are consistent with previous reports evaluating the impact of positive sibling relationships on management of stressful life events (Caya & Liem, 1998; Frey-Angel, 1989). There are two primary aspects of the design of the intensive sibling group play therapy intervention that may have contributed to a number of statistically significant findings and may have enhanced the therapeutic effects
exemplified in the group process: siblings as therapeutic partners and daily therapy sessions.

The results of this study are consistent with previous research findings which reported therapeutic benefits to providing sibling group play therapy (Frey-Angel, 1989). A possible explanation that may account for the high degree and number of positive emotional and behavioral changes after exposure to intensive sibling group play therapy is the fact that these children began the therapeutic process with an already existing familial context in which to frame their therapeutic work. This context may expedite the therapeutic process with regards to issues related to family dynamics. Additionally, the development of a trusting and understanding relationship had already been established between the siblings. Often this relationship has been intensified through the experience of similarly traumatic events within the family of origin. The pre-existing bonded relationship perhaps allowed the children to demonstrate and acknowledge a loving connection, thereby developing a non-threatening support system and enhancing therapeutic exploration and catharsis within the group context (Caya & Liem, 1998; Leavitt, et al., 1996; Leavitt et al., 1998). Further, this research is supportive of previous findings which provide evidence for the protective effects of sibling support on individual adjustment within a stressful family environment. Knowing that they are not alone during times of family stress is an important factor associated with positively coping with family conflict (Caya & Liem, 1998).
In addition to the curative and preventative qualities of the sibling relationship, consistent sibling interactions serve to enhance the development of new interactional skills within the relationship. The siblings quickly learn new problem solving methods that they can readily practice with one another. The acquisition of problem solving skills and social skills can help to prevent further emotional and psychological damage by dysfunctional family dynamics.

Another advantage to pairing siblings together as group members can be seen in terms of consistency. Since this population is highly transient, establishing a group that relies on two families to reside at the shelter for the same period of time is extremely difficult. Often, families abruptly leave the shelter with little or no transition time for the others who remain in residence at the shelter. This dynamic could easily exacerbate already existing feelings of abandonment for children who are unrelated and matched in therapy groups.

Of equal importance when working with child witnesses of domestic violence who are residing in a shelter is the family’s length of stay. The intensive sibling group play therapy model, which collapses weekly sessions into a two week, daily treatment model appeared to have a dramatic impact on the children. As discussed earlier, the children entering domestic violence shelters are often in crisis. Daily treatment has the advantage of allowing the children to steadily work through issues on a daily basis. This phenomenon was evident by the fact that most children began each session nearly exactly where they left off. For example, if they concluded one session with a dinner party, the
next play session would often pick up with the children leaving the dinner party. This has advantages in that each session serves as a continuation and a consistent environment to continue to process valuable emotional material.

Similar results have been reported by Bratton, Landreth, and Homeyer (1993) who developed and evaluated intensive supervision of play therapists. In an attempt to maximize and intensify the supervision experience for graduate students, a 3-day intensive training program required live observation of play therapy sessions, which occurred in a consecutive, condensed format. Not only did they observe a growth in the clinicians, but the children who participated in play therapy sessions 3 times a day, for 3 days showed a significant amount of improvement during this time frame. Marathon groups, which were popular in the 70's, are based on the premise that intense therapeutic interventions yield more long lasting and beneficial results. The dynamics observed in intensive sibling group play therapy and intensive individual play therapy support the notion that therapeutic intensity accounts for more in-depth and more expedient intrapersonal change.

Recommendations

1. The utilization of intensive sibling group play therapy is a viable intervention for child witnesses of domestic violence, particularly when focusing on self-concept, internalizing behavior problems, externalizing behavior problems, and feelings of anxiety and depression.
2. A follow-up study to investigate the long term effects of intensive play therapy with child witnesses of domestic violence.

3. Intensive filial therapy with mothers involved in domestic violence to determine whether a focus on parenting skills or a focus on the child’s adjustment is more effective.

4. Further research is needed to investigate intensive sibling group play therapy with child witnesses of domestic violence. A larger sample size may yield more powerful results.

5. A comparative analysis of sibling group play therapy versus non-sibling group play therapy with child witnesses of domestic violence.

6. A reduction of time between session would be beneficial in working with children in crisis.

7. Immediate intervention after a crisis situation is recommended because it is believed that a safe, nurturing relationship will foster more positive change.

Concluding Remarks

This study has demonstrated promising results specific to intensive sibling play therapy with child witnesses of domestic violence. Additionally, the inclusion of siblings in interventions with child witnesses of domestic violence has the potential to serve a protective mechanism. However, most importantly is the prospect of breaking the cycle of intergenerational transmission of violent familial interactions. The reduction of
aggression has a great deal of promise in terms of creating new patterns of interacting.

And finally, the structure provided in the intensive sibling play therapy model has a variety of benefits when working on a limited time schedule with children in crisis.
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. This study has been approved by the Human Subjects Board at the University of North Texas. 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.

Play therapy is a therapeutic approach used for working with young children that utilizes selected play materials. The trained counselor helps the child 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 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 your permission to participate in play sessions. 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 the material. Information obtained from the questionnaires will be recorded with a code number. Only the investigator, Ashley Tyndall-Lind, will have a list of the participants’ names. At the end of this study the list of participants’ names will be destroyed.

If you agree to participate, please fill out and sign the consent form on the back of this page. For further information please contact Ashley Tyndall-Lind (940) 565-3864 (work) or (214) 340-565-3864 (home). Thank you very much for your time, cooperation and your participation.

Sincerely,

Ashley Tyndall-Lind
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 of the information presented to you on the front of this form and until all of your questions about the research have been answered to your satisfaction. You understand that participation is voluntary and you and/or you child may chose to withdraw at any time during the study. You signature indicates that you meet all of the requirements for participation as explained by Ashley Tyndall-Lind and have decided to participate, having read the information an the front of this form.

________________________________________   ____________
Signature of Parent                       Date

________________________________________   ____________
Name of Child                             Age

________________________________________   ____________
Signature of Witness                     Date

________________________________________   ____________
Signature of Investigator                 Date
APPENDIX B

RESEARCH INFORMATION FOR CHILDREN
IN THE EXPERIMENTAL GROUP
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 your help. You can help me by playing in the playroom with another child who will be selected from the children who are staying in this shelter. Both of you will meet with a counselor for 45 minutes every day for two weeks.

In the playroom, you can play with the toys, draw pictures, talk to the counselor, and do other things 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.

I have talked to your mother and she told me that it would be all right 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 all right 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 or you can choose not to do this. Tell me which you choose. (Allow the 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 questions 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.
REFERENCES


