



**An-Najah National University**

**Faculty of Graduate Studies**

**THE EFFICACY OF PLAY THERAPY  
PROGRAM IN REDUCING CONDUCT  
DISORDERS AMONG CHILDREN OF  
RESIDENTIAL INSTITUTIONS**

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## **Dedication**

To my parents, who stood by me and helped me tremendously to get to where I am today.

## **Acknowledgments**

First and foremost, I am honored to extend my deepest gratitude and appreciation to An-Najah National University, its President, and its esteemed faculty members. I offer them my sincere thanks.

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## Declaration

I, the undersigned, declare that I submitted the thesis entitled:

**THE EFFICACY OF PLAY THERAPY PROGRAM IN REDUCING  
CONDUCT DISORDERS AMONG CHILDREN OF RESIDENTIAL  
INSTITUTIONS**

I declare that the work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

**Student's Name:** Roaa Takrohi

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**Date:** 3/11/24

## List of Contents

Dedication.....	III
Acknowledgments .....	IV
Declaration.....	V
List of Contents.....	VI
List of Tables .....	VIII
List of Appendices .....	IX
Abstract.....	X
Chapter one: Introduction .....	1
1.1 Theoretical Background.....	1
1.2 Problem Statement.....	22
1.3 Study Hypotheses .....	23
1.4 Significance of the Study.....	23
1.5 Objectives of the Study.....	23
1.6 Aim of the Study.....	24
1.7 Research Question .....	24
Chapter Two: Method.....	25
2.1 Study Design.....	25
2.2 Participants.....	25
2.3 Sampling Technique .....	25
2.4 Measures .....	25
2.5 Validity and Reliability of Burks Behavior Rating Scale.....	27
2.6 Intervention.....	28
2.6.1 Therapeutic Program.....	28
2.6.2 Program Philosophy.....	37
2.6.3 The Importance of the Program .....	37
2.6.4 Program Goals .....	37
2.6.5 The Content of the Program.....	38
2.6.6 Inclusion and Exclusion Criteria.....	39
2.6.7 Program Application Procedures .....	39
2.6.8 Data Collection Process .....	39
2.6.9 Study Variables.....	40
2.6.10 Statistical Analysis.....	40
2.7 Ethical Considerations .....	40

Chapter Three: Results.....	41
3.1 Characteristics of the Participants.....	41
3.2 Effects of the Intervention on Participants' Behaviors as Measured by the Burks Behavior Rating Scale .....	41
3.3 Associations between Characteristics of the Participants and the Changes Caused by the Intervention in Each Item of the Burks Behavior Rating Scale.....	43
Chapter Four: Discussions and Conclusions .....	44
4.1 Conclusion .....	47
4.2 Limitations of the Study .....	48
4.3 Recommendation .....	48
References.....	49
Appendices.....	57
الملخص.....	ب

## **List of Tables**

Table 1: Interpretation of Scale Results.....	27
Table 2: Play Therapy Intervention .....	29
Table 3: Characteristics of the Participants .....	41
Table 4: Effects of the Intervention on Participants' Scores across Different Domains.	42

## **List of Appendices**

Appendix A: Scale of behavioral problems among children in residential institutions from the counselor's point of view .....	57
Appendix B: Consent to participate in scientific research.....	60
Appendix D: Burks Behavior rating scale .....	62
Appendix E: Tables of Study.....	64
Table E1: Effects of the Intervention on Participants' Behaviors across Different Domains .....	64
Table E2: The effects of the intervention on the scores of the participants in each item of the Burks Behavior Rating Scale .....	66
Table E3: Association between age, sex, and living with parents and the change caused by the intervention in each item of the Burks Behavior Rating Scale .....	71

# **THE EFFICACY OF PLAY THERAPY PROGRAM IN REDUCING CONDUCT DISORDERS AMONG CHILDREN OF RESIDENTIAL INSTITUTIONS**

**By**

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## **Abstract**

**Background:** Family deprivation is one of the worst experiences a person can have. Children living in residential facilities and separated from their families suffer from many psychological damages. These psychological issues can be reflected in their behavior, leading to conduct disorders.

**Aim:** To identify the conduct disorders of children deprived of their family environment and residing in residential institutions. It also aims to assess the effect of play therapy on these disorders.

**Method:** In this study, we used a quasi-experimental design. It was divided into a control and an experimental group. The Burks Behavior Rating Scale (Arabic version) (Al-Qaryouti & Jarrar, 1987) was administered to the participants. The Play Therapy Program was implemented, and data analysis was conducted using the Statistical Package for the Social Sciences (SPSS), version 24.

**Results:** The results indicated that play therapy is effective in reducing the severity of conduct disorders among children residing in residential institutions.

**Conclusion:** Symptoms of conduct disorders are prevalent among children residing in residential institutions. Effective interventions, such as play therapy, can help reduce these disorders. It is essential to increase awareness in residential institutions, schools, and similar settings about conduct disorders and effective strategies for managing them. This can be achieved through workshops, lectures, and training courses focused on play therapy.

**Keywords:** Conduct disorders; Residential institutions; Play therapy.

# Chapter one

## Introduction

### 1.1 Theoretical Background

Conduct disorders are becoming a significant social issue, especially among children. These disorders manifest in various ways, including issues related to peer relationships, theft, violence, lying, bullying, and other antisocial behaviors (Mahrous & Metwally, 2021). A study by Wolańczyk conducted in Polish primary and secondary schools during the 1999/2000 school year found that 17% of children and adolescents aged 12 to 19 exhibited deviant behaviors compared to their peers (Pawliczuk et al., 2018).

Conduct disorders have recently become a very common social problem, and we also see them in children such as problems related to relationships with peers, theft, violence, lying, bullying and others (Buitelaar et al., 2013). Behavioral problems in childhood often manifest as symptoms of emotional or interpersonal maladjustment, characterized by negative and sometimes unacceptable behavior patterns that are influenced by the social environment (Yavuzer, 2018). Behaviors such as aggression, non-cooperation, inattentiveness to rules, hyperactivity, defiance, conduct problems, and destructive actions are common (Liu, 2004; Olivier et al., 2020; Petersen & LeBeau, 2021).

The National Institute for Health and Clinical Excellence (NICE) in England highlights that conduct disorders are prevalent among children and are the most prevalent mental health issue. Specifically, externalizing conduct problems—which encompass a broad range of disruptive symptoms—are the most prevalent mental health concerns. Negative behaviors, such as hostile defiance, destructiveness, and impulsivity, can disrupt peer relationships, academic performance, and adulthood, potentially limiting opportunities for social and emotional skills acquisition and causing adverse outcomes (Vazifehghelichi, 2023). External behaviors in children may indicate deeper emotional issues, potentially leading to personal and social challenges like substance abuse, school dropout, and criminal involvement (Meany-Walen & Teeling, 2016).

Externalizing behavior problems refer to problematic behaviors children display that negatively impact their environment. These can range from following rules to physically acting out, causing communication issues with family, peers, and teachers. The severity of these behaviors can range from physical aggression to strict rules (CDC, 2022; Liu, 2004).

Petersen and LeBeau (2021) highlight the significant costs externalizing problems impose on families, healthcare, and the educational system. These issues hinder a child's learning and academic achievements, disrupt classrooms, and negatively impact other students' education (Petersen & LeBeau, 2021). Furthermore, childhood externalizing issues can negatively impact a child's later development. Behavioral issues in childhood often indicate subsequent conduct problems and severe mental health issues, including delinquent behaviors, school dropout, violence, drug abuse, and antisocial personality disorder in adolescence and adulthood (Carter et al., 2004; Petersen & LeBeau, 2021).

Research indicates that children with disruptive behaviors may exhibit significant externalizing issues, regardless of their diagnosis of a behavioral disorder (Cooper et al., 2009; Delfos, 2004; Vazifehghelichi, 2023). These behaviors may stem from biological factors, vulnerable developmental phases, or adverse childhood experiences like trauma, negative familial interactions, and socio-economic challenges. Therefore, therapy is necessary for children with disruptive behaviors, even without a specific diagnosis. Given the potential long-term consequences of childhood behavior problems, it is crucial to study the effectiveness of interventions targeting these issues.

The family is the most important social system responsible for the upbringing and care of a child, influencing the child from the moment of birth. Children tend to adopt their parents' values and imitate their behaviors (Nafi, 2020).

A child's health, wellbeing, and education throughout their life are greatly influenced by social determinants, such as living circumstances and the family's sociodemographic makeup, as well as by maternal health, parenting style, interpersonal relationships, and learning environments (Maggi et al., 2010).

Childhood adversities, such as poverty, neglect and abuse of children, family violence, parental substance use, early mental health issues, poor nutrition and health, and growing up in a welfare-dependent household, have a detrimental effect on children's social and cognitive development and have long-lasting effects on their welfare and health as adults (Felitti et al., 1998).

Early childhood is a crucial developmental period that is influenced by a child's continuous interactions and relationships with both their immediate (family) and larger (community) social settings (Dunlop, 2008). Early learning and the interactions between parents have an impact on a child's surroundings. Through accessibility (the amount of time a parent is available to the kid) and engagement (the amount of time a parent spends directly engaging with the child in at-home learning activities like reading or playing), parental participation can result in beneficial outcomes in the development of the child (Wise , 2003). Parents' educational background and socioeconomic standing have been proven to have less of an impact on educational success than the volume of at-home learning activities (Melhuish et al., 2008). Higher intellectual and social/behavioral scores have also been linked to a healthy home learning environment (Sylva et al., 2004).

Healthy development requires that a child grow up in a caring family and a supportive environment that meets their basic living needs from the moment of birth. This helps the child learn the right behaviors, such as proper ways of communicating with others, adapting to their environment, and expressing themselves and their feelings in healthy ways through listening to and being guided by their parents. This may be reflected in their lives in the long run when they grow up and become parents and raise generations or learn different professions, as healthy growth makes them reflect this in a positive way in society and raising their children. Since the brain begins its biological development before birth and continues into adolescence, children who are raised in unhealthy families and environments or are separated from their parents later in life are more likely to experience health, developmental, learning, and behavioral problems. These problems may persist and have a cumulative lifelong effect, which may hinder the ability to fully participate and integrate into society, leading to issues in social status and incompatibility with society, such as behavioral problems (Shonkoff, 2017; Ballan, 2011).

Negative experiences in childhood, such as child neglect, abuse, family violence, parental drug use, parental separation, all have a negative impact on a child's social and cognitive development (Al-Hawyan & Dawoud, 2015).

During times of war, Palestinian children are exposed to many difficult and painful experiences related to their family and community life. This exposure can be direct and personal or indirect, through witnessing others around them facing challenging situations. The impact of violent events on a child depends on the nature of the event and its significance to them. For instance, parents represent security, safety, and love for the child, and the child feels their love when they are present. However, when the family faces problems and disintegration, the child loses this sense of security and experiences increased fear and tension. When a child sees their family going through violent times, it disturbs their sense of security. The issue gets worse when a child misses their family support, like a father or another family member. Consequently, the child may develop a range of conduct disorders (Al-sabbah & Za'oul, 2008).

The risk of developing conduct disorders is high among children in residential institutions. This is because the home environment's conditions differ from residential institutions. Before entering the institution, these children often experience various situations that affect their behavior, such as difficult social and living conditions, weak parenting skills of their biological parents, and exposure to traumatic events (Pawliczuk et al., 2018).

Research indicates that early intervention with disadvantaged and vulnerable children and families positively affects their development into adolescence and adulthood. The benefits of such interventions come from reducing and preventing child abuse or neglect and improving educational outcomes. When children receive support at an early age, the long-term benefits are likely greater (Ibrahim & Muhammad, 2020).

Early childhood interventions are programs designed to enhance the health and development of young children. They may concentrate on preventing problems from arising or on slowing the advancement of issues that have already arisen (Wise et al., 2005). It has been demonstrated that early intervention targeted at underprivileged and vulnerable children and families has a positive impact on children as they enter adolescence and adulthood (Nelson et al. 2012; Schweinhart et al. 2011). According to

the London School of Economics (2007), early intervention can be a cost-effective way to counteract the impacts of disadvantage and produce both social and economic advantages. Reduced interactions with the juvenile and adult justice systems, fewer reports of child abuse and neglect, and better educational and career success are some examples of these advantages (Moore & McDonald 2013). Benefits are expected to be bigger and persist longer for children who get care at a younger age (Heckman 2008; Lee et al. 2012). Heckman (2008) contends that the ideal age for a child to receive support is between 0 and 3 years old, and that this needs to be followed up on in order to yield the highest return on investment.

Approaches to the treatment of externalizing behavior problems vary regarding severity, context, and underlying factors. What adds to the effective intervention literature on children with externalizing problems is the need for parent-training and child-training programs. However, it should be realized that not all children respond to these interventions equitably. However, it is crucial to recognize that not all children respond equally to these interventions. Individual differences and certain specific factors make some children require more or other types of interventions than others. For instance, in cases where there is a high level of disruptive behaviors or serious emotional problems, a strict framework may not work. In the same way, not every parent is always ready or capable of participating in family-based interventions due to a lack of interest, inability to handle tantrums, or because they are too busy. In such cases, a more flexible intervention focused initially on the child may be required. (Eyberg et al., 2008; Vazifehghelichi, 2023).

Behavioral problems are about emotional variables, and the self-regulating capability of our feelings is a very significant contributor to our behavior. Being able to handle our emotions and acting prudently to prevent ourselves from destructive tendencies are some of the features of self-regulation. Children must develop these social-emotional skills for interacting with other children; the skills will include sympathy, social competency, problem-solving, self-understanding, cognitive-behavioral control, and accountability. Besides acting as protective factors, which diminish general difficulties in daily functions and prevent negative behaviors like hostility and violence, the above skills can help in scholarly performance (Vazifehghelichi, 2023).

Play therapy helps the child practice social skills such as cooperation, developing the ability to interact socially and express emotions. It also helps the child solve problems and make decisions and gives the child the opportunity to vent emotionally, which reduces his feelings of tension and anxiety. Play is also important in diagnosis and understanding. By observing the child's interactions, expressions, feelings and thoughts, the therapist can reach a better understanding of the nature of the child's problem (Green & Powell, 2005).

Therefore, positive play activities facilitate expressing the child's thoughts, feelings, and concerns. Therefore, incorporating play as a therapeutic technique can significantly enhance children's ability to self-express (Hall, 2019; Kottman, 2014). The Association for Play Therapy (APT, 1997; Vazifehghelichi, 2023) defines play therapy as the systematic application of a theoretical model to establish an interpersonal process where trained play therapists use play's therapeutic powers to assist clients in preventing or resolving psychosocial difficulties and promoting optimal growth and development. Play's therapeutic powers refer to its ability to facilitate desired changes in a child, and the elements of treatment initiated, supported, or enhanced by play. Research supports the effectiveness of play therapy, with studies showing medium to large effect sizes (O'Connor et al., 2017).

Play is used effectively in treating children with adaptive problems, as play activity is used in a planned manner in order to achieve changes in the child's behavior and personality so that his life becomes happier and more productive (Carmichael, 2006)

Play is a highly effective method for treating conduct disorders as it allows children to express their feelings about conflict, frustration, and psychological tension, which may be challenging to articulate through words. Play, particularly in childhood, is both exciting and joyful for children and occupies a significant portion of their time. Psychologists view play as a crucial means of expression in children's lives, representing their own world and encompassing experiences that foster various aspects of growth, including emotional, social, cognitive, and motor skills, as well as imagination, creativity, and unlimited thinking (Al-Safti, 2021).

The play therapist establishes a nurturing bond with the child through play, fostering unconditional positive regard, empathy, and reflection on their emotions and behaviors (Burgin & Ray, 2022). Through play, the child gains knowledge about the external world, explores their environment, learns about its various elements and stimuli, understands their own roles and those of others, and assimilates the culture, language, values, and morals of their community. Recent studies confirm that children's play is an effective means for achieving comprehensive and integrated development. During play, the mind is exposed to new information, skills, and experiences through various forms of play, which enrich cognitive abilities and develop higher mental functions such as memory, thinking, and cognition (Al-Hawyan & Dawoud, 2015).

Play is both a developmental necessity and a fundamental right for children, serving as their primary means of expression. As a symbolic language, play represents the most powerful form of communication for children (Nussbaum, 2002; UNICEF, 2018; Haight et al., 1999; Landreth, 2012). Through play, children can alleviate distressing emotions, mitigate harmful behaviors, and acquire new skills (Kaminski & Claussen, 2017; Lin & Bratton, 2015; Ray, Armstrong, Balkin, & Jayne, 2015).

The goal of play therapy is to relieve the emotional pain resulting from abuse through various expressive and imaginative tools. In addition, it helps the child in self-expression, and it makes the child recall his hidden emotions and confront them (Kaduson, H; Schaefer, C., 2001) Play therapy can teach the child life skills and new ways to adapt to his environment. Children need help to adapt to their environment, a skill that many children lack, which develops a sense of anxiety in them. Through play therapy, the child projects feelings of tension and anxiety onto dolls and toys. Play therapy also provides the child with the opportunity to discover his readiness to perform tasks (Kotze, 2006).

Child-Centered Play Therapy (CCPT) is a counseling method specifically designed for children aged 3 to 12 that is based on developmental appropriateness. It supports the child's journey toward social adjustment and self-actualization by fostering self-expression and processing experiences within a therapeutic relationship characterized by empathic attunement, unconditional positive regard, and authenticity (Cochran & Cochran, 2017; Landreth, 2012). CCPT fosters a secure environment for children to express their emotions and develop coping strategies through play therapy. This

approach enhances self-efficacy and self-recognition (Hall, 2019). CCPT provides children with autonomy and control, fostering adaptive coping skills, exploration, decision-making, and effective problem-solving in a supportive, non-threatening manner (Hall, 2019).

CCPT is a widely used nondirective approach in childhood mental health counseling, emphasizing the therapist-child relationship as the primary therapeutic agent (Landreth, 2012; Parker et al., 2021; Ray, 2011). Virginia M. Axline developed CCPT before 1947, based on the belief that play is a child's natural medium of self-expression. (Vazifehghelichi, 2023, p. 6). Axline built upon Carl Rogers' nondirective therapy theory to formulate CCPT, which posits that individuals inherently possess the capacity for self-direction and positive growth when provided with the right conditions (Rogers, 1951). Rogers (1951) proposed that children are constantly evolving and have an inherent need for acceptance in relationships within a constantly evolving world of experiences. According to this theory, a child's behavior aligns with their self-concept, shaped by their life experiences. The goal of CCPT is for play therapists to deeply understand the child's perspective and values and to accept the child without imposing solutions or optimism. Through play, the therapist fosters an accepting and caring relationship, employing unconditional positive regard, empathy, and reflections on the child's feelings and behaviors (Burgin & Ray, 2022).

Child-Centered Play Therapy (CCPT) involves play therapists using skills like tracking, content reflection, feelings reflection, and limit setting to establish therapeutic relationships, the essence of this program is that it makes the child feel important (O'Connor et al., 2015). Axline (1947) proposed eight basic principles with which a CCPT therapist ought to work, as identified by Vazifehghelichi (2023). These principles are: (1) being friendly with a child; (2) unconditional appreciation; (3) providing a safe and, at the same time, relatively permissive context that encourages emotional expression; (4) childhood emotion reflection with the further intent of making the child realize his or her feelings; (5) considering the child's problem-solving ability; (6) Avoid interfering with the child's actions unless it is necessary, allowing the child to take full responsibility for their choices; (7) letting therapy sessions go forward at the kid's speed without hurrying; and (8) setting limits only as necessary to adjust the therapy to reality and help the child understand their responsibility in the therapeutic process. According

to Ray et al. (2013), there is evidence to suggest that this intervention is beneficial in mitigating disruptive behaviors as it fosters prosocial relationships, social skills, and self-regulation.

Research on the effectiveness of CCPT hence calls for the use of an appropriate theoretical framework for accurate interpretation of the results. CCPT is based on the person-centered therapeutic orientation that was developed by Carl Rogers (1951) and adapted for play therapy by Virginia Axline (1947) (Vazifehghelichi, 2023). This theory suggests that individuals have an inherent drive to continuously improve and achieve self-actualization throughout their lives.

In person-centered theory, the therapeutic relationship is the primary mechanism of change. The therapist fosters a sense of trust in the child's potential to move toward actualization (Crenshaw & Brown, 2015). Establishing a strong relationship with the child is emphasized in all forms of play therapy, with the primary objective being to create a therapeutic environment where children feel heard, understood, and accepted (Crenshaw & Brown, 2015). Play fosters an accepting and facilitative relationship, allowing children to gain mastery over their experiences and their world. They learn to rely on their own internal evaluations rather than the external negative judgments they may encounter in their environment (Swan & Schottelkorb, 2015).

Conduct disorders may include attention deficit hyperactivity disorder, impulsivity, and stubborn behavior, as these hinder the child's ability to learn, interact well with peers, and harmonize with the surrounding environment. A child who suffers from conduct disorders exhibits unacceptable behavior and experiences deficiencies in the ability to pay attention and focus. He is reckless, nervous, impulsive, and aggressive, does not control his behavior, finds it difficult to stay in his place and follow the rules, and is often busy doing annoying things and speaking in a loud voice. Therefore, it is necessary to pay attention to this group and provide them with intervention programs to modify their behavior in accordance with community standards (Al-Safti, 2021).

Bouchaib (2022) conducted a study to explain the concept of behavioral and emotional disorders in terms of varying significance, types, and causes. The results of this study revealed that behavioral and emotional disturbances represent a deviation from the standards set for normal behavior in terms of their severity, which exceeds the usual

level, as well as the duration of their occurrence, which is characterized by abnormal repetition, stereotypes, and randomness, and in terms of their negative repercussions on psychological and social life. These disorders are often classified as either internal disorders oriented toward the self or external disorders directed toward others. They are also characterized by multiple factors, such as genetic, psychological, and social factors.

In a study done by Fairchild et al. (2019) to establish conduct disorders, it was suggested that conduct disorder is a psychological disorder that can develop mostly in childhood or during adolescence whereby the affected person exhibits aggressive, antisocial behavioral disorder. They often combine with attention deficit hyperactivity disorder, making the patient turn into an antisocial personality disorder as a grown adult. Males are two times more prone to conduct disorder than females, and the condition affects about 3% of school-aged children. The disorder is classified according to the age of onset, either childhood or adolescence, and based on the presence or absence of severe non-emotional features. There are numerous causes of conduct disorder, such as genetic predispositions and environmental factors, as well as a combination of both. It is also associated with neurocognitive impairment.

A study examined by Olivier et al. (2020) analyzed how global and specific behavior problems relate to each other under the scope of student engagement. The study involved students from primary and secondary schools. Global externalizing has been discovered to relate to lower levels of behavioral engagement, whereas global internalizing was found to relate to lower levels of cognitive engagement. Lower levels of emotional engagement were correlated with the specific construct of anxiety, whereas the symptoms of depression were found to lower both the general level and the individual-targeted emotional engagement. Bifactor-CFA analysis and path analyses of bifactor structure were employed in the study. The reported findings most importantly indicate that there is a need to teach these factors to both the educators and the students to promote engagement and general wellbeing.

The study signifies that externalizing behaviors play a huge role in student disengagement during childhood and adolescence, whereas internalizing behaviors become more dominant as the students age.

A study conducted by Abdullah and Aziz (2019) investigated the approaches adopted by parents to manage the conduct disorder observed in adolescents. It was identified that adolescents are more susceptible to conduct disorders compared to the other age groups. Teenagers with this disorder generally denigrate the rights of others or violate laws and social norms. It was established in the study that the prevalence of conduct disorder went up to 12% according to the report of the parents (8% of which were males and 4% females), while according to teachers' reports, it amounted to 7% (6% of whom were males and 1% females). The study also revealed that parents use positive methods, such as participation and positive treatment, more frequently than negative methods like poor supervision, inconsistency, and physical punishment. It was found that the methods of poor supervision and positive treatment explained 10.9% of the variance in the degrees of conduct disorder (according to the parents' questionnaire). Specifically, poor supervision was identified as the best predictor, explaining 5.1% of the variance, while positive treatment explained 0.7% of the variance. According to the teachers' questionnaire, poor supervision was the only significant predictor, explaining 3.4% of the variance in conduct disorder degrees.

Al-Obaidi (2023) also conducted a study on emotional contradiction and its relationship to oppositional defiant disorder among behaviorally disturbed students. The sample consisted of 400 preparatory stage students. The researcher found that 155 male and female students out of the 400 were behaviorally disturbed. The study revealed differences in conduct disorders between males and females, with a higher prevalence in males. Additionally, the study identified emotional contradiction and oppositional defiant disorder among behaviorally disturbed students.

Kaminski and Claussen's 2017 review of psychosocial treatments for disruptive behaviors in children found two treatments, group parent behavior therapy and individual parent behavior therapy with child participation, to be well-established. The review also identified thirteen other treatments as probably efficacious. However, the study found substantial variability in the effectiveness of different programs within the same treatment family, suggesting that a particular level of evidence may not apply uniformly to every program.

The authors highlight the importance of carrying out systematic research on how these interventions are being used, disseminated, and adopted to ensure that children and families receive effective treatments. They recommended that combining the best components of the best approaches might lead to enrollment in more effective therapies.

Vazifehghelichi's (2023) study aimed to implement CCPT in children displaying externalizing behavior issues while helping to foster socioemotional competencies in children aged 3 to 12 years. Using play, CCPT employs nonverbal communication in a way that children and therapists can receive and understand each other and children can feel secure and accepted, hence self-regulating and more manageable behavior can be achieved. A systematic review of the literature was also performed to evaluate the effectiveness of CCPT in the remission of externalizing behaviors and the promotion of socioemotional competencies. Such analysis was carried out on six related studies that were conducted over the last ten years. In the obtained studies, CCPT was effective in the reduction of externalizing behavior problems; however, it was unclear how they presented social-emotional skills. The study confesses such limitations as a small number of studies performed on the topic and a small number of subjects. Nonetheless, it highlights a research gap regarding the effectiveness of child-centered play therapy in addressing both externalizing problems and children's social and emotional functioning.

Swan and Schottelkorb (2015) examined the CCPT procedure for a child with an intellectual disability through a case study (N = 1). A task-analytic method is used to evaluate the effects of the therapist's use of contact reflections on the client's reparation of contact. Measures of both process and outcome were used to distinguish between treatment processes and outcomes. The results showed that the contact work included in CCPT had an impact on the child's usage of contact behaviors as well as the appearance of behavioral issues.

Burgin and Ray's (2022) study examined the efficacy of CCPT for depression in young children in the southwestern United States. The sample size is 71 from five Title 1 elementary schools. Included are African American, Asian American, biracial, Caucasian, and Latino children. Children were randomly assigned to either the control group or the experimental group, which received twice-weekly CCPT for eight weeks. The mood and feelings questionnaire Parent and the Direct Observation Form Sluggish

Cognitive Tempo Scale were used to measure depressive symptoms. The results showed that the CCPT reduced the children's total number of problem behaviors.

Petersen and LeBeau (2021) explored several key questions: (a) whether changes in language ability within a child predict changes in externalizing problems within the same child, (b) whether social skills act as a potential mechanism that explains the link between language ability and externalizing problems, and (c) whether there are sex-related differences in the relationship between language ability and externalizing problems. The study tracked 1,364 children annually from ages 4 to 10. Language ability was assessed using a measure of receptive language (i.e., vocabulary), while externalizing problems were rated by mothers and teachers. Social skills were evaluated by mothers, fathers, and teachers.

A study (Seligman, 1990) aimed to identify the source of depression that affects a number of children in elementary school, where (60) children whose parents were divorced and living separately were followed up, and they were observed for a period of three years, and compared with children living in normal families. Among the results reached by that study were that the children of divorced parents face life with difficulty, and that they are also more sad and more prone to depression than children living in normal families. Also, the children of divorced parents are less successful in school, their self-esteem is lower, and complaints of various physical pains are more common among them than their peers, the children of non-divorced parents.

Camden (2010) conducted a study to identify the behaviors of abused children through play therapy and the content of physical and sexual abuse by comparing two groups of abused and non-abused children. The study sample consisted of (63) children aged between (3-5) years. The results indicated that abused children had a higher level of aggression compared to non-abused children, and that males expressed a higher level of aggression in play sessions compared to non-abused children. Children who were exposed to physical and sexual abuse had higher frequency of emotional arousal compared to non-abused children.

The findings indicated that within-child changes in language ability did indeed predict within-child changes in externalizing problems, even when controlling for the family's income-to-needs ratio. Social skills were found to partially mediate the relationship

between lower language ability and later externalizing problems, although this was primarily observed in between-person effects. There was no suggestion that the association varies based on gender. These results suggest that language ability may influence the development of externalizing issues in both males and females. They also suggest that social skills may be one of the underlying processes explaining this association. It's also possible that language ability, social skills, and externalizing behaviors are all affected by the same underlying factors.

The study (Utting, 1997) aimed to identify the school problems suffered by orphaned children and the causes of these problems, and to compare normal children and orphaned children in terms of academic achievement. The study sample amounted to (200) students from different schools in the city of London, including (100) orphaned students and (100) students living with their families. The results of the study showed that most of the problems faced by orphaned children are represented by inferiority and neglect in school by teachers and students, as well as not taking good care of them academically in the orphanage, in addition to feeling inferior in schools compared to normal children, which makes them exposed to poor school adjustment. This study also showed a significant decrease in academic achievement scores in all subjects among students living in residential institutions compared to students living with their parents.

Stutey et al.'s (2017) study used Adlerian play therapy to reduce externalizing behaviors among African American preschoolers. After seven weeks of individual and group sessions of play therapy, children showed moderate to high effect-size improvements in reducing disruptive classroom behaviors. This paper underlines the importance of Adlerian play therapy for those play therapists working with African American preschool children who are living in poverty. It also emphasizes the necessity of externalizing behavior-threatening interventions and provides some recommendations for future research.

Ray et al. (2017) conducted a study entitled: Child-Centered Play Therapy—Research Integrity Checklist: Development, Reliability, and Use. The purpose was to create a measure that could be used to determine adherence to treatment fidelity. To determine the validity of the measure and establish intrinsic reliability, four experienced CCPT therapists reviewed the literature and observed play therapy sessions conducted by other experienced play therapists. The results revealed a free marginal multi-rater kappa of

0.82, while an intraclass correlation coefficient (ICC) of 0.95 was also obtained. Both constituted very strong consistency and inter-rater reliability among the raters for the Child-Centered Play Therapy-Research Integrity Checklist (CCPT-RIC). Also, CCPTRIC defined verbal categories to allow for research coding as well.

Misurell (2010) conducted a study that aimed to reveal the therapeutic effectiveness of play based on cognitive behavioral theory with children who were exposed to sexual and physical abuse. The study worked to reduce some problems such as anxiety, depression, psychological trauma, behavioral disorder, inappropriate sexual behavior, and low self-concept, in a sample of sexually abused and rough-treated children aged between (5-10) years, numbering (37) females and (23) males. The post-test results showed that the therapeutic program reduced the severity of the problems suffered by these children and improved their social skills and self-perception.

Hall (2019) studied the efficacy of play therapy for use with children who witnessed domestic violence. The study demonstrates the effectiveness of play therapy in treating both externalizing and internalizing issues in children exposed to domestic violence, suggesting the need for child-centered interventions.

Nahwi (2016) conducted a study titled "The Effectiveness of Play Therapy in Addressing Behavioral and Educational Performance Issues in Children." Nahwi's research indicates that play therapy is a highly effective method for engaging children and promoting therapist-child responsiveness. According to psychologists, play therapy is particularly effective, allowing for the diagnosis of disorders and the development of treatment strategies, especially within behavioral and systemic frameworks. Practitioners of play therapy observe positive responses regardless of the type of disorder, highlighting the significance of play in children's lives. Since play is a psychological need, its patterns, methods, models, duration, and type are closely related to the child's psychological, cognitive, social, and linguistic development. Play therapy is a crucial psychological and educational tool that enhances educational performance and addresses behavioral issues in children.

Earls (2009) studied the effect of play group on the development of social skills in African American male adolescents, in the treatment of social relationship disorder and to identify the effect of age and educational level on the results of the therapeutic

intervention. The study sample consisted of (14) adolescents aged between (10-17) years in two groups, each containing (7) adolescents. Social skills were trained through play for one hour per week over ten weeks. The results showed that the therapeutic intervention contributed to improving the level of social skills in adolescents who received play therapy. No differences were found attributable to age or educational level.

Morrison (2009) conducted a case study of a boy who was treated with Adlerian play after experiencing trauma. The therapy provided this boy with the opportunity to express and overcome his painful experience. Through play and the therapeutic relationship, the boy gained an understanding of himself and his experience, and improved his social interest and sense of belonging.

Ray (2008) conducted a study entitled *The Effect of Play Therapy on the Strained Parent-Child Relationship in a Child Mental Health Training Environment*. This study examined the effect of play therapy on the strained parent-child relationship using archival data from (202) children who were counseled and divided into behavioral therapy groups over (74) sessions in a mental health training center. The results showed that this method was effective for children who were diagnosed with internalizing and externalizing behavioral problems, and children who were not classified as having behavioral problems but whose parents requested guidance services. Statistically significant differences were also found due to the length of treatment.

Shaaban (2021) conducted a study to discover the effectiveness of play therapy in reducing the severity of conduct disorders in children with attention deficit hyperactivity disorder (ADHD). The study was applied to a sample of 60 children in the sixth grade of primary school in a special education school in Banha, Qalyubia Governorate, during the academic year 2019/2020. The sample was divided into an experimental group of 30 children who were taught through the play-learning strategy, and a control group of 30 children in the comparative group who received traditional instruction. Both groups were pre- and post-tested using the above-mentioned tools. The statistical analysis of data revealed significant differences between the scores of the experimental group in pre- and post-measurements; post-measurement scores showed an improvement in conduct disorders in children with ADHD. There were also significant differences in post-measurement conduct disorders between the experimental

and control groups, with the experimental group showing favorable conditions. It was recommended that attention should be given to the strategy of learning through play, that it should be included in curricula, particularly in the treatment of conduct disorders in ADHD-diagnosed children, and expanded to various levels and academic subjects.

Ibrahim and Muhammad (2020) examined the effectiveness of a training program using kinematic rhythm to reduce certain behavioral disorders in children with hyperactivity disorder and attention deficit. The researchers employed an experimental method with a sample of children from the kindergarten at Nour Islam Primary Model School in the new administration of Damietta, under the central administration of Damietta institutes. The study involved 16 children, divided into two groups: an experimental group (8 children) and a control group (8 children). Another exploratory sample was randomly selected, comprising six children from the same research population and within the same age group.

The key findings of this study indicated that the training program using motor rhythm proposed in the current study was effective and had a positive statistical effect in modifying attention disturbances among kindergarten children.

Benseghir and Hamdi's (2023) study examined the effectiveness of play therapy in reducing behavioral problems in children with ASD. The sample included ten children aged 6–8 years selected from an Autism Center in Algeria. Therapeutic games were incorporated into the play therapy intervention to improve social interaction, motor skills, communication, focus, and attention. In addition, the severity of the behavioral problems was assessed using the Childhood Autism Rating Scale before and after the treatment. This indeed showed a considerable difference between the pre-and post-intervention CARS scores, with a statistical decrease in scores. Therefore, play therapy was very effective in reducing behavioral problems in children with ASD as an intervention strategy.

Shahabizadeh and Toozandehjani (2016) studied how well child-centered play therapy worked in decreasing behavioral disorders in primary school children. The sample size included 30 children with behavioral disorders who were referred to the Center for Counseling and Psychological Services in Mashhad. They were then divided into an experimental and a control group randomly, with 15 children in each group. For the

experimental group, 12 sessions of child-centered play therapy were held, while the control group did not receive any treatment. The results showed a significant decrease in the scores of behavioral disorders in the experimental group compared to the control group. Child-centered play therapy, according to this study, is therefore effective in reducing the incidence of behavioral disorders among children in primary school.

A study (McClure et al., 2007) entitled "Cooperation, Conflict, and Cooperation Responses in Adolescents with Mood and Anxiety Disorders". It aimed to examine and test models of emotional and behavioral responses to conflict and cooperation in adolescents with mood disorders and anxiety disorders with a group that does not suffer from these disorders. The study tool was a comparison of the achievement of emotional responses between the two groups on a game that includes competitive and cooperative responses. The study sample consisted of two groups: the first group consisted of 21 adolescents with depression and anxiety disorders, and the second group consisted of 29 adolescents without these disorders or any other disorder. The results of the study showed that: adolescents with mood and anxiety disorders were significantly more likely to have a play pattern and emotional responses to the game than the comparison group; adolescents with mood and anxiety disorders responded significantly more cooperatively to cooperative offers from their playmates; females with mood and anxiety disorders reported more angry responses toward their playmates than females in the comparison group; and adolescents with mood and anxiety disorders, especially females, responded particularly well to stressful social exchange situations.

Parker et al.'s (2021) meta-analysis examined child-centered play therapy as an intervention for disruptive behavior among children. The study reviewed data from 23 studies with 908 participants. These studies used waitlist controls in which no treatment was given and alternative treatment comparisons. Results showed a medium Hedges's effect size for externalizing and overall problem behaviors versus the alternative treatment and waitlist controls, while small Hedges's effect sizes were found in the case of aggressive behaviors. The present study underlines the efficiency of CCPT in behavioral disorders and also makes some recommendations concerning the treatment of childhood behavioral disorders.

In a study conducted by Darwish et al. (2022), they tried to establish whether play therapy would be effective in reducing behavioral disorders among children. The sample included 28 children, aged from 7 to 9 years. Results showed a decline in the severity of behavioral disorders after treatment with play therapy. Scientific theories and techniques used in the study looked into different aspects of the child's personality in cognitive, emotional, and behavioral dimensions.

Mercan and Özdemir's study (2023) tries to measure the effectiveness of play therapy in decreasing behavioral problems among five- and six-year-old Istanbul children. The sampling includes 20 children from socioeconomically disadvantaged families receiving counseling at a primary school play therapy room. Data about family assessment were obtained from parents through the "Social Competence and Behavior Evaluation-30 Scale" form and a pre-interview form. The data revealed that all three subscales—socially competent, anger-aggression, and anxiety-withdrawal—improved significantly on a pre-post basis. Post-test comparisons, however, revealed only social competence to show a significant difference, while the anger-aggression and anxiety-withdrawal subscales did not indicate any significant changes.

In a related study, Abdelfattah (2016) investigated a play therapy program for the reduction of some behavioral disorders among autistic children in the United Arab Emirates. The paper aimed to design a play therapy program and a behavioral disorder index questionnaire to collect teachers' opinions about the effect of the program on reducing these disorders after conducting the therapy sessions.

Moreover, the social behavior assessment list was prepared to assess the social behaviors of children with autism, observed by their teachers at their specialized center.

A behavioral disorders scale for autistic children was also developed to identify and assess the severity and prevalence of different behavioral disorders among these children. Furthermore, a form was prepared to assess the cultural, economic, and social background of the families, focusing on children aged 9 to 13 years.

The researcher adopted an experimental methodology, where the play therapy program (independent variable) was tested against the behavioral disorders of autistic children (dependent variable). The sample was selected from the Gulf Autism Center in Abu

Dhabi, with the training program lasting six months, consisting of two sessions per week. The sample included 20 autistic children with an average age between 9 and 13 years, divided into an experimental group of 10 children, a control group of 10 children, with an additional exploratory sample of 15 children.

Using various research tools administered to teachers of both groups before and after the intervention, the researcher analyzed the results with the help of statistical tests such as the t-test for mean differences, the SPSS software (version 7.55), Cronbach's alpha, the MannWhitney test for independent samples, the Wilcoxon test, and Pearson correlation coefficient.

The study found statistically significant differences between pre- and post-test scores in the experimental group regarding self-harm, temper tantrums, aggressive behavior, communication deficits, hyperactivity, and inattention. Significant differences were also found between the experimental and control groups. Obvious improvements in communicating with siblings, using language, and playing behaviors, through which children could express their fancies and tendencies more naturally, were brought about by the intervention of play therapy.

The study also evidenced less aggressive behavior, more ability to involve with peers and a better way of expressing anger without self-injury. Such improvement came because the children stopped being self-centered and began expressing themselves with others and their environment, hence proving that the play therapy program was effective in reducing behavioral disorders.

The study was conducted on vocational high school students to reduce aggressive behavior and develop psychological adjustment for students through the usage of play therapy. The sample included 60 students, 30 students in an experimental group, and 30 in a control one. Participants were from the second year of vocational high school at Abutiej Secondary Industrial School in Assiut. Participants' ages range from 16 to 18 years, with a mean of 17.1 and a standard deviation of 0.82. Several tools were used, such as the socioeconomic and cultural level scale, the Stanford-Binet Intelligence Scale, the aggressive behavior scale, the psychological adjustment scale, and the play therapy program developed by the researcher. Data are statistically analyzed using SPSS. Results revealed that the play therapy program decreased aggressive behavior for

students participating in the experimental group and enhanced psychological adjustment.

Furthermore, Cornell et al. (2018) conducted a study on play therapy for students with conduct disorders, presenting results from a systematic review of the literature that examined published study results on play therapy-based interventions for children and youth with conduct disorders, specifically ADHD. The study was guided by the research question: What is the current evidence for using play-based interventions to improve outcomes for students with ADHD? The results indicate that there is a positive effect of play-based interventions for students with conduct disorders. Although the results indicate that play therapy-based interventions for students with conduct disorders cannot be considered an evidence-based practice, it appears to be a promising practice.

Children residing in residential institutions are considered family-deprived. Every child deprived of appropriate family care lacks the necessary support to satisfy their needs. Deprivation is linked to the concept of comprehensiveness, which normatively relates to the type and degree of satisfaction of the child's various needs. This deprivation may result from the loss of a father, mother, or both, or it may exist despite the presence of parents, stemming from the parents' inability to lead a normal life. This situation often leads to the end of the relationship and the permanent exchange of affection with the parents.

Consequently, separation leads to deprivation, prompting the child to move to an alternative family or a residential institution where they receive full care and the opportunity to interact with others (Nafi, 2020).

Al-Enezi and Sayer (2019) conducted a study titled "The Effectiveness of Counseling Program in Reducing Some Conduct Disorders Among Family-Deprived Children in the State of Kuwait." The purpose of the study was to identify conduct disorders in Kuwaiti children who were not raised in a family and to create a counseling program to lessen the severity of these disorders and their effects. A sample of twenty children who were deprived of their families was divided into an experimental group and a control group using a quasi-experimental methodology. Measures of aggressive behavior and social anxiety were used in the study, along with a therapeutic counseling program aimed at lowering conduction disorder problems in the children. The results showed that

there were statistically significant differences in the average scores of the control and experimental groups in the post-measurement of the two scales after the application of the therapeutic program to the experimental group. The average ranks indicated no significant difference at the level of the experimental group's scores in the post- and follow-up measurements on the aggressive behavior and social anxiety scales.

Bulbazin and Assous (2018) developed the study to describe the variables that contributed to the development of psychological and behavioral disorders in children who suffer daily from a father addicted to alcohol and drugs.

Their research also shed light on the impact of these psychological and behavioral conditions on the child's personality during adolescence and adulthood. The results indicated that a child living in a tense and negative atmosphere often experiences a sense of inferiority, loss of self-confidence, and dissatisfaction. Such children are frequently afflicted with feelings of fear, inner anger, and extreme sadness, and there is a high probability that they will neglect their studies, potentially leading to school failure.

Furthermore, their behavior may become withdrawn, escapist, suicidal, or deviant.

## **1.2 Problem Statement**

Many studies have explored conduct disorders across various variables, yet there is a noticeable lack of research that directly addresses conduct disorders among children residing in residential institutions in Palestine`. It is well-known that children living in residential institutions often face extremely challenging circumstances, which can lead to severe conduct disorders.

Family issues, especially when accompanied by aggression and violence, have a profound impact on an individual's behavior, disrupting their natural thought processes and often leading to various conduct disorders. Consequently, children in residential institutions frequently suffer from such disorders, and if left untreated, the severity can escalate, potentially leading to violent behaviors. Therefore, these children may require psychological support and therapy that take into account their living conditions within the institution.

I used to work in one of these institutions and during my work I observed the absence of a play therapy program, which sparked my curiosity to explore the conduct disorders present and to implement a play therapy program to address them. This study, therefore, aims to identify the conduct disorders among children residing in residential institutions in Taybeh, Palestine, and to evaluate the effectiveness of play therapy in treating these disorders. The central research question that arises is can play therapy successfully treat or reduce behavioral disorders among children residing in residential institutions?

### **1.3 Study Hypotheses**

There are statistically significant differences at the 0.05 level between the mean scores of the group members in the pre- and post-measurements on all dimensions of the conduct disorders scale and the total score of the scale, in favor of the post-measurement.

### **1.4 Significance of the Study**

Children who live in residential institutions are often victims of circumstances beyond their control, leading to a life that differs significantly from that of their relatives, schoolmates, and other children. This disparity can diminish their self-confidence and increase their vulnerability to behavioral problems. Therefore, it is crucial to focus on this group of children and address their needs by providing care, fostering self-development, and building their self-confidence.

This research is of great importance as it aims to treat and improve the behavior of these children, making them happier, more comfortable, and better able to understand themselves. Additionally, it benefits the staff working in these institutions by potentially easing their challenges in managing children with conduct disorders. Improving the behavior of these children not only supports their individual well-being but also contributes to building a safer and healthier society.

### **1.5 Objectives of the Study**

The general objective of the study is to apply play therapy to children with conduct disorders. The specific sub-goals are:

- To treat conduct disorders by implementing a play therapy program and effectively manage these disorders.

- To enhance cooperation and interdependence among children residing in the institution through the application of play therapy.

### **1.6 Aim of the Study**

The aim of this study is to use play therapy to reduce conduct disorders among children residing in residential institutions.

### **1.7 Research Question**

Can play therapy successfully treat or reduce behavioral disorders among children residing in residential institutions?

## **Chapter Two**

### **Method**

#### **2.1 Study Design**

An experimental design was employed, featuring an experimental group in which each participant engaged in the same intervention program. Social functioning skills were assessed for each participant both before and after the intervention.

#### **2.2 Participants**

The study sample comprised 30 children diagnosed with conduct disorders, residing in a residential institution in Al-Taybeh, Palestine. The sample included 17 females and 13 males (56.7% and 43.3%, respectively), aged between 7 and 14 years. The institution was selected because it is the only one in the region, housing children from various cities and villages.

The children were randomly assigned to two groups. Random assignment was achieved by numbering the children sequentially and assigning them alternately (e.g., the first child was assigned to Group 1, the second child to Group 2, the third child to Group 1, the fourth child to Group 2, and so on). Each group consisted of 15 children. Measurements were taken both before and after the intervention for both groups.

#### **2.3 Sampling Technique**

A visit to the residential institution was conducted to select participants. A list of children aged 7 to 14 years residing in the institution was created. From this list, 30 children were randomly selected using a systematic sampling method: one child was chosen out of every three children on the list.

#### **2.4 Measures**

Before and immediately after the intervention, counselors working with children in the residential institution were asked to complete a self-report questionnaire about the children.

This questionnaire consists of two parts: the first part collects socio-demographic information about the children, and the second part involves the Burkes Behavior Rating Scale, translated into Arabic (Al-Qaryouti & Jarrar, 1987).

The Burkes Behavior Rating Scale is useful for identifying problem behaviors in children and enumerates 19 patterns, such as excessive anxiety, self-blame, weak physical strength, weak ego strength, poor sense of identity, and poor control of anger. Each dimension of the scale can be used to identify specific problems in children. The scale is applicable to children in primary and preparatory stages, typically ages 6 to 15.

**Application and Correction Instructions:** The scale is noted for its ease of application, as it does not require extensive training. Teachers, psychologists, or social workers can apply it without special training, and the process is relatively quick, taking about 30 minutes. The scale is not administered directly to the child; instead, data are collected from individuals familiar with the child, such as parents or teachers, eliminating the need to place the child in a test situation.

**Table 1***Interpretation of Scale Results*

Dimension	Not significant	Significant	Highly significant
Excessive Self-Blame	5 – 10	11 - 17	18 - 25
Excessive Anxiety	5 – 10	11 - 17	18 - 25
Excessive Withdrawal	6 – 12	13 - 21	22 - 30
Excessive Dependency	6 – 12	13 - 21	22 - 30
Poor Ego Strength	7 – 14	15 - 24	25 - 35
Poor Physical Strength	5 – 10	11 - 17	18 - 25
Poor Coordination	5 – 10	11 - 17	18 - 25
Poor Intellectual	7 – 14	15 - 24	25 - 35
Poor Achievement	5 – 10	11 - 17	18 - 25
Poor Attention	5 – 10	11 - 17	18 - 25
Poor Impulse Control	5 – 10	11 - 17	18 - 25
Poor Reality Contact	8 – 16	17 - 28	29 - 40
Poor Sense of Identity	5 – 10	11 - 17	18 - 25
Excessive Suffering	7 – 14	15 - 24	25 - 35
Poor Anger Control	5 – 10	11 - 17	18 - 25
Excessive Sense of Persecution	5 – 10	11 - 17	18 - 25
Excessive Aggressive	6 – 12	13 - 21	22 - 30
Excessive Resistance	5 – 10	11-17	18-25
Poor Social Conformity	8 – 16	17 - 28	29 - 40

**2.5 Validity and Reliability of Burks Behavior Rating Scale**

The Burks Behavior Rating Scale is validated and reliable for assessing symptoms of conduct disorders. The scale has demonstrated strong reliability and internal consistency. Results indicate that parent ratings across all scales were positively correlated (average  $r=0.37, p<0.01$ ), and teacher ratings were also positively correlated (average  $r=0.27, p<0.01$ ). These correlations underscore the scale's effectiveness in evaluating conduct disorders, as confirmed by both English (Edelbrock & Reed, 1983) and Arabic references (Al-Qaryouti & Jarrar, 1987).

## **2.6 Intervention**

### **2.6.1 Therapeutic Program**

The therapeutic program was developed by the researcher based on insights from previous studies. It was implemented at the residential institution in Al-Taybeh, where the researcher visited approximately six months prior to the program's initiation to familiarize themselves with the children. Before starting the program, written consent was obtained from both the director of the institution and the counselors, confirming their approval for the children to participate.

The program, which is grounded in play therapy, comprises 10 sessions, each lasting approximately one hour. The sessions are designed to address topics related to conduct disorders, with the goal of mitigating these issues through structured play-based interventions.

**Table 2***Play Therapy Intervention*

Session Number	Title of the Session	Target	Tools
1	Acquaintance	Introduction and acquaintance	Ball of wool
2	Break the Barriers	Enhancing self-confidence, interacting with others, enhancing energy to carry out normal activities, and adjusting voluntary muscles and sense organs	Balloons, wool threads
3	Cooperation with Others	Interdependence and cohesion, learning to cooperate, enhance focus and attention, and adjusting activity	Cups, wool threads, computer
4	Diversity	Developing a sense of identity, respect for the demands of the other, and social compliance	Papers, pens, timer
5	Social Skills	Developing communication strategies, respect for the demands of the other, and social compliance	Pens, papers, box, timer
6	From Pairs to Quadruplets	Focusing attention on the speaker, showing listening in a nonverbal way, and understanding others without arguing	Timer, sentiment cards
7	Emotional Catharsis	Adjusting feelings of anger and emptying negative feelings	Paper, chopsticks, headphone
8	Honesty	Promoting contact with reality and social compliance	Computer, answer cards (true/false)
9	Forgiveness of Wrongdoer	Emotional relief and tolerance the	Paper, watercolor, chopsticks
10	Conclusion achievements	Reevaluation and investigation of and Farewell	Wool ball, rating scale

- **Session 1: Acquaintance**

**Session Goal:** To introduce the researcher to the children and establish a positive relationship with them.

**Tools:** Ball of wool.

The aim of this session was to break the ice between the researcher and the children while clarifying the program's objectives and rules. The session featured an activity involving a ball of wool. The children sat in a circle on the ground, and the ball of wool was passed around to create a web-like structure. Each child, upon receiving the ball, shared an attribute they like about themselves and one they dislike. After all members had participated, they stood up while maintaining the structure of the web. The researcher then used verbal cues ("number 1" and "number 2") to direct the group:

"number 1" signified moving backward to tighten the web, while "number 2" signified moving forward to loosen it. Mistakes resulted in elimination from the game.

At the end of the session, the researcher summarized the activities, shared feedback, and encouraged open discussion to further build rapport and clarify any uncertainties.

- **Session 2: Brake the Barriers**

**Session Goal:** Enhancing self-confidence, interacting with others, enhancing energy to carry out normal activities, and adjusting voluntary muscles and sense organs.

**Tools:** Balloons and wool threads.

The session begins with each child sharing their feelings and experiences from the day. The researcher then explains the activities planned for the session.

1. **Balloon War:** Each balloon is inflated and tied with a rope, ensuring the rope is at least 50 cm long. The balloons are then tied to the participants' ankles. When the activity starts, each participant's goal is to pop the balloons of others while protecting their own. The winner is the child whose balloon remains intact.
2. **Balloon Race and Support:** The group is divided into pairs. A balloon is placed between each pair, which must be held in place without using hands. The pairs race back and forth, and the pair that drops the balloon is disqualified. The winning pair is the one that completes the race in the shortest time without dropping the balloon.

At the end of the session, the therapist summarizes the activities and facilitates a discussion to share opinions and feedback.

- **Session 3: Cooperation with Others**

**Session Goal:** Interdependence and cohesion, learning to cooperate, enhancing focus and attention, and adjusting activity.

**Tools:** Cups, wool threads, and computer.

At the beginning of the session, each child shares their feelings and how their day was. Next, we watch a video about the theme of the session, which is cooperation. The researcher then explains the activities that will be performed.

**Cups Activity:** The children are divided into two groups, each with 6 cups and woolen threads. The threads are tied to form a circle around the cups. The goal is for the group members to cooperate in arranging the cups using the threads. One member from each group is secretly instructed to sabotage the group's efforts and not cooperate, without the rest of the group knowing.

At the end of the session, the therapist summarizes the meeting and facilitates a discussion where participants share their opinions.

- **Session 4: Diversity**

**Session Goal:** Developing a sense of identity, respect for the demands of others, and social compliance.

**Tools:** Papers, pens, and timer.

At the beginning of the session, each child shares their feelings and how their day was. The researcher then explains the activities planned for the session.

**Moving Paper:** Each child receives a sheet of paper and either draws or writes something that expresses their feelings or interests. Once the timer is set and the activity begins, each child passes their paper to the person next to them. The next person adds to or modifies the drawing or writing based on what they see. When the paper returns to its original owner, each child explains what they observed and liked about the changes made by others.

At the end of the session, the therapist summarizes the meeting and facilitates a discussion where participants share their opinions.

- **Session 5: Social Skills**

**Session Goal:** Developing communication strategies, respecting others' demands, and enhancing social compliance.

**Tools:** Pens, papers, box, and timer.

At the beginning of the session, each child shares their feelings and how their day was.

The researcher then explains the planned activities.

**Social Wish Box Activity:** Each child writes on a piece of paper what they would like to see changed in their social status. The papers are placed in a box, which is sealed and reopened only during the final discussion meeting.

**With and Counterclockwise:** The group is divided into two circles—an inner ring and an outer ring—facing each other. The therapist starts with a sentence prompt, and each participant must quickly complete it and discuss their response with the person opposite them. After each prompt, the therapist signals for participants to switch chairs: the inner ring moves to the right, and the outer ring moves to the left. The therapist then starts a new sentence prompt, and the process continues. Example prompts include “I would like to...,” “I am not in the mood for...,” “An adjective that distinguishes me is...,” “I would like to study in the future...,” “I get angry when...”

Finally, the group returns to the Social Wish Box to discuss the contents and whether the activities addressed any of the wishes.

At the end of the session, the therapist summarizes the meeting and facilitates a discussion where participants share their opinions.

- **Session 6: From Pairs to Quadruplets**

**Session Goal:** Focus attention on the speaker, showing listening in a nonverbal way, and understanding others without arguing.

**Tools:** Timer and sentiment cards.

The session begins with each child sharing their feelings and how their day was. The researcher then explains the activities for the session.

**Listen to Talk Activity**

**Step 1:** The class is divided into pairs, labeled as Number 1 and Number 2. Number 1 speaks on a specific topic for one minute (e.g., "my negative behavior," "situations I can't handle," "situations that frustrate me"). Number 2 listens without interrupting, asking questions, or making observations.

**Step 2:** After Number 1 finishes, they select a sentiment card to express their feelings about how well they felt listened to by Number 2. Did they feel genuinely heard? Was there any body language indicating active listening? Students then switch roles.

**Step 3:** The activity expands by combining two pairs into a group of four. Each student speaks for one minute, and afterward, everyone in the group shares their thoughts on how the group listened. Each member comments on whether the speaker made them feel personally addressed.

### **Listening and Clarification Questions Activity**

**Step 1:** Students are again divided into pairs. Each pair discusses three topics that have been on their minds recently. Number 1 shares their thoughts (for 1-2 minutes), while Number 2 listens and asks clarification questions (e.g., "Why does this situation worry you?" "How do you feel when this happens?" "Do you intend to get rid of this anxious fear?") Without sharing their personal opinion.

**Step 2:** After the discussion, students switch roles. Some students may present their partner's concerns to the group based on their understanding. The partner then provides feedback on how well their position was understood, using the sentiment cards to indicate their feelings.

At the end of the session, the therapist summarizes the meeting, encouraging participants to share their opinions and reflections on the activities.

- **Session 7: Emotional Catharsis**

**Session Goal:** Adjusting feelings of anger and emptying negative emotions.

**Tools:** Paper, chopsticks, and headphones.

The session begins with each child sharing their feelings and how their day has been.

Following this, the researcher explains the activities planned for the session.

## **Paper Shredding Activity**

Each participant is given a sheet of paper. They are instructed to imagine a situation, person, or event that has caused them harm or distress. The children then express their emotions by symbolically representing the situation or person on the paper, which they proceed to shred.

## **Relaxation and Meditation**

After the shredding activity, the children engage in a guided relaxation and meditation exercise. This helps them calm down, process their emotions, and return to a state of equilibrium.

At the end of the session, the therapist summarizes the meeting, inviting participants to share their thoughts and feelings about the activities.

### **• Session 8: Honesty**

**Session Goal:** Promoting contact with reality and encourage social compliance.

**Tools:** Computer and answer cards (True/False).

The session begins with each child sharing their feelings and discussing how their day has been. Following this, the group watches a video focused on the theme of honesty. The researcher then explains the activities for the session.

### **Challenge Questions Activity:**

1. The activity starts with simple, factual questions to engage the children and introduce the concept of truth versus falsehood. For example:

- "Is the sum of four and three fifteen? True or False?"
- "Is the sea green? True or False?"
- "Is the sun yellow? True or False?"

2. After these straightforward questions, the activity transitions to behavior-related questions, designed to help the children distinguish between truth and lies:

- "I point to my feet. Is this my hand? True or False?"

- "The chicken is bigger than the elephant. True or False?"
  - The questions are simple and lead into a discussion about lying. The researcher explicitly asks the children, "Do you know what the person who lies is called?" and the children respond, "A liar."
3. For example:
- The researcher throws a ball away and asks, "I didn't move the ball. True or False?" The children identify this as a lie.
  - The researcher leaves a water tap open and then claims, "I didn't leave the water tap open. True or False?" The children again identify this as a lie.
4. The activity progresses to real-life scenarios, such as taking money from the table, and the children are asked to determine whether the statement is true or a lie.

At the end of the session, the therapist summarizes the meeting and invites the children to share their opinions and reflections on the activities.

- **Session 9: Forgiveness of the Wrongdoer**

**Session Goal:** Emotional relief and tolerance.

**Tools:** Paper, watercolor, and chopsticks.

The session begins with each child sharing their feelings and discussing how their day has been. After this, the researcher explains the activities for the session.

**Tear and Beautify the Paper Activity:**

- Paper and chopsticks are distributed to each participant. The therapist asks each child to silently recall a situation or person that has deeply annoyed or hurt them, and to imagine that the paper represents this situation or person.
- The participants are then instructed to tear the paper into pieces using the chopsticks, symbolizing the release of their negative emotions associated with the memory. Afterward, the therapist asks each participant to reflect on how they feel after tearing the paper.

- Following this, the participants are encouraged to "beautify" the torn paper by drawing or coloring on it, transforming the torn pieces into something more positive. In the end, each participant shares their transformed paper with the group, describing what it represents to them and how they feel about it now.

At the end of the session, the therapist summarizes the meeting, invites the children to share their opinions, and reflects on the emotions and lessons from the activity.

- **Session 10: Conclusion and Farewell**

**Session Goal:** Reevaluation and investigation of achievements.

**Tools:** Reevaluation activities and group discussion.

The session begins with a repetition of the wool ball activity from the first session. Each participant sits in a circle, passing the ball of wool around as they did initially. This time, as they receive the wool, each person reflects on what has changed in their personality during the course of the program and shares an achievement they are proud of.

- **Program Reevaluation:** Following the wool ball activity, the group engages in a discussion to evaluate the overall treatment program. This includes a review of the sessions, group discussion on the experiences and outcomes, and the application of post-measurement tools to assess progress.
- **Closing Party:** The session concludes with a closing party, celebrating the participants' progress and the bonds formed during the program. This final gathering serves as a positive closure to the therapeutic journey.

At the end of the session, the therapist ensures that all participants have the opportunity to share their thoughts and feelings, reinforcing the sense of accomplishment and closure.

### **2.6.2 Program Philosophy**

The philosophy of this program is grounded in the diagnostic and statistical manual of mental disorders outlines criteria and classifications for diagnosing and treating mental health issues - Fifth Edition (DSM-5), which addresses various aspects of conduct disorders such as assaults on people and animals, destruction of property, deception or theft, and gross violations of rules.

The program also draws from the perspective that play therapy serves as a powerful approach to gaining a deeper understanding of a child's life. By utilizing play activities in a structured and intentional manner, play therapy facilitates significant changes in a child's behavior and personality. It effectively alleviates emotional pain caused by abuse through various expressive and imaginative tools. Moreover, play therapy helps the child express himself, confront and overcome their fearful feelings, and address their problems. Through these play tools; children can more effectively channel their anxiety, fear, and guilt into the activities, rather than projecting these emotions onto people.

### **2.6.3 The Importance of the Program**

The importance of the program is underscored by previous studies that have confirmed the significant impact of play therapy in addressing and developing various aspects related to conduct disorders.

### **2.6.4 Program Goals**

**General Goal:** To reduce conduct disorders in children aged 7-14 years residing in residential institutions.

**Procedural (Sub-goals):** The training program aims to achieve the following objectives:

- Enhancing self-confidence.
- Improving the ability to control feelings.
- Developing social skills.
- Fostering respect and acceptance of others.

### **2.6.5 The Content of the Program**

The program content translates its objectives into activities and events through which participants learn targeted behaviors, ensuring these behaviors are adopted rather than merely understood.

To achieve the program's primary and secondary objectives, the content was designed with the following considerations:

- All activities align with the previously identified program objectives.
- Activities require group interaction, ensuring all participants have the opportunity to engage.
- Play activities are tailored to the children's ages, challenging but not overwhelming them, and preventing boredom.
- Immediate feedback is provided to children regarding their behavior during play and sessions, whether the behavior is appropriate or not.

**Sessions:** The program consists of 10 sessions, spanning approximately a month and a half, with two sessions per week, each lasting about an hour.

**Training Environment:** Sessions are conducted in the institution's events room, which has been modified to create a more comfortable and enjoyable setting.

**Training Method:** The program employs group training methods.

**Techniques Used in the Program:** The program utilizes several behavior modification techniques, including positive reinforcement, negative reinforcement, punishment, modeling, and gestures.

- **Positive reinforcement:** The child receives a reward or praise in response to appropriate behavior, encouraging repetition.
- **Negative reinforcement:** The child experiences a form of punishment or reprimand for negative behavior, discouraging its recurrence.

- **Punishment:** A crucial technique across age stages, punishment helps reinforce the consequences of inappropriate behavior.
- **Modeling:** The trainer demonstrates a specific activity or behavior, which the child observes and then imitates.
- **Gestures:** Facial expressions or specific movements are used to signal to the child what they should do in certain situations.

#### **2.6.6 Inclusion and Exclusion Criteria**

The study included children residing in the residential institution in the city of Al-Taybeh. However, new children who had been at the institution for less than 6 months were excluded. Additionally, children for whom counselors found it difficult to complete the questionnaire were excluded due to the inability to accurately assess their behavior.

#### **2.6.7 Program Application Procedures**

The program was implemented through several stages. Initially, a pre-assessment was conducted to measure the children's behavior using the Burks Behavior Estimation Scale. Following this, the program was applied after ensuring that the plan was appropriate for the target group and aligned with the institution's regulations. Necessary approvals were obtained to proceed with the implementation. The program was then administered to the children with two sessions per week, each lasting about an hour, over a period of a month and a half. Finally, a post-assessment was conducted to re-measure the children's behavior immediately after completing the program.

#### **2.6.8 Data Collection Process**

I visited the institution in the city of Al-Taybeh and met with the entire professional team working there. During this meeting, I provided a thorough explanation of the purpose and nature of the research, and I distributed the assessment scale and treatment program to all members. After obtaining their consent to participate, we randomly selected the children who would be part of the study. The names of the selected children were then assigned to their respective guides, each of whom was responsible for a group of children participating in the treatment. The guides were tasked with filling out the scale for each child under their care. To ensure accuracy, it was agreed that the

questionnaire would be converted into an electronic format and distributed to the guides for completion.

### **2.6.9 Study Variables**

The study focused on several key variables. The dependent variable was the symptoms of conduct disorders, as measured by the Play Therapy Program. The independent variables included the children residing in the residential institutions and various socio-demographic factors.

### **2.6.10 Statistical Analysis**

The data were entered into IBM SPSS v.22.0. Descriptive statistics like frequencies (n), percentages (%), mean  $\pm$  standard deviation (SD), median with the interquartile range (IQR = upper quartile “Q1” and lower quartile “Q3”) were generated. Because of the small sample size, nonparametric inferential tests were used to analyze the data. To determine statistically significant differences in proportions of the paired data (pre-intervention and post-intervention), the McNemar’s test was used. The pre-intervention and post-intervention paired scores were compared using Wilcoxon rank-sum test. A p of  $< 0.05$  was considered statistically significant.

Due to the small sample size, nonparametric inferential tests were employed for data analysis. The McNemar’s test was used to identify statistically significant differences in proportions of paired data (pre-intervention and post-intervention). Additionally, the Wilcoxon rank-sum test was applied to compare the paired scores from pre-intervention and post-intervention. A p-value of less than 0.05 was considered statistically significant.

## **2.7 Ethical Considerations**

The research received Institutional Review Board (IRB) approval from An-Najah National University prior to its commencement, with approval number Jan. 2023/4. Additionally, permission was obtained from the residential institution's director and guides (see Appendix B). The purpose of the study was explained, and assurances were given that the collected data would be used solely for the study's purposes. The research protocol included specifying the date and time of data collection, and measures were taken to ensure confidentiality and anonymity in the responses.

## Chapter Three

### Results

#### 3.1 Characteristics of the Participants

This intervention study included 30 participants. The mean age of the participants was  $10.3 \pm 2.1$  years, with a median age of 10.0 years (IQR = 8.8, 12.0 years). Among the participants, 17 (56.7%) were 10 years old or younger, 17 (56.7%) were female, and 24 (80.0%) had parents who were either separated or had one parent deceased. The remaining 6 participants (20.0%) had parents who were currently married and living together. The detailed characteristics of the participants are presented in Table 3.

**Table 3**

*Characteristics of the Participants*

Variable	N	%
Age (Years) $\leq 10$	17	56.7
> 10	13	43.3
Gender Male	13	43.3
Female	17	56.7
Marital Status of the Parents Currently Married and Living Together	6	20.0
Not Living Together (Separated/Deceased)	24	80.0
Total	30	100

#### 3.2 Effects of the Intervention on Participants' Behaviors as Measured by the Burks Behavior Rating Scale

When comparing the different domains of the Burks Behavior Rating Scale before and after the intervention, the McNemar Test showed that the intervention significantly improved the participants' behaviors across various domains. Table E1 in Appendix E highlights the improvements observed in specific domains, including excessive self-blame, excessive anxiety, excessive withdrawal, excessive dependency, poor ego strength, poor physical strength, poor coordination, poor intellectual abilities, poor achievement, poor attention, poor impulse control, poor reality contact, poor sense of identity, excessive suffering, poor anger control, excessive sense of persecution, excessive aggression, excessive resistance, and poor social conformity.

Similarly, when the scores of the Burks Behavior Rating Scale across the different domains were compared using the Wilcoxon rank-sum test, the intervention significantly reduced the scores in these domains, as shown in Table 4.

**Table 4**

*Effects of the Intervention on Participants' Scores across Different Domains*

Domain	Pre-intervention			Post-intervention			Z	p
	Q1	M	Q3	Q1	M	Q3		
Excessive Self Blame	10.0	12.0	16.0	9.0	10.0	11.0	-2.7	0.006
Excessive Anxiety	15.0	17.5	22.0	6.0	9.0	11.0	-4.7	0.000
Excessive Withdrawal	11.0	16.0	19.0	6.0	7.0	9.0	-4.5	0.000
Excessive Dependency	15.0	16.5	20.0	7.0	10.0	12.0	-4.4	0.000
Poor Ego Strength	16.0	22.0	28.0	8.0	10.5	12.0	-4.5	0.000
Poor Physical Strength	9.0	12.5	16.0	5.0	6.0	8.0	-4.2	0.000
Poor Coordination	8.0	11.5	19.0	5.0	6.0	8.0	-4.1	0.000
Poor Intellectual	18.0	20.0	25.0	9.0	10.0	13.0	-4.6	0.000
Poor Achievement	16.0	19.5	25.0	6.0	7.0	9.0	-4.5	0.000
Poor Attention	13.0	17.0	24.0	7.0	8.0	10.0	-4.5	0.000
Poor Impulse Control	17.0	22.0	25.0	6.0	8.0	10.0	-4.7	0.000
Poor Reality Contact	14.0	19.0	26.0	8.0	9.0	11.0	-4.5	0.000
Poor sense of Identity	12.0	14.0	19.0	6.0	7.0	9.0	-4.5	0.000
Excessive Suffering	19.0	22.0	29.0	9.0	12.0	13.0	-4.7	0.000
Poor Anger Control	18.0	21.0	25.0	7.0	8.0	12.0	-4.5	0.000
Excessive Sense of Persecution	15.0	18.0	22.0	7.0	8.0	9.0	-4.7	0.000
Excessive Aggressive	16.0	19.0	27.0	8.0	9.0	12.0	-4.6	0.000
Excessive Resistance	13.0	16.5	25.0	6.0	7.0	9.0	-4.4	0.000
Poor Social Conformity	17.0	27.5	34.0	10.0	12.0	14.0	-4.6	0.000

Q1: First quartile, Q3: Third quartile, M: Median

To investigate the effects of the intervention on each item of the Burks Behavior Rating Scale, the Wilcoxon rank-sum test was applied to each item. Apart from asking questions and feeling upset after making a mistake, the intervention was shown to reduce the scores of each item on the Burks Behavior Rating Scale, as shown in Appendix E2.

### **3.3 Associations between Characteristics of the Participants and the Changes Caused by the Intervention in Each Item of the Burks Behavior Rating Scale**

To investigate the association between participants' characteristics and the changes caused by the intervention in each item of the Burks Behavior Rating Scale, the Mann-Whitney U test was used for each variable. These associations are detailed in Appendix E.

When comparing the differences in scores between the two age categories, the intervention caused significantly greater changes in the older age group (above 10 years old) concerning exaggerated remorse after making a mistake, self-blame if things did not go as desired, showing many fears, worries, and self-trust.

For gender categories, significantly greater changes were observed among male participants. These changes were relevant to claiming to be oppressed, not forgiving when offended, accusing others, poor reading, being late to school, performing reckless acts, absence from school, refusing to follow instructions, inconsistent drawing, self-trust, seeming unhappy, desiring punishment by others, feeling frustrated after failure, deceiving others, seeming depressed, and attracting attention by clowning.

Regarding the marital status of parents, the intervention led to significantly greater changes among participants whose parents were not living together. These changes involved claiming to be oppressed, making inappropriate responses, improving attention, accusing others, self-blame, showing many fears, telling lies, excessive movement, keeping promises, worrying a lot, seizing the property of others, shaking the body in different directions, drawings that do not correspond to reality, performing reckless acts, not being aware of their actions, deliberately opposing, being stubborn and uncooperative, self-harm, refusing to follow instructions, getting angry, playing games of the opposite sex, denying responsibility for acts, getting frustrated, inconsistent drawing, accepting the guidance and suggestions of others, behaving differently from others, feeling good about poor performance, feeling satisfied with acting as a leader, putting oneself in situations that invite criticism, deceiving others, not showing interest in the work of others, and attracting attention by clowning.

## **Chapter Four**

### **Discussions and Conclusions**

One of the most significant findings of this research is the substantial behavioral improvement observed among participants after the intervention. The results indicated a marked enhancement in the conduct of children residing in the residential institution, all of whom were suffering from conduct disorders. The results of this study agree with earlier studies on the efficacy of play therapy in treating behavioral issues in children.

The study showed that play therapy is extremely effective at improving behaviors among children with behavioral disorders. This result comes from analyzing the data from the Burks Behavior Rating Scale that was distributed before and after the first implementation of the therapeutic program. To prove the hypotheses suggested, calculations of arithmetic means and standard deviations were made before and after the treatment program.

The McNemar test was used to evaluate improvements in the behavior of children after the intervention, revealing highly significant improvements in diverse areas of the Burks Behavior Rating Scale. Also, the Wilcoxon rank-sum test supported that the intervention produced a significant decline in scores across a variety of scale domains. The results support the study's hypotheses by showing a major improvement in the behaviors of children as a consequence of participating in the play therapy program. The conclusions emphasize the key role that play has in enhancing behavior and in diminishing behavioral disorders.

The activities concentrated on teamwork showed that peer interaction in group play can lead to improved attention and reduced hyperactivity. According to Shaaban (2021), the findings show a beneficial impact of interventions based on play for children affected by attention deficit hyperactivity disorder (ADHD). Shaaban's research recommended adding play-based learning strategies to general curricula, specifically for addressing conduct disorders in children affected by ADHD.

According to Cornell et al. (2018), the results of the study underway support findings that indicate positive effects of play interventions for students with behavioral disorders. Like others, Darwish et al. (2022) noted a beneficial outcome of play therapy in alleviating the seriousness of behavioral disorders in young children.

According to Nahwi (2016), play therapy is a powerful and interactive therapeutic method for children ranging from 6 to 14, supplying psychological care to those suffering from challenges related to behavioral disorders and poor emotional regulation, such as hyperactivity, anxiety, anger, aggression, depression, and learning problems, those whose personalities have not been properly developed due to certain circumstances, such as children who are deprived by their families and reside in residential institutions.

There exists a research study by Abdulfattah (2016) that assesses how well play therapy reduces the seriousness of behavioral disorders. The study showed that the experimental group had significantly different average result scores before and after the measurements about self-harm, tantrums, aggressive behavior, communication difficulties, hyperactivity, and attention deficit. The findings of this study indicated important advancement in multiple areas, such as communication, family interactions with siblings, and language proficiency. In addition, the behaviors of the participants improved during play, which created an opportunity for them to articulate their desires and tendencies more naturally.

The research indicated that play therapy contributed to a decrease in the extent of aggressive behavior found in children. They became better able to navigate relationships with others and enhanced their skill to articulate anger in a productive manner that did not lead to harming themselves. The attribution of this improvement is the child's switch from an internal focus to participatory engagement with peers and the environment, thereby integrating better with their environment. This evidence shows that the program is capable of lowering behavioral disorders via play.

According to the research of Ali (2016), play therapy might reduce antisocial behavior and encourage favorable psychological adjustment. The program's psychological play therapy successfully lowered aggressive behavior and improved psychological adjustment among the participants.

Vazifehghelichi (2023) found that child-centered play therapy successfully lessens externalizing behavioral problems and increases social and emotional skills. The findings from this study agree with Benseghir and Hamdi (2023), who researched how play therapy lowers behavioral disorders in children with Autism Spectrum Disorder (ASD).

The study showed a noteworthy difference between pre- and post-intervention scores on the behavioral assessment scale, reflecting the success of play therapy in reducing behavioral challenges in children with ASD and its role as a treatment strategy for the behavioral difficulties children with autism spectrum disorder experience.

The findings correspond with those of Shahabizadeh and Toozandehjani (2016) regarding the effectiveness of play therapy centered on children in diminishing behavioral disorders among elementary school students. The experimental group showed a clear decrease in behavioral disorder scores during the post-test analysis when compared to the control group.

Similarly, Mercan and Özdemir's (2023) research on child-centered play therapy showed significant improvement in social competence, anger aggression, and anxiety withdrawal subscales within the experimental group from pre-test to post-test.

The Mann-Whitney U test was used to investigate the relationship between participant variables and the changes caused by the intervention in each item of the scale. The findings were as follows:

- **Age:** Significant improvements were observed in the group over 10 years old compared to those under 10. The improvements included reductions in exaggeration of remorse after making mistakes, self-blame when things did not go as desired, and showing excessive concern, anxiety, and lack of self-confidence.
- **Gender:** Males showed greater changes due to the intervention in areas such as claiming persecution, intolerance when wronged, accusing others, poor reading, tardiness to school, engaging in reckless behaviors, school absences, refusal to follow instructions, inconsistent drawing, self-confidence, appearance of unhappiness, desiring punishment by others, frustration after failure, deception, depressive appearance, and attention-seeking behavior through clowning.

- **Parental Marital Status:** Children whose parents were not living together exhibited significantly greater changes in areas such as claiming persecution, giving inappropriate responses, improving attention, accusing others, self-blame, showing excessive concern, lying, excessive movement, keeping promises, great concern, seizing others' property, body shaking in different directions, unrealistic drawings, reckless actions, lack of awareness of surroundings, intentional opposition, stubbornness, non-cooperation, self-harm, refusal to follow instructions, anger, playing games of the opposite sex, denial of responsibility, frustration, inconsistent drawing, acceptance of others' guidance and suggestions, behavior that differs from peers, satisfaction with poor performance, satisfaction with leadership roles, putting oneself in critical situations, deception, lack of interest in others' work, and attention-seeking behavior through clowning.

This study demonstrates that play therapy is an enjoyable and effective method for treating children with conduct disorders. It has proven successful in improving various behavioral issues across multiple domains. The research confirms that play activities are a very effective strategy for early intervention and behavioral adjustment in children with conduct disorders.

The results of this study agree with previous works on play therapy in underscoring its importance in reducing behavioral disorders. It's essential to recognize that not all children with behavioral issues may benefit from these findings. Factors such as the child's age, the severity of the condition, and the timing of the intervention should be considered to ensure the effectiveness of therapy.

#### **4.1 Conclusion**

The present study confirms the results of earlier studies that play therapy indeed is an effective tool to reduce conduct disorders. It thus shows the beneficial effect of play therapy on children with conduct disorders, especially those living in residential institutions. This study is one of the early investigations that has focused on this particular population and suggests calls for more research in this direction.

This may form the basis for further research since there are no previous studies on play therapy for children with conduct disorders residing in residential institutions. Awareness needs to be created in residential institutions, schools, and other similar

places regarding conduct disorder and its ways of intervention. These need to be provided through workshops, lectures, and training courses focusing on the methods of play therapy.

#### **4.2 Limitations of the Study**

1. It is difficult to generalize the result to the category of children residing in residential institutions because the program was implemented in one institution due to the lack of residential institutions in the region.
2. A higher proportion of females included in the sample may influence the results in some variables and limit the generalizability of the results to male children with conduct disorders.
3. The scale was filled from a personal point of view of the counselors, which may introduce subjective bias.

#### **4.3 Recommendation**

1. Making play therapy a permanent program feature, the more the child plays, the greater the effect.
2. Further studies on the effectiveness of play therapy as a mode of treatment of conduct disorders are recommended to evaluate play therapy's efficacy, increase public awareness, identify the causes of conduct disorders, and develop more potent therapeutic approaches.
3. The objective is to develop and refine play therapy strategies to improve children's overall behavioral abilities.

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## Appendices

### Appendix A

#### Scale of behavioral problems among children in residential institutions from the counselor's point of view

مقياس المشكلات السلوكية لأطفال المؤسسة السكنية من وجهة نظر المرشد

ارجو من سيادتكم نتيجة لاحتكاكم المستمر بالطفل وتعاملكم الدائم معه ان تقوموا باستكمال هذا الاستبيان والإجابة على بنوده المتضمنة حتى نحاول التعرف على المشكلات السلوكية التي يبديها الطفل داخل المؤسسة، لكي نتمكن من تقديم المساعدات المطلوبة في هذا السن حتى لا تتطور حالته وتزداد سوءاً.

#### معلومات ديموغرافية

عمر الطفل:

الجنس: ذكر/انثى

مصدر المعلومات:

#### استبيان المشكلات السلوكية

تصف الفقرات التالية بعض المظاهر السلوكية لدى الأطفال، يرجى تقدير الطفل على كل فقرة من فقرات المقياس، وذلك بوضع علامة على الدرجة المناسبة في المربع المخصص لذلك وفقاً للمعيار التالي:

الدرجة (1) إذا كان الطفل لا يظهر السلوك مطلقاً.

الدرجة (2) إذا كان الطفل نادراً ما يظهر السلوك.

الدرجة (3) إذا كان الطفل قليلاً ما يظهر السلوك.

الدرجة (4) إذا كان الطفل كثيراً ما يظهر السلوك.

الدرجة (5) إذا كان الطفل كثيراً جداً ما يظهر السلوك.

الرقم	الفقرات	التقديرات			
		إطلاقاً	نادراً	قليلاً	كثيراً كثيراً جداً
1.	يبدو مشتتاً وغير مستقر فسرعان ما ينتقل من موضوع إلى آخر	1	2	3	4
2.	يسأل أسئلة تظهر قلقاً على المستقبل	1	2	3	4
3.	دائم الشكوى من أن الأطفال الآخرين يضايقونه	1	2	3	4
4.	لا يسأل أسئلة	1	2	3	4
5.	ينزعج جداً إذا اخطأ	1	2	3	4
6.	لا يستطيع أن ينوع في استجاباته	1	2	3	4
7.	غير مثابر وسريعاً ما يتشتت انتباهه	1	2	3	4
8.	يدعي بأنه مظلوم وحقوقه مهضومة	1	2	3	4
9.	يقوم باستجابات (ردود فعل) غير ملائمة للموقف	1	2	3	4
10.	يبالغ في تأنيب الضمير إذا اخطأ	1	2	3	4
11.	فترة انتباهه لا تتحسن سواء عوقب أم أثيب	1	2	3	4
12.	لا يبدي خيالاً (ضيق الأفق)	1	2	3	4
13.	لا يعفر للآخرين إذا أسأوا إليه	1	2	3	4
14.	ينزعج إذا لم يكن كل شيء في غاية الكمال	1	2	3	4
15.	فترة انتباهه قصيرة	1	2	3	4
16.	يجد صعوبة في تذكر الأشياء أو الأحداث	1	2	3	4
17.	يتهم الآخرين بأشياء لم يفعلوها معه حقيقة	1	2	3	4
18.	يبدو الضعف واضحاً في مفرداته اللغوية	1	2	3	4
19.	يشكو من أن الآخرين لا يحبونه	1	2	3	4
20.	لا يتم عملاً، إذ يستمر في التنقل من عمل إلى آخر	1	2	3	4
21.	يلوم نفسه إذا لم تسر الأمور كما يجب	1	2	3	4
22.	غير منطقي في حكمه على الأشياء	1	2	3	4
23.	يظهر مخاوف كثيرة	1	2	3	4
24.	يحكي قصصاً غريبة ولا معنى لها	1	2	3	4
25.	يظهر ضعفاً في القراءة	1	2	3	4
26.	يتهيج بسرعة	1	2	3	4
27.	لغته غير مفهومة	1	2	3	4
28.	لا يهتم بردود فعل الآخرين ويفعل ما يحلو له	1	2	3	4
29.	يقع في أخطاء إملائية عندما يكتب	1	2	3	4
30.	يكذب	1	2	3	4
31.	حركته زائدة	1	2	3	4
32.	يبدو شارد الذهن مستغرقاً في أحلام اليقظة	1	2	3	4
33.	يبدو متوتراً ومتضايقاً	1	2	3	4
34.	لا يفي بوعوده	1	2	3	4
35.	يثور بسرعة ويقوم بأعمال غير متوقعة	1	2	3	4
36.	يظهر على وجهه حركات لا إرادية ودون سبب ظاهر	1	2	3	4
37.	يعتريه القلق كثيراً	1	2	3	4
38.	يستولي على ممتلكات غيره	1	2	3	4
39.	يبدو ضعيفاً في اتباع التعليمات الأكاديمية	1	2	3	4
40.	يضحك في سره ويكلم نفسه	1	2	3	4
41.	قليل الاحترام للسلطة والمسؤولين	1	2	3	4
42.	يحمر (يتورد) وجهه بسهولة	1	2	3	4
43.	يدأوم على هز جسمه باتجاه معين	1	2	3	4
44.	يكتب مهماته المدرسية بشكل غير مننظم	1	2	3	4
45.	يتأخر عن الدوام المدرسي	1	2	3	4
46.	متهور ولا يضبط نفسه	1	2	3	4
47.	رسوماته لا تتفق مع الواقع	1	2	3	4
48.	يقوم بأعمال طائشة وغير مقبولة	1	2	3	4
49.	يبدو عصيباً	1	2	3	4
50.	لا يعي ما يدور حوله	1	2	3	4
51.	لا يقوم بأداء واجباته المدرسية أو يؤديها غير مكتملة	1	2	3	4
52.	عندما ينفعل لا يضبط نفسه (كأن يصرخ أو يقفز من كرسيه)	1	2	3	4
53.	يتغيب عن المدرسة دون عذر مقبول	1	2	3	4
54.	يتحاشى الاحتكاك الجسمي أثناء اللعب ويتجنب الألعاب الخشنة	1	2	3	4
55.	سريع الغضب	1	2	3	4

5	4	3	2	1	يتعمد أن يكون معارضا	.56
5	4	3	2	1	عنيد وغير متعاون	.57
5	4	3	2	1	يواجه صعوبة في حمل الأشياء	.58
5	4	3	2	1	يتعرض للإصابة (يؤذي نفسه) أثناء اللعب	.59
5	4	3	2	1	يرفض إتباع التعليمات والقواعد ويتمرد عند محاولة ضبطه	.60
5	4	3	2	1	يغضب إذا طلب منه القيام بعمل ما	.61
5	4	3	2	1	يظهر عدم تناسق في أداء النشاطات والحركات العضلية الكبيرة	.62
5	4	3	2	1	يميل إلى ألعاب الجنس الآخر	.63
5	4	3	2	1	يتعب بسرعة	.64
5	4	3	2	1	خطه ضعيف وغير متناسق	.65
5	4	3	2	1	ينكر مسؤوليته عن أفعال قام بها	.66
5	4	3	2	1	يحبط ويفقد القدرة على ضبط انفعالاته بسرعة	.67
5	4	3	2	1	يفضل أن يكون وحيدا	.68
5	4	3	2	1	رسوماته غير متناسقة وتلوينه للأشكال غير متقن	.69
5	4	3	2	1	لا يقبل توجيهات الآخرين ويصر على استخدام أسلوبه عند القيام بعمل ما	.70
5	4	3	2	1	لا يشترك الآخرين في الألعاب الخشنة	.71
5	4	3	2	1	متعثر في مشيه إذ يصطدم بالآخرين أو بالأشياء من حوله	.72
5	4	3	2	1	ينفجر غضبا تحت تأثير الضغوطات	.73
5	4	3	2	1	لا يتقبل زملاءه ويعبر عن ذلك بطريقة عدائية	.74
5	4	3	2	1	يبدو خاملا وثقيل الحركة	.75
5	4	3	2	1	لا يتقبل اقتراحات من الآخرين	.76
5	4	3	2	1	ينفجر غضبا على زملاءه إذا ضايقوه في مزاحهم أو دفعوه بأيديهم	.77
5	4	3	2	1	يتعمد أن يكون سلوكه مختلفا عن الآخرين	.78
5	4	3	2	1	عبوس الوجه مقطب الجبين	.79
5	4	3	2	1	يصعب فهمه أو التودد إليه	.80
5	4	3	2	1	لا يتق بقدراته ويقفل من شأنه	.81
5	4	3	2	1	يسر عندما يرى غيره في مأزق	.82
5	4	3	2	1	يعتمد على الآخرين وينقاد لهم	.83
5	4	3	2	1	يضرب ويدفع الآخرين	.84
5	4	3	2	1	يبدو غير سعيد	.85
5	4	3	2	1	لا يتعاطف مع الآخرين في حزنهم	.86
5	4	3	2	1	خنوع, مبالغ في الطاعة	.87
5	4	3	2	1	يشعر بالرضا تجاه أداءه الضعيف	.88
5	4	3	2	1	يرغب في عقاب الآخرين له	.89
5	4	3	2	1	ينسحب بسرعة من النشاطات الجماعية بحيث يفضل أن يعمل بمفرده	.90
5	4	3	2	1	يتجنب المواقف التي تتضمن منافسة	.91
5	4	3	2	1	لا يرضى إلا أن يقوم بدور القائد للآخرين	.92
5	4	3	2	1	يقاد ويدعن لغيره بسهولة	.93
5	4	3	2	1	خجول	.94
5	4	3	2	1	يتعمد وضع نفسه في مواقف تستدعي الانتقاد	.95
5	4	3	2	1	يسخر من الآخرين	.96
5	4	3	2	1	إذا فشل فمن السهل أن يحبط ولا يحاول مرة أخرى	.97
5	4	3	2	1	يصعب التعرف على مشاعره لكونه لا يظهر مشاعر نحو الآخرين	.98
5	4	3	2	1	يظهر نفسه بمظهر المغلوب على أمره (يتمسكن)	.99
5	4	3	2	1	يغضب ويضايق الآخرين	.100
5	4	3	2	1	يتصرف بسخافة	.101
5	4	3	2	1	يتكل على غيره في أداء الأعمال التي يفترض أن يقوم هو بها	.102
5	4	3	2	1	شديد الحساسية, تؤذى مشاعره بسهولة	.103
5	4	3	2	1	يبدو قليل الثقة بنفسه	.104
5	4	3	2	1	شديد التعلق بالكبار ( الراشدين) إذ من الصعب أن يفارقهم	.105
5	4	3	2	1	يخدع الأطفال الآخرين ويحتال عليهم	.106
5	4	3	2	1	لا يظهر اهتماما بأعمال غيره من الأطفال	.107
5	4	3	2	1	يبدو مكتئبا	.108
5	4	3	2	1	يبحث عن التشجيع والمدح باستمرار	.109
5	4	3	2	1	يحاول جذب انتباه زملاءه عن طريق التهريج	.110

## Appendix B

### Consent to participate in scientific research

#### موافقة للمشاركة في بحث علمي

تحية طيبة وبعد

انا طالبة ماجستير علم نفس اكلينيكي في جامعة النجاح الوطنية، أقوم بدراسة حول فاعلية برنامج علاجي باللعب في الحد من اضطرابات السلوك لدى أطفال المؤسسات السكنية. فأرجو من حضرة المرشد في المؤسسة السكنية التوقيع على المشاركة في هذا البحث عوضاً عن الطفل، علماً أن كافة المعلومات الموجودة سيتم استخدامها فقط لغرض البحث العلمي مع الحفاظ على السرية التامة والحفاظ على هذه المعلومات بما يستوجب ويتناسب مع اخلاقيات البحث العلمي.

اشكرك على حسن المشاركة والموافقة

مع احترامي وجزيل شكري

رؤى تكروري

توقيع المرشد

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## Appendix C

### Scale Results Guide

الدلالات لنتائج المقياس:

ذات دلالة عالية	دالة	غير دالة	البعد
18 - 25	11 - 17	5 - 10	الافراط في لوم النفس
18 - 25	11 - 17	5 - 10	الافراط في القلق
22 - 30	13 - 21	6 - 12	الاستجابة الزائدة
22 - 30	13 - 21	6 - 12	الاعتمادية الزائدة
25 - 35	15 - 24	7 - 14	ضعف قوة الأنا
18 - 25	11 - 17	5 - 10	ضعف القوة الجسدية
18 - 25	11 - 17	5 - 10	ضعف التآزر الحركي
25 - 35	15 - 24	7 - 14	انخفاض القدرة العقلية
18 - 25	11 - 17	5 - 10	الضعف الأكاديمي
18 - 25	11 - 17	5 - 10	ضعف الانتباه
18 - 25	11 - 17	5 - 10	ضعف القدرة على ضبط النشاط
29 - 40	17 - 28	8 - 16	ضعف الاتصال بالواقع
18 - 25	11 - 17	5 - 10	ضعف الشعور بالهوية
25 - 35	15 - 24	7 - 14	الإفراط في المعاناة
18 - 25	11 - 17	5 - 10	الضعف في ضبط مشاعر الغضب
18 - 25	11 - 17	5 - 10	المبالغة في الشعور بالظلم
22 - 30	13 - 21	6 - 12	العدوانية الزائدة
18 - 25	11 - 17	5 - 10	العناد والمقاومة
29 - 40	17 - 28	8 - 16	ضعف الإنصياح الاجتماعي

## **Appendix D**

### **Burks Behavior rating scale**

Scale dimensions:

1. Excessive Self Blame, it is defined as an exaggerated tendency to blame oneself for real or imagined mistakes, measured by paragraphs: (2 - 5 - 10 - 14 - 21).
2. Excessive Anxiety, it is defined as the observable expression of a feeling of pain or lack of pleasure, measured by the paragraphs: (49 - 42 - 37 - 33 - 23).
3. Excessive Withdrawal, showing the unwillingness to respond emotionally to others, as measured by paragraphs: (107 - 98 - 94 - 90 - 86 - 80).
4. Excessive Dependency, exaggeration in showing the need for the support and support of others, measured by paragraphs: (109-105-102-93-87-83).
5. Poor Ego Strength, stop expressing abilities due to weak self-confidence, measured by paragraphs: (110 - 104 - 101 - 97 - 91 - 88 - 81).
6. Poor Physical Strength, the inability to maintain the level of energy needed for normal activities or the inability to participate effectively in activities that require physical contact with others, as measured by paragraphs: (75-71-64-59-54).
7. Poor Coordination, inability to control voluntary muscles and sense organs in important activities, measured by the paragraphs: (58 – 62 – 65 – 69 – 62 – 72).
8. Poor Intellectual, the emergence of observable indicators that indicate a low level of cognitive abilities, measured by paragraphs: (22-18-16-12-9-6-4).
9. Poor achievement, the child's inability to succeed in basic school subjects, as measured by paragraphs: (51-44-39-29-25).
10. Poor Attention, the inability to recall things to the circle of consciousness and the inability to hold them for a long time, measured by the items: (1-7-11-15-20).
11. Poor Impulse Control, the inability to delay responses in an appropriate manner, as measured by paragraphs: (52-46-35-31-26).

12. Poor Reality Contact, the severe inability to evaluate correctly and not respond appropriately to the enrichment of the requirements of daily life, as measured by paragraphs: (24-27-32-36-40-50-47-43).
13. Poor Sense of Identity, demonstrate the desire to differ from others, as measured by paragraphs: (78 - 74 - 68 - 63 - 56).
14. Excessive Suffering, the apparent expression of an inner desire to fail or self-harm, measured by paragraphs: (79 - 85 - 89 - 95 - 99 - 103 - 108).
15. Poor Anger Control, chronic weakness of the ability to control or suppress intense feelings of anger, measured by paragraphs: (55 - 61 - 67 - 73 - 77).
16. Excessive Sense of Persecution, an unrealistic and exaggerated feeling of mistreatment of others, as measured by paragraphs: (3 - 8 - 13 - 17 - 19).
17. Excessive Aggressive, the desire to harm others through words or actions measured by paragraphs: (82 - 84 - 92 - 96 - 100 - 106).
18. Excessive Resistance, the desire not to respect the demands of others, measured by paragraphs: (57 - 60 - 66 - 70 - 76).
19. Poor Social Conformity, the inability to control personal behavior in accordance with accepted moral standards, measured by paragraphs (28-30-34-38-41-45-53-48).

## Appendix E

### Tables of Study

**Table E1**

*Effects of the Intervention on Participants' Behaviors across Different Domains*

Domain	Pre-intervention		Post-intervention		p
	n	%	n	%	
Excessive Self Blame					
Insignificant	9	30.0	19	63.3	0.031
Significant	21	70.0	11	36.7	
Excessive Anxiety					
Insignificant	0	0.0	21	70.0	0.000
Significant	30	100.0	9	30.0	
Excessive Withdrawal					
Insignificant	10	33.3	29	96.7	0.000
Significant	20	66.7	1	3.3	
Excessive Dependency					
Insignificant	2	6.7	23	76.7	0.000
Significant	28	93.3	7	23.3	
Poor Ego Strength					
Insignificant	6	20.0	28	93.3	0.000
Significant	24	80.0	2	6.7	
Poor Physical Strength					
Insignificant	14	46.7	27	90.0	0.002
Significant	16	53.3	3	10.0	
Poor Coordination					
Insignificant	14	46.7	28	93.3	0.001
Significant	16	53.3	2	6.7	
Poor Intellectual					
Insignificant	4	13.3	26	86.7	0.000
Significant	26	86.7	4	13.3	
Poor Achievement					
Insignificant	4	13.3	25	83.3	0.000
Significant	26	86.7	5	16.7	
Poor Attention					
Insignificant	5	16.7	25	83.3	0.000
Significant	25	83.3	5	16.7	
Poor Impulse Control					
Insignificant	1	3.3	23	76.7	0.000
Significant	29	96.7	7	23.3	
Poor Reality Contact					
Insignificant	10	33.3	30	100.0	0.000

Significant	20	66.7	0	0.0	
Poor Sense of Identity					
Insignificant	5	16.7	27	90.0	0.000
Significant	25	83.3	3	10.0	
Excessive Suffering					
Insignificant	4	13.3	26	86.7	0.000
Significant	26	86.7	4	13.3	
Poor Anger Control					
Insignificant	2	6.7	20	66.7	0.000
Significant	28	93.3	10	33.3	
Excessive Sense of Persecution					
Insignificant	4	13.3	25	83.3	0.000
Significant	26	86.7	5	16.7	
Excessive Aggressive					
Insignificant	5	16.7	25	83.3	0.000
Significant	25	83.3	5	16.7	
Excessive Resistance					
Insignificant	16	53.3	30	100.0	0.000
Significant	14	46.7	0	0.0	
Poor Social Conformity					
Insignificant	7	23.3	27	90.0	0.000
Significant	23	76.7	3	10.0	

**Table E2***The effects of the intervention on the scores of the participants in each item of the Burks Behavior Rating Scale*

#	Item	Pre-intervention			Post-intervention			Z	p
		Q1	M	Q3	Q1	M	Q3		
1	The child seems distracted and unstable, as he/she quickly moves from one topic to another	2.0	3.5	5.0	1.0	2.0	3.0	-3.8	0.000
2	The child asks questions that show concern for the future	2.0	3.5	5.0	2.0	2.5	3.0	-3.2	0.001
3	The child always complains that other children are harassing him/her	2.8	4.0	5.0	1.0	2.0	3.0	-3.8	0.000
4	The child does not ask questions	1.0	2.0	3.0	1.0	2.0	3.0	-0.8	0.444
5	The child is very upset if he/she makes a mistake	2.0	2.5	3.3	2.0	2.5	3.0	-0.8	0.451
6	The child cannot diversify his/her responses	1.8	3.0	4.0	1.0	2.0	2.0	-3.1	0.002
7	The child is indigent and quickly distracted	2.8	4.5	5.0	1.0	2.0	2.3	-4.2	0.000
8	The child claims to be oppressed and his/her rights are infringed	3.0	5.0	5.0	1.0	2.0	2.0	-4.5	0.000
9	The child makes inappropriate responses to the situation	3.0	4.0	5.0	1.0	1.0	2.0	-4.5	0.000
10	The child exaggerates remorse if he/she makes a mistake	1.0	1.0	3.0	1.0	2.0	2.0	-0.7	0.498
11	The child's attention span does not improve whether he/she is punished or rewarded	1.0	3.0	5.0	1.0	1.0	2.0	-3.6	0.000
12	The child does not show imagination (narrow-minded)	1.0	2.5	4.0	1.0	1.0	1.3	-3.7	0.000
13	The child does not forgive others if they offend him/her	2.0	4.0	5.0	1.0	2.0	2.0	-4.0	0.000
14	The child gets upset if everything is not so perfect	2.0	2.5	4.3	1.0	2.0	2.3	-2.9	0.003
15	The child's attention span is short	3.0	4.0	5.0	1.0	1.0	2.0	-4.3	0.000
16	The child finds it difficult to remember objects or events	1.0	3.0	4.0	1.0	1.0	2.0	-4.0	0.000
17	The child accuses others of things they have not really done with him/her	2.0	3.0	4.0	1.0	1.0	2.0	-4.5	0.000
18	The child's weakness is evident in his/her vocabulary	3.0	3.5	5.0	1.0	1.0	1.3	-4.3	0.000
19	The child complains that others do not like him/her	2.0	3.0	4.3	1.0	1.0	2.0	-4.4	0.000

20	The child does not complete his/her work and continues to move from one task to another	2.8	4.0	5.0	1.0	1.0	2.0	-4.5	0.000
21	The child blames him/herself if things do not go as he/she likes	1.0	2.0	3.3	1.0	1.5	2.0	-2.1	0.032
22	The child is illogical in his/her judgment of things	3.0	3.5	5.0	1.0	1.0	2.0	-4.4	0.000
23	The child shows many fears	2.8	3.5	5.0	1.0	2.0	2.3	-3.9	0.000
24	The child tells strange and meaningless stories	2.0	3.0	4.0	1.0	1.0	2.0	-4.1	0.000
25	The child shows poor reading	3.0	4.0	5.0	1.0	1.0	2.3	-4.1	0.000
26	The child irritates quickly	4.0	4.0	5.0	1.0	2.0	3.0	-4.8	0.000
27	The child's language is incomprehensible	1.0	2.0	3.0	1.0	1.0	1.0	-3.9	0.000
28	The child does not care about the reactions of others and does what he/she likes	2.8	4.0	5.0	1.0	2.0	2.0	-4.5	0.000
29	The child makes spelling mistakes when he/she writes	3.0	4.0	5.0	1.0	1.0	2.0	-4.2	0.000
30	The child keeps lying	2.0	4.0	5.0	1.0	2.0	2.0	-4.0	0.000
31	The child's movement is excessive	3.0	4.0	5.0	1.0	2.0	2.3	-4.3	0.000
32	The child seems absent-minded and absorbed in daydreaming	2.0	3.0	4.0	1.0	1.0	2.0	-3.9	0.000
33	The child seems nervous and annoyed	3.0	4.0	5.0	1.0	1.5	2.0	-4.6	0.000
34	The child does not keep his/her promises	2.8	3.0	5.0	1.0	1.0	2.0	-4.0	0.000
35	The child erupts quickly and does unexpected actions	3.0	5.0	5.0	1.0	1.0	2.0	-4.6	0.000
36	The child's involuntary movements appear on his/her face for no apparent reason	1.0	2.0	3.0	1.0	1.0	1.0	-3.5	0.000
37	The child worries a lot	2.8	4.0	5.0	1.0	1.0	3.0	-4.2	0.000
38	The child seizes the property of others	1.0	3.0	4.3	1.0	1.0	2.0	-4.0	0.000
39	The child seems weak in following academic instructions	3.0	4.0	5.0	1.0	1.0	2.0	-4.4	0.000
40	The child laughs in secret and talks to him/herself	1.0	2.0	3.0	1.0	1.0	1.0	-3.5	0.001
41	The child shows low respect for authority and officials	2.8	4.0	5.0	1.0	1.0	2.0	-4.4	0.000
42	The child's face blushes easily	2.0	3.0	4.0	1.0	1.0	2.0	-3.9	0.000
43	The child keeps shaking his/her body in a certain direction	1.0	1.5	3.0	1.0	1.0	1.0	-3.4	0.001
44	The child writes his/her homework irregularly	3.0	4.0	5.0	1.0	1.0	2.0	-4.4	0.000
45	The child is late for school	1.0	3.0	5.0	1.0	1.0	2.0	-3.7	0.000

46	The child is impulsive and does not control him/herself	3.0	4.0	5.0	1.0	1.0	2.0	-4.4	0.000
47	The child's drawings do not correspond to reality	1.0	2.0	4.0	1.0	1.0	1.0	-3.5	0.000
48	The child performs reckless and unacceptable acts	3.0	4.5	5.0	1.8	2.0	3.0	-4.0	0.000
49	The child looks nervous	1.0	1.0	2.0	3.0	5.0	5.0	-4.6	0.000
50	The child is not aware of what he/she is about	1.0	2.0	3.3	1.0	1.0	1.0	-3.6	0.000
51	The child does not perform his/her homework or performs it incomplete	2.8	4.0	5.0	1.0	1.0	2.0	-4.2	0.000
52	When the child gets agitated, he/she does not control him/herself (such as screaming or jumping out of his/her chair)	4.0	5.0	5.0	1.0	1.5	2.0	-4.6	0.000
53	The child absents from school without an acceptable excuse	1.0	3.0	5.0	1.0	1.0	2.0	-3.5	0.001
54	The child avoids physical contact while playing and avoids rough games	1.0	2.5	4.0	1.0	1.0	2.0	-3.4	0.001
55	The child is quick-tempered	3.0	4.5	5.0	1.0	2.0	2.0	-4.5	0.000
56	The child deliberately be an opponent	2.0	3.0	5.0	1.0	1.0	2.0	-4.1	0.000
57	The child is stubborn and uncooperative	3.0	3.5	5.0	1.0	2.0	2.0	-4.2	0.000
58	The child has difficulty carrying things	1.0	2.0	4.3	1.0	1.0	1.0	-3.5	0.001
59	The child gets injured (hurts him/herself) while playing	1.0	2.0	3.0	1.0	1.0	1.0	-3.7	0.000
60	The child refuses to follow the instructions and rules and rebels when trying to adjust him/her	2.0	3.0	5.0	1.0	1.0	2.0	-4.2	0.000
61	The child gets angry if he/she is asked to do something	2.8	3.0	5.0	1.0	2.0	2.0	-4.1	0.000
62	The child asymmetry appears in the performance of large muscular activities and movements	1.0	2.0	3.3	1.0	1.0	1.3	-3.1	0.002
63	The child tends to games of the opposite sex	1.0	1.0	1.3	1.0	1.0	2.0	-0.6	0.570
64	The child gets tired quickly	1.8	2.5	4.0	1.0	1.0	2.0	-3.6	0.000
65	The child's handwriting is weak and inconsistent	2.0	3.0	5.0	1.0	1.0	2.0	-4.2	0.000
66	The child denies responsibility for acts he/she has committed	2.0	4.0	5.0	1.0	1.0	2.0	-3.7	0.000
67	The child gets frustrated and loses the ability to quickly adjust his/her emotions	3.0	4.0	5.0	1.0	1.0	2.0	-4.5	0.000
68	The child is preferably alone	2.0	3.0	4.0	1.0	1.0	2.0	-4.2	0.000
69	The child's drawings are inconsistent and his/her coloring of shapes is not elaborate	1.0	2.0	4.0	1.0	1.0	2.0	-3.1	0.002

70	The child does not accept the guidance of others and insists on using his/her own style when doing something	3.0	4.0	5.0	1.0	1.0	2.0	-4.2	0.000
71	The child does not share others in rough games	2.0	2.5	4.0	1.0	1.0	2.0	-3.4	0.001
72	The child stumbling in his/her walk as he/she collides with others or objects around him/her	1.0	2.0	4.0	1.0	1.0	1.3	-3.6	0.000
73	The child bursts out of anger under the influence of pressures	4.0	5.0	5.0	1.0	2.0	3.0	-4.3	0.000
74	The child does not accept his/her colleagues and expresses it in a hostile way	3.0	3.0	5.0	1.0	1.0	2.0	-4.6	0.000
75	The child seems idle and heavy in motion	1.0	2.0	4.0	1.0	1.0	2.0	-3.4	0.001
76	The child does not accept suggestions from others	2.0	3.0	5.0	1.0	2.0	2.0	-4.2	0.000
77	77. He bursts out of anger at his colleagues if they harass him in their banter or push him with their hands	4.0	5.0	5.0	1.0	2.0	3.0	-3.8	0.000
78	The child deliberately behaves differently from others	2.0	4.0	5.0	1.0	1.0	2.0	-3.9	0.000
79	The child frown face frown forehead	2.0	3.0	5.0	1.0	1.0	2.0	-4.4	0.000
80	The child is difficult to understand or woo	1.8	2.5	5.0	1.0	1.0	2.0	-3.5	0.001
81	The child does not trust his/her abilities and underestimates him/her	1.0	3.0	4.0	1.0	1.0	1.3	-3.8	0.000
82	The child is pleased when he/she sees others in trouble	2.0	3.0	5.0	1.0	1.0	1.0	-4.2	0.000
83	The child depends on others and is led by them	1.0	2.5	4.0	1.0	1.0	2.0	-3.5	0.000
84	The child hits and pushes others	2.8	4.0	5.0	1.0	1.5	2.0	-4.1	0.000
85	The child seems unhappy	3.0	4.0	5.0	1.0	2.0	3.0	-4.0	0.000
86	The child does not sympathize with others in their grief	1.8	2.5	4.3	1.0	1.0	1.0	-4.0	0.000
87	The child is subservience and exaggerates in obedience	1.0	1.0	2.3	1.0	1.0	1.3	-2.5	0.013
88	The child feels good about his/her poor performance	2.0	3.0	4.0	1.0	1.0	2.0	-4.1	0.000
89	The child desires others to punish him/her	1.0	2.0	4.0	1.0	1.0	1.0	-3.7	0.000
90	The child withdraws quickly from group activities so that he/she prefers to work alone	1.8	3.0	4.0	1.0	1.0	2.0	-3.7	0.000
91	The child avoids situations involving competition	1.0	3.0	4.0	1.0	1.0	2.0	-3.6	0.000
92	The child is only satisfied to act as a leader for others	2.0	3.0	4.0	1.0	2.0	3.0	-2.7	0.008
93	The child is easily led and submitted to others	1.0	1.5	3.0	1.0	1.0	2.0	-2.4	0.017
94	The child is shy	3.0	3.0	4.0	1.0	2.0	2.0	-4.3	0.000

95	The child deliberately puts him/herself in situations that call for criticism	1.0	3.5	5.0	1.0	1.0	2.0	-3.7	0.000
96	The child makes fun of others	2.0	3.0	5.0	1.0	2.0	2.0	-4.1	0.000
97	If the child fails he/she is easy to be frustrated and not try again	2.8	4.0	5.0	1.0	1.0	2.0	-4.7	0.000
98	It is difficult to recognize the feelings of the child because he/she does not show feelings towards others	2.0	3.0	5.0	1.0	1.0	2.0	-4.0	0.000
99	The child shows him/herself as helpless (clinging)	2.8	4.0	5.0	1.0	1.0	1.0	-4.4	0.000
100	The child is teasing and harassing others	2.8	4.0	5.0	1.0	1.0	2.0	-4.4	0.000
101	The child is acting ridiculously	2.0	3.5	5.0	1.0	2.0	2.0	-4.2	0.000
102	The child elies on others to perform the work he/her is supposed to do	2.8	3.5	5.0	1.0	2.0	3.0	-3.9	0.000
103	The child is hypersensitive, hurt his/her feelings easily	3.8	4.0	5.0	1.0	2.0	3.0	-4.5	0.000
104	The child seems to have little confidence in him/herself	2.0	3.0	4.3	1.0	1.0	2.0	-4.1	0.000
105	The child is very attached to adults as it is difficult to leave them	3.0	3.0	5.0	1.0	1.5	3.0	-4.1	0.000
106	The child deceives other children	1.0	3.5	5.0	1.0	2.0	2.0	-3.1	0.002
107	The child does not show interest in the work of other children	2.0	3.5	5.0	1.0	2.0	2.0	-3.9	0.000
108	The child seems depressed	2.0	3.0	5.0	1.0	2.0	3.0	-3.8	0.000
109	The child constantly seeks encouragement and praise	3.0	4.0	5.0	1.0	2.0	3.0	-3.4	0.001
110	The child tries to attract the attention of his/her colleagues by clowning	1.0	3.5	5.0	1.0	2.0	3.0	-2.4	0.018

Q1: first quartile, Q3: third quartile, M: Median

**Table E3**

*Association between age, sex, and living with parents and the change caused by the intervention in each item of the Burks Behavior Rating Scale*

#	Item	Age (years)	N	Post-intervention change				Sex	N	Post-intervention change				Living with both parents	N	Post-intervention change			
				Q1	M	Q3	p			Q1	M	Q3	p			Q1	M	Q3	p
1	The child seems distracted and unstable, as he/she quickly moves from one topic to another	≤ 10	17	-2.0	-1.0	0.0	0.410	Male	13	-2.0	-2.0	-1.0	0.159	Yes	6	-2.0	-1.0	0.0	0.555
		> 10	13	-2.0	-2.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	-1.5	-1.0	
2	The child asks questions that show concern for the future	≤ 10	17	-1.0	-1.0	0.0	0.053	Male	13	-2.0	-1.0	0.0	0.664	Yes	6	-2.0	0.0	1.0	0.205
		> 10	13	-2.0	-1.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	-1.0	0.0	
3	The child always complains that other children are harassing him/her	≤ 10	17	-2.0	-2.0	0.0	0.609	Male	13	-3.0	-2.0	-1.0	0.565	Yes	6	-4.0	-1.0	1.0	0.731
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-3.0	-2.0	-1.0	
4	The child does not ask questions	≤ 10	17	0.0	0.0	1.0	0.831	Male	13	0.0	0.0	0.0	0.586	Yes	6	0.0	1.0	2.0	0.078
		> 10	13	0.0	0.0	0.0		Female	17	-1.0	0.0	1.0		No	24	0.0	0.0	0.0	
5	The child is very upset if he/she makes a mistake	≤ 10	17	0.0	0.0	1.0	0.104	Male	13	0.0	0.0	1.0	<b>0.025</b>	Yes	6	-1.0	0.0	1.0	0.807
		> 10	13	-2.0	0.0	0.0		Female	17	-1.0	-1.0	0.0		No	24	-1.0	0.0	0.0	
6	The child can not diversify his/her responses	≤ 10	17	-2.0	-1.0	0.0	0.492	Male	13	-3.0	-1.0	-1.0	0.056	Yes	6	-1.0	0.0	1.0	0.075
		> 10	13	-2.0	-1.0	0.0		Female	17	-2.0	0.0	0.0		No	24	-2.0	-1.0	0.0	
7	The child is indigent and quickly distracted	≤ 10	17	-3.0	-1.0	-1.0	0.159	Male	13	-3.0	-3.0	-2.0	0.073	Yes	6	-3.0	-1.5	0.0	0.428
		> 10	13	-3.0	-3.0	-2.0		Female	17	-3.0	-1.0	-1.0		No	24	-3.0	-2.0	-1.0	
8	The child claims to be oppressed and his/her rights are infringed	≤ 10	17	-4.0	-2.0	-1.0	0.263	Male	13	-4.0	-3.0	-2.0	<b>0.041</b>	Yes	6	-2.0	-1.0	1.0	<b>0.046</b>
		> 10	13	-4.0	-3.0	-2.0		Female	17	-3.0	-2.0	-1.0		No	24	-4.0	-3.0	-1.5	
9	The child makes inappropriate responses to the situation	≤ 10	17	-3.0	-2.0	-1.0	0.378	Male	13	-4.0	-3.0	-2.0	0.220	Yes	6	-2.0	-0.5	0.0	<b>0.006</b>
		> 10	13	-4.0	-3.0	-1.0		Female	17	-3.0	-2.0	-1.0		No	24	-4.0	-3.0	-1.0	
10	The child exaggerates remorse if he/she makes a mistake	≤ 10	17	0.0	0.0	1.0	<b>0.006</b>	Male	13	0.0	0.0	1.0	0.096	Yes	6	0.0	0.0	1.0	0.254
		> 10	13	-2.0	-1.0	0.0		Female	17	-1.0	0.0	0.0		No	24	-1.0	0.0	0.5	
11	The child's attention span does not improve	≤ 10	17	-3.0	-1.0	0.0	0.126	Male	13	-4.0	-3.0	-2.0	0.143	Yes	6	0.0	0.0	1.0	<b>0.002</b>
		> 10	13	-3.0	-2.0	-1.0		Female	17	-3.0	-1.0	0.0		No	24	-3.0	-2.5	-1.0	

	whether he/she is punished or rewarded																			
12	The child does not show imagination (narrow-minded)	≤ 10	17	-3.0	-1.0	0.0	0.609	Male	13	-3.0	-2.0	-1.0	0.092	Yes	6	-1.0	0.0	1.0	0.061	
		> 10	13	-2.0	-1.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-3.0	-1.5	-0.5		
13	The child does not forgive others if they offend him/her	≤ 10	17	-3.0	-2.0	-1.0	0.654	Male	13	-3.0	-3.0	-2.0	<b>0.003</b>	Yes	6	-3.0	-1.0	1.0	0.195	
		> 10	13	-3.0	-3.0	0.0		Female	17	-2.0	-1.0	0.0		No	24	-3.0	-2.0	-1.0		
14	The child gets upset if everything is not so perfect	≤ 10	17	-2.0	0.0	1.0	0.061	Male	13	-2.0	-2.0	-1.0	0.173	Yes	6	-2.0	1.0	1.0	0.065	
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	0.0	1.0		No	24	-2.0	-1.0	0.0		
15	The child's attention span is short	≤ 10	17	-3.0	-2.0	-1.0	0.285	Male	13	-4.0	-3.0	-2.0	0.239	Yes	6	-3.0	-2.0	-1.0	0.314	
		> 10	13	-4.0	-3.0	-2.0		Female	17	-3.0	-2.0	-1.0		No	24	-4.0	-3.0	-1.0		
16	The child finds it difficult to remember objects or events	≤ 10	17	-3.0	-1.0	0.0	0.370	Male	13	-3.0	-2.0	-2.0	0.159	Yes	6	-2.0	0.0	0.0	0.096	
		> 10	13	-3.0	-2.0	-2.0		Female	17	-3.0	-1.0	0.0		No	24	-3.0	-2.0	-1.0		
17	The child accuses others of things they have not really done with him/her	≤ 10	17	-2.0	-1.0	-1.0	0.448	Male	13	-3.0	-2.0	-1.0	<b>0.039</b>	Yes	6	-1.0	-0.5	0.0	<b>0.030</b>	
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	-1.0	-1.0		No	24	-3.0	-2.0	-1.0		
18	The child's weakness is evident in his/her vocabulary	≤ 10	17	-3.0	-2.0	0.0	0.163	Male	13	-4.0	-3.0	-2.0	0.062	Yes	6	-2.0	-1.0	0.0	0.117	
		> 10	13	-4.0	-3.0	-2.0		Female	17	-3.0	-2.0	0.0		No	24	-4.0	-2.5	-1.5		
19	The child complains that others do not like him/her	≤ 10	17	-3.0	-2.0	-1.0	0.521	Male	13	-3.0	-2.0	-1.0	0.638	Yes	6	-3.0	-1.5	0.0	0.525	
		> 10	13	-3.0	-2.0	-1.0		Female	17	-3.0	-2.0	-1.0		No	24	-3.0	-2.0	-1.0		
20	The child does not complete his/her work and continues to move from one task to another	≤ 10	17	-4.0	-2.0	-1.0	0.491	Male	13	-4.0	-2.0	-1.0	0.228	Yes	6	-3.0	-1.0	0.0	0.135	
		> 10	13	-4.0	-2.0	-2.0		Female	17	-3.0	-2.0	-1.0		No	24	-4.0	-2.0	-1.0		
21	The child blames him/herself if things do not go as he/she likes	≤ 10	17	-1.0	0.0	1.0	<b>0.024</b>	Male	13	-2.0	0.0	1.0	0.429	Yes	6	0.0	0.5	1.0	<b>0.042</b>	
		> 10	13	-3.0	-2.0	0.0		Female	17	-2.0	-1.0	0.0		No	24	-2.5	-1.0	0.0		
22	The child is illogical in his/her judgment of things	≤ 10	17	-3.0	-2.0	-1.0	0.273	Male	13	-3.0	-3.0	-2.0	0.081	Yes	6	-2.0	-0.5	1.0	0.070	
		> 10	13	-3.0	-2.0	-2.0		Female	17	-2.0	-2.0	-1.0		No	24	-3.0	-2.0	-1.5		
23	The child shows many fears	≤ 10	17	-2.0	-1.0	0.0	<b>0.015</b>	Male	13	-3.0	-2.0	-1.0	0.209	Yes	6	-1.0	0.0	0.0	<b>0.031</b>	
		> 10	13	-3.0	-3.0	-2.0		Female	17	-3.0	-1.0	0.0		No	24	-3.0	-2.0	-1.0		
24	The child tells	≤ 10	17	-3.0	-1.0	0.0	0.623	Male	13	-4.0	-2.0	-2.0	0.054	Yes	6	-2.0	0.0	1.0	0.053	

	strange and meaningless stories	> 10	13	-2.0	-2.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-3.0	-2.0	-1.0	
25	The child shows poor reading	≤ 10	17	-3.0	-3.0	0.0	0.983	Male	13	-4.0	-3.0	-2.0	<b>0.031</b>	Yes	6	-3.0	-3.0	-1.0	0.979
		> 10	13	-4.0	-2.0	-1.0		Female	17	-3.0	-2.0	0.0		No	24	-4.0	-2.0	-0.5	
26	The child irritates quickly	≤ 10	17	-3.0	-2.0	-2.0	0.755	Male	13	-3.0	-2.0	-2.0	0.593	Yes	6	-3.0	-2.0	-1.0	0.700
		> 10	13	-2.0	-2.0	-2.0		Female	17	-3.0	-2.0	-1.0		No	24	-3.0	-2.0	-2.0	
27	The child's language is incomprehensible	≤ 10	17	-2.0	-1.0	0.0	0.633	Male	13	-3.0	-1.0	0.0	0.795	Yes	6	-2.0	-0.5	0.0	0.502
		> 10	13	-2.0	-1.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	-1.0	0.0	
28	The child does not care about the reactions of others and does what he/she likes	≤ 10	17	-3.0	-2.0	-1.0	0.590	Male	13	-3.0	-3.0	-2.0	0.271	Yes	6	-2.0	-1.0	0.0	0.051
		> 10	13	-3.0	-2.0	-2.0		Female	17	-3.0	-2.0	-1.0		No	24	-3.0	-2.5	-2.0	
29	The child makes spelling mistakes when he/she writes	≤ 10	17	-4.0	-2.0	-1.0	0.898	Male	13	-4.0	-2.0	-2.0	0.428	Yes	6	-4.0	-2.5	-1.0	0.791
		> 10	13	-3.0	-2.0	-2.0		Female	17	-3.0	-2.0	0.0		No	24	-3.0	-2.0	-1.0	
30	The child keeps lying	≤ 10	17	-3.0	-2.0	0.0	0.881	Male	13	-3.0	-3.0	-2.0	0.079	Yes	6	-1.0	-0.5	1.0	<b>0.038</b>
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-3.0	-2.0	-1.0	
31	The child's movement is excessive	≤ 10	17	-3.0	-2.0	-1.0	0.534	Male	13	-3.0	-2.0	-2.0	0.128	Yes	6	-2.0	0.0	0.0	<b>0.007</b>
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	-1.0	-1.0		No	24	-3.0	-2.0	-1.0	
32	The child seems absent-minded and absorbed in daydreaming	≤ 10	17	-2.0	-1.0	0.0	0.253	Male	13	-2.0	-2.0	-1.0	0.211	Yes	6	-2.0	-1.0	0.0	0.190
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-2.5	-2.0	-0.5	
33	The child seems nervous and annoyed	≤ 10	17	-3.0	-2.0	-2.0	0.667	Male	13	-3.0	-3.0	-2.0	0.547	Yes	6	-3.0	-1.5	-1.0	0.240
		> 10	13	-3.0	-3.0	-2.0		Female	17	-3.0	-2.0	-2.0		No	24	-3.0	-3.0	-2.0	
34	The child does not keep his/her promises	≤ 10	17	-3.0	-2.0	0.0	0.406	Male	13	-3.0	-3.0	-1.0	0.136	Yes	6	-2.0	0.0	1.0	<b>0.025</b>
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	-2.0	0.0		No	24	-3.0	-2.0	-1.0	
35	The child erupts quickly and does unexpected actions	≤ 10	17	-4.0	-3.0	-2.0	0.812	Male	13	-4.0	-3.0	-3.0	0.072	Yes	6	-3.0	-1.5	1.0	0.068
		> 10	13	-4.0	-3.0	-2.0		Female	17	-3.0	-2.0	-2.0		No	24	-4.0	-3.0	-2.0	
36	The child's involuntary movements appear on his/her face for no apparent reason	≤ 10	17	-3.0	-1.0	0.0	0.230	Male	13	-2.0	-1.0	0.0	0.748	Yes	6	-4.0	-3.0	0.0	0.137
		> 10	13	-1.0	-1.0	0.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	-1.0	0.0	
37	The child worries a lot	≤ 10	17	-2.0	-2.0	-1.0	<b>0.042</b>	Male	13	-3.0	-2.0	-2.0	0.797	Yes	6	-2.0	-0.5	0.0	<b>0.044</b>
		> 10	13	-3.0	-3.0	-2.0		Female	17	-3.0	-2.0	-1.0		No	24	-3.0	-2.0	-1.5	

38	The child seizes the property of others	≤ 10	17	-3.0	-2.0	0.0	0.748	Male	13	-3.0	-3.0	-1.0	0.079	Yes	6	-2.0	0.0	1.0	<b>0.047</b>
		> 10	13	-3.0	-2.0	-1.0		Female	17	-3.0	-1.0	0.0		No	24	-3.0	-2.0	-1.0	
39	The child seems weak in following academic instructions	≤ 10	17	-3.0	-3.0	-1.0	0.401	Male	13	-4.0	-3.0	-2.0	0.127	Yes	6	-4.0	-0.5	1.0	0.192
		> 10	13	-4.0	-3.0	-2.0		Female	17	-3.0	-2.0	-1.0		No	24	-4.0	-3.0	-2.0	
40	The child laughs in secret and talks to him/herself	≤ 10	17	-2.0	-1.0	0.0	0.856	Male	13	-1.0	0.0	0.0	0.182	Yes	6	0.0	0.0	0.0	0.057
		> 10	13	-1.0	0.0	0.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	-1.0	0.0	
41	The child shows low respect for authority and officials	≤ 10	17	-3.0	-2.0	-1.0	0.265	Male	13	-4.0	-3.0	-2.0	0.113	Yes	6	-3.0	-0.5	0.0	0.084
		> 10	13	-4.0	-3.0	-2.0		Female	17	-3.0	-2.0	-1.0		No	24	-4.0	-3.0	-2.0	
42	The child's face blushes easily	≤ 10	17	-2.0	-1.0	-1.0	0.745	Male	13	-2.0	-2.0	0.0	0.795	Yes	6	-4.0	-2.5	-1.0	0.147
		> 10	13	-2.0	-2.0	-1.0		Female	17	-2.0	-1.0	-1.0		No	24	-2.0	-1.0	-1.0	
43	The child keeps shaking his/her body in a certain direction	≤ 10	17	-2.0	0.0	0.0	0.697	Male	13	-2.0	0.0	0.0	0.819	Yes	6	-2.0	-1.0	0.0	<b>0.017</b>
		> 10	13	-1.0	0.0	0.0		Female	17	-1.0	0.0	0.0		No	24	-3.0	-1.5	-1.0	
44	The child writes his/her homework irregularly	≤ 10	17	-3.0	-2.0	-1.0	0.451	Male	13	-3.0	-3.0	-2.0	0.149	Yes	6	-3.0	-3.0	-2.0	0.323
		> 10	13	-3.0	-3.0	-2.0		Female	17	-3.0	-2.0	-1.0		No	24	-2.0	-1.0	0.0	
45	The child is late for school	≤ 10	17	-3.0	-1.0	0.0	0.636	Male	13	-3.0	-2.0	-1.0	<b>0.004</b>	Yes	6	-3.0	-1.5	0.0	0.594
		> 10	13	-2.0	-2.0	0.0		Female	17	-2.0	0.0	0.0		No	24	-3.0	-0.5	1.0	
46	The child is impulsive and does not control him/herself	≤ 10	17	-3.0	-2.0	-2.0	0.490	Male	13	-4.0	-3.0	-2.0	0.077	Yes	6	-4.0	-3.0	-2.0	0.103
		> 10	13	-4.0	-3.0	-2.0		Female	17	-3.0	-2.0	-1.0		No	24	0.0	0.5	1.0	
47	The child's drawings do not correspond to reality	≤ 10	17	-2.0	-1.0	0.0	0.250	Male	13	-4.0	-2.0	0.0	0.250	Yes	6	-3.0	-2.0	-1.0	<b>0.002</b>
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	-1.0	0.0	
48	The child performs reckless and unacceptable acts	≤ 10	17	-3.0	-2.0	-2.0	0.320	Male	13	-4.0	-3.0	-3.0	<b>0.013</b>	Yes	6	-3.0	-3.0	-2.0	<b>0.013</b>
		> 10	13	-4.0	-3.0	-1.0		Female	17	-3.0	-2.0	-1.0		No	24	-3.0	-2.5	2.0	
49	The child looks nervous	≤ 10	17	-3.0	-2.0	-1.0	0.847	Male	13	-3.0	-2.0	-2.0	0.898	Yes	6	-3.0	-2.0	-1.0	0.915
		> 10	13	-3.0	-2.0	-1.0		Female	17	-3.0	-2.0	-1.0		No	24	0.0	0.0	1.0	
50	The child is not aware of what he/she is about	≤ 10	17	-2.0	0.0	0.0	0.272	Male	13	-3.0	-1.0	0.0	0.322	Yes	6	-3.0	-1.0	-0.5	<b>0.001</b>
		> 10	13	-2.0	-1.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	-0.5	0.0	
51	The child does not perform his/her homework or performs it	≤ 10	17	-3.0	-2.0	0.0	0.103	Male	13	-4.0	-3.0	-2.0	0.065	Yes	6	-3.5	-3.0	-1.0	0.111
		> 10	13	-4.0	-3.0	-2.0		Female	17	-3.0	-2.0	0.0		No	24	-4.0	-1.5	0.0	

	incomplete																		
52	When the child gets agitated, he/she does not control him/herself (such as screaming or jumping out of his/her chair)	≤ 10	17	-4.0	-3.0	-1.0	0.171	Male	13	-4.0	-3.0	-2.0	0.259	Yes	6	-4.0	-3.0	-2.0	0.170
		> 10	13	-4.0	-3.0	-3.0		Female	17	-3.0	-3.0	-2.0		No	24	-2.0	-0.5	0.0	
53	The child absents from school without an acceptable excuse	≤ 10	17	-2.0	-1.0	0.0	0.550	Male	13	-4.0	-2.0	-1.0	<b>0.025</b>	Yes	6	-3.0	-1.0	0.0	0.291
		> 10	13	-2.0	-1.0	0.0		Female	17	-2.0	0.0	0.0		No	24	-2.0	-0.5	1.0	
54	The child avoids physical contact while playing and avoids rough games	≤ 10	17	-2.0	-1.0	0.0	0.565	Male	13	-3.0	-1.0	-1.0	0.670	Yes	6	-3.0	-1.0	0.0	0.329
		> 10	13	-3.0	-1.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	-1.5	1.0	
55	The child is quick-tempered	≤ 10	17	-3.0	-2.0	-1.0	0.830	Male	13	-3.0	-2.0	-2.0	0.491	Yes	6	-3.0	-2.0	-1.5	0.150
		> 10	13	-3.0	-2.0	-1.0		Female	17	-3.0	-2.0	-1.0		No	24	-2.0	0.0	1.0	
56	The child deliberately be an opponent	≤ 10	17	-3.0	-2.0	-1.0	0.623	Male	13	-4.0	-3.0	-1.0	0.185	Yes	6	-3.5	-2.0	-1.0	<b>0.042</b>
		> 10	13	-3.0	-2.0	0.0		Female	17	-2.0	-2.0	0.0		No	24	-2.0	0.0	1.0	
57	The child is stubborn and uncooperative	≤ 10	17	-3.0	-2.0	-1.0	0.468	Male	13	-3.0	-3.0	-1.0	0.669	Yes	6	-3.5	-2.0	-1.0	<b>0.019</b>
		> 10	13	-4.0	-3.0	-1.0		Female	17	-3.0	-2.0	-1.0		No	24	-2.0	0.0	1.0	
58	The child has difficulty carrying things	≤ 10	17	-4.0	-2.0	0.0	0.881	Male	13	-3.0	-2.0	-1.0	0.469	Yes	6	-3.0	-1.5	-1.0	0.132
		> 10	13	-2.0	-1.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-1.0	0.0	0.0	
59	The child gets injured (hurts him/herself) while playing	≤ 10	17	-2.0	-1.0	-1.0	0.500	Male	13	-2.0	-1.0	-1.0	0.420	Yes	6	-2.0	-1.0	-1.0	<b>0.014</b>
		> 10	13	-2.0	-1.0	0.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	0.5	1.0	
60	The child refuses to follow the instructions and rules and rebels when trying to adjust him/her	≤ 10	17	-3.0	-2.0	-1.0	0.548	Male	13	-4.0	-3.0	-2.0	<b>0.017</b>	Yes	6	-4.0	-2.0	-1.0	<b>0.017</b>
		> 10	13	-4.0	-2.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-1.0	0.0	1.0	
61	The child gets angry if he/she is asked to do something	≤ 10	17	-3.0	-2.0	0.0	0.932	Male	13	-3.0	-3.0	0.0	0.848	Yes	6	-3.0	-2.0	-1.0	<b>0.040</b>
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	-1.0	-1.0		No	24	0.0	0.0	1.0	
62	The child asymmetry appears in the performance of large muscular activities and movements	≤ 10	17	-3.0	-1.0	0.0	0.983	Male	13	-3.0	0.0	0.0	0.913	Yes	6	-2.0	-1.0	0.0	0.084
		> 10	13	-2.0	0.0	0.0		Female	17	-1.0	-1.0	0.0		No	24	0.0	0.5	1.0	

63	The child tends to games of the opposite sex	≤ 10	17	0.0	0.0	0.0	0.887	Male	13	0.0	0.0	0.0	0.553	Yes	6	-0.5	0.0	0.0	<b>0.028</b>
		> 10	13	0.0	0.0	0.0		Female	17	-1.0	0.0	0.0		No	24	-1.0	0.0	1.0	
64	The child gets tired quickly	≤ 10	17	-2.0	-1.0	0.0	0.344	Male	13	-3.0	-2.0	0.0	0.183	Yes	6	-2.5	-1.0	0.0	0.099
		> 10	13	-2.0	-2.0	0.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	-0.5	0.0	
65	The child's handwriting is weak and inconsistent	≤ 10	17	-3.0	-1.0	0.0	0.207	Male	13	-4.0	-3.0	-1.0	0.285	Yes	6	-4.0	-2.0	-1.0	0.106
		> 10	13	-4.0	-2.0	-2.0		Female	17	-2.0	-2.0	-1.0		No	24	-1.0	0.5	2.0	
66	The child denies responsibility for acts he/she has committed	≤ 10	17	-4.0	-1.0	0.0	0.441	Male	13	-4.0	-3.0	-2.0	0.080	Yes	6	-4.0	-2.5	-1.0	<b>0.005</b>
		> 10	13	-4.0	-2.0	-1.0		Female	17	-3.0	-1.0	0.0		No	24	-2.0	-1.5	1.0	
67	The child gets frustrated and loses the ability to quickly adjust his/her emotions	≤ 10	17	-4.0	-2.0	-2.0	0.309	Male	13	-4.0	-3.0	-2.0	0.330	Yes	6	-4.0	-3.0	-2.0	<b>0.037</b>
		> 10	13	-3.0	-3.0	-2.0		Female	17	-3.0	-2.0	-2.0		No	24	-1.0	-1.0	0.0	
68	The child is preferably alone	≤ 10	17	-3.0	-1.0	-1.0	0.574	Male	13	-2.0	-1.0	-1.0	0.634	Yes	6	-2.5	-1.0	-1.0	0.296
		> 10	13	-2.0	-1.0	0.0		Female	17	-2.0	-1.0	0.0		No	24	0.0	0.5	1.0	
69	The child's drawings are inconsistent and his/her coloring of shapes is not elaborate	≤ 10	17	-2.0	0.0	0.0	0.295	Male	13	-4.0	-2.0	-1.0	<b>0.008</b>	Yes	6	-3.0	-1.0	0.0	<b>0.003</b>
		> 10	13	-2.0	-1.0	0.0		Female	17	-1.0	0.0	0.0		No	24	-1.0	-0.5	1.0	
70	The child does not accept the guidance of others and insists on using his/her own style when doing something	≤ 10	17	-3.0	-2.0	-1.0	0.208	Male	13	-4.0	-3.0	-2.0	0.092	Yes	6	-4.0	-2.0	-1.5	<b>0.011</b>
		> 10	13	-4.0	-2.0	-2.0		Female	17	-2.0	-2.0	-1.0		No	24	-2.0	-0.5	0.0	
71	The child does not share others in rough games	≤ 10	17	-2.0	-1.0	0.0	0.519	Male	13	-2.0	-1.0	0.0	0.797	Yes	6	-2.0	-1.0	0.0	0.558
		> 10	13	-1.0	-1.0	0.0		Female	17	-2.0	-1.0	0.0		No	24	-1.0	0.0	0.0	
72	The child stumbling in his/her walk as he/she collides with others or objects around him/her	≤ 10	17	-2.0	-1.0	0.0	0.556	Male	13	-3.0	-1.0	0.0	0.983	Yes	6	-2.0	-1.0	0.0	0.186
		> 10	13	-2.0	0.0	0.0		Female	17	-2.0	-1.0	0.0		No	24	-4.0	-3.5	0.0	
73	The child bursts out of anger under the influence of pressures	≤ 10	17	-3.0	-3.0	-1.0	0.160	Male	13	-3.0	-3.0	-2.0	0.812	Yes	6	-3.0	-3.0	-2.0	0.668
		> 10	13	-4.0	-3.0	-2.0		Female	17	-4.0	-3.0	-1.0		No	24	-2.0	-1.5	0.0	
74	The child does not accept his/her	≤ 10	17	-3.0	-2.0	-1.0	0.383	Male	13	-4.0	-2.0	-2.0	0.169	Yes	6	-3.5	-2.0	-2.0	0.105
		> 10	13	-4.0	-2.0	-2.0		Female	17	-3.0	-2.0	-1.0		No	24	-2.0	0.0	0.0	

	colleagues and expresses it in a hostile way																		
75	The child seems idle and heavy in motion	≤ 10	17	-2.0	-1.0	0.0	0.715	Male	13	-2.0	-1.0	0.0	0.426	Yes	6	-2.0	-1.0	0.0	0.456
		> 10	13	-2.0	-1.0	0.0		Female	17	-2.0	0.0	0.0		No	24	-1.0	-0.5	0.0	
76	The child does not accept suggestions from others	≤ 10	17	-2.0	-1.0	0.0	0.108	Male	13	-3.0	-2.0	-1.0	0.072	Yes	6	-3.0	-2.0	-1.0	0.030
		> 10	13	-4.0	-2.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	-2.0	2.0	
77	The child bursts out of anger at his/her colleagues if they harass him/her in their banter or push him/her with their hands	≤ 10	17	-3.0	-2.0	0.0	0.061	Male	13	-3.0	-2.0	-2.0	0.401	Yes	6	-3.0	-3.0	-2.0	0.158
		> 10	13	-3.0	-3.0	-2.0		Female	17	-4.0	-3.0	-2.0		No	24	0.0	1.0	2.0	
78	The child deliberately behaves differently from others	≤ 10	17	-3.0	-2.0	-1.0	0.267	Male	13	-4.0	-3.0	-1.0	0.124	Yes	6	-4.0	-3.0	-1.0	0.002
		> 10	13	-4.0	-3.0	-1.0		Female	17	-3.0	-2.0	-1.0		No	24	-3.0	-1.5	0.0	
79	The child frown face frown forehead	≤ 10	17	-3.0	-1.0	-1.0	0.730	Male	13	-3.0	-2.0	-1.0	0.155	Yes	6	-2.5	-1.5	-1.0	0.709
		> 10	13	-2.0	-2.0	-1.0		Female	17	-2.0	-1.0	-1.0		No	24	-2.0	0.5	1.0	
80	The child is difficult to understand or woo	≤ 10	17	-3.0	-1.0	0.0	0.915	Male	13	-3.0	-2.0	-1.0	0.143	Yes	6	-3.0	-1.5	0.0	0.127
		> 10	13	-3.0	-1.0	0.0		Female	17	-2.0	0.0	0.0		No	24	-1.0	0.0	0.0	
81	The child does not trust his/her abilities and underestimates him/her	≤ 10	17	-2.0	0.0	0.0	0.035	Male	13	-3.0	-2.0	-2.0	0.007	Yes	6	-3.0	-2.0	0.0	0.066
		> 10	13	-3.0	-2.0	-2.0		Female	17	-2.0	0.0	0.0		No	24	-4.0	-2.5	1.0	
82	The child is pleased when he/she sees others in trouble	≤ 10	17	-4.0	-2.0	-1.0	0.139	Male	13	-4.0	-2.0	-1.0	0.506	Yes	6	-3.0	-2.0	-1.0	0.958
		> 10	13	-2.0	-1.0	0.0		Female	17	-3.0	-1.0	-1.0		No	24	-2.0	0.0	1.0	
83	The child depends on others and is led by them	≤ 10	17	-3.0	-1.0	0.0	0.882	Male	13	-3.0	-2.0	0.0	0.524	Yes	6	-3.0	-1.5	0.0	0.236
		> 10	13	-2.0	-2.0	0.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	0.0	1.0	
84	The child hits and pushes others	≤ 10	17	-3.0	-2.0	-1.0	0.594	Male	13	-3.0	-2.0	-1.0	0.551	Yes	6	-3.0	-2.5	-1.0	0.057
		> 10	13	-3.0	-2.0	0.0		Female	17	-3.0	-1.0	0.0		No	24	-3.0	-1.0	0.0	
85	The child seems unhappy	≤ 10	17	-3.0	-1.0	0.0	0.392	Male	13	-3.0	-2.0	-1.0	0.044	Yes	6	-2.5	-2.0	-1.0	0.442
		> 10	13	-2.0	-2.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-4.0	-0.5	0.0	
86	The child does not sympathize with others in	≤ 10	17	-3.0	-2.0	-1.0	0.609	Male	13	-4.0	-2.0	-1.0	0.080	Yes	6	-3.0	-2.0	-1.0	0.476
		> 10	13	-3.0	-1.0	0.0		Female	17	-2.0	-1.0	0.0		No	24	-1.0	-0.5	0.0	

their grief																			
87	The child is subservient and exaggerates in obedience	≤ 10	17	-1.0	0.0	0.0	0.377	Male	13	-1.0	0.0	0.0	0.930	Yes	6	-1.0	0.0	0.0	0.935
		> 10	13	-1.0	-1.0	0.0		Female	17	-1.0	0.0	0.0		No	24	-2.0	0.5	1.0	
88	The child feels good about his/her poor performance	≤ 10	17	-3.0	-2.0	0.0	0.609	Male	13	-4.0	-3.0	-1.0	0.125	Yes	6	-3.5	-2.5	-1.0	0.009
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	-2.0	-1.0		No	24	-2.0	0.0	0.0	
89	The child desires others to punish him/her	≤ 10	17	-3.0	0.0	0.0	0.531	Male	13	-3.0	-2.0	-2.0	0.006	Yes	6	-3.0	-1.5	0.0	0.362
		> 10	13	-2.0	-2.0	-1.0		Female	17	-1.0	0.0	0.0		No	24	-3.0	0.0	1.0	
90	The child withdraws quickly from group activities so that he/she prefers to work alone	≤ 10	17	-3.0	-1.0	0.0	0.278	Male	13	-3.0	-2.0	-1.0	0.278	Yes	6	-3.0	-2.0	-1.0	0.292
		> 10	13	-3.0	-2.0	-2.0		Female	17	-3.0	-1.0	0.0		No	24	-2.0	0.0	1.0	
91	The child avoids situations involving competition	≤ 10	17	-3.0	0.0	0.0	0.347	Male	13	-3.0	-2.0	0.0	0.608	Yes	6	-3.0	-2.0	0.0	0.185
		> 10	13	-3.0	-2.0	-1.0		Female	17	-3.0	-1.0	0.0		No	24	0.0	0.5	1.0	
92	The child is only satisfied to act as a leader for others	≤ 10	17	-2.0	0.0	0.0	0.425	Male	13	-2.0	0.0	0.0	0.413	Yes	6	-2.5	-1.0	0.0	0.019
		> 10	13	-2.0	-1.0	0.0		Female	17	-3.0	-1.0	0.0		No	24	-2.0	0.0	0.0	
93	The child is easily led and submitted to others	≤ 10	17	-2.0	0.0	0.0	0.216	Male	13	-1.0	-1.0	0.0	0.896	Yes	6	-1.5	-1.0	0.0	0.572
		> 10	13	-1.0	-1.0	0.0		Female	17	-2.0	0.0	0.0		No	24	-3.0	-2.0	-1.0	
94	The child is shy	≤ 10	17	-2.0	-1.0	-1.0	0.708	Male	13	-2.0	-1.0	-1.0	0.391	Yes	6	-2.0	-1.0	-1.0	0.200
		> 10	13	-2.0	-2.0	-1.0		Female	17	-2.0	-2.0	-1.0		No	24	-1.0	0.0	1.0	
95	The child deliberately puts him/herself in situations that call for criticism	≤ 10	17	-2.0	-1.0	0.0	0.259	Male	13	-3.0	-2.0	-2.0	0.067	Yes	6	-3.0	-2.0	-1.0	0.048
		> 10	13	-4.0	-2.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-3.0	-1.0	0.0	
96	The child makes fun of others	≤ 10	17	-3.0	-1.0	-1.0	0.931	Male	13	-3.0	-3.0	-1.0	0.137	Yes	6	-3.0	-1.5	-1.0	0.393
		> 10	13	-4.0	-1.0	0.0		Female	17	-3.0	-1.0	0.0		No	24	-3.0	-2.5	-2.0	
97	If the child fails he/she is easy to be frustrated and not try again	≤ 10	17	-3.0	-2.0	-1.0	0.087	Male	13	-4.0	-3.0	-3.0	0.003	Yes	6	-3.0	-3.0	-1.0	0.936
		> 10	13	-3.0	-3.0	-2.0		Female	17	-3.0	-1.0	-1.0		No	24	-4.0	-2.0	1.0	
98	It is difficult to recognize the feelings of the child because he/she does not show feelings towards others	≤ 10	17	-3.0	-2.0	-1.0	0.593	Male	13	-3.0	-2.0	-1.0	0.417	Yes	6	-3.0	-2.0	-1.0	0.979
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	-1.0	-1.0		No	24	-4.0	-2.5	0.0	

99	The child shows him/herself as helpless (clinging)	≤ 10	17	-3.0	-3.0	-1.0	0.966	Male	13	-4.0	-3.0	-2.0	0.454	Yes	6	-3.0	-2.5	-1.0	0.874
		> 10	13	-3.0	-2.0	-2.0		Female	17	-3.0	-2.0	-1.0		No	24	-2.0	-0.5	1.0	
100	The child is teasing and harassing others	≤ 10	17	-3.0	-2.0	-2.0	0.830	Male	13	-3.0	-3.0	-2.0	0.197	Yes	6	-3.0	-3.0	-2.0	0.070
		> 10	13	-4.0	-3.0	-1.0		Female	17	-3.0	-2.0	-1.0		No	24	-4.0	-0.5	1.0	
101	The child is acting ridiculously	≤ 10	17	-2.0	-1.0	-1.0	0.403	Male	13	-3.0	-2.0	-2.0	0.059	Yes	6	-3.0	-2.0	-1.0	0.381
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	-1.0	-1.0		No	24	-1.0	-1.0	1.0	
102	The child elies on others to perform the work he/her is supposed to do	≤ 10	17	-3.0	-1.0	-1.0	0.798	Male	13	-3.0	-2.0	-1.0	0.733	Yes	6	-3.0	-2.0	-0.5	0.215
		> 10	13	-2.0	-2.0	0.0		Female	17	-2.0	-1.0	0.0		No	24	-3.0	-2.5	-1.0	
103	The child is hypersensitive, hurt his/her feelings easily	≤ 10	17	-3.0	-1.0	-1.0	0.269	Male	13	-2.0	-1.0	-1.0	0.309	Yes	6	-3.0	-1.5	-1.0	0.591
		> 10	13	-3.0	-2.0	-1.0		Female	17	-3.0	-2.0	-1.0		No	24	-4.0	-2.0	0.0	
104	The child seems to have little confidence in him/herself	≤ 10	17	-3.0	-1.0	0.0	0.442	Male	13	-3.0	-2.0	0.0	0.670	Yes	6	-3.0	-1.5	-0.5	0.634
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	-2.0	-1.0		No	24	-2.0	-1.5	0.0	
105	The child is very attached to adults as it is difficult to leave them	≤ 10	17	-2.0	-1.0	0.0	0.257	Male	13	-3.0	-2.0	-1.0	0.881	Yes	6	-3.0	-2.0	-0.5	0.672
		> 10	13	-3.0	-2.0	-1.0		Female	17	-3.0	-2.0	0.0		No	24	0.0	0.5	1.0	
106	The child deceives other children	≤ 10	17	-2.0	-1.0	0.0	0.159	Male	13	-3.0	-3.0	-1.0	<b>0.022</b>	Yes	6	-3.0	-1.0	0.0	<b>0.022</b>
		> 10	13	-3.0	-1.0	0.0		Female	17	-1.0	0.0	0.0		No	24	-1.0	1.0	1.0	
107	The child does not show interest in the work of other children	≤ 10	17	-3.0	-1.0	0.0	0.196	Male	13	-3.0	-3.0	-1.0	0.350	Yes	6	-3.0	-2.0	-1.0	<b>0.019</b>
		> 10	13	-3.0	-3.0	-1.0		Female	17	-2.0	-1.0	0.0		No	24	-2.0	-0.5	0.0	
108	The child seems depressed	≤ 10	17	-2.0	-1.0	0.0	0.716	Male	13	-2.0	-2.0	-2.0	<b>0.019</b>	Yes	6	-2.0	-1.0	0.0	0.541
		> 10	13	-2.0	-2.0	0.0		Female	17	-1.0	-1.0	0.0		No	24	-2.0	-1.0	1.0	
109	The child constantly seeks encouragement and praise	≤ 10	17	-3.0	-2.0	0.0	0.865	Male	13	-3.0	-2.0	-1.0	0.832	Yes	6	-3.0	-2.0	-1.0	0.197
		> 10	13	-3.0	-1.0	-1.0		Female	17	-3.0	-2.0	0.0		No	24	0.0	0.5	2.0	
110	The child tries to attract the attention of his/her colleagues by clowning	≤ 10	17	-2.0	0.0	0.0	0.144	Male	13	-3.0	-2.0	-1.0	<b>0.046</b>	Yes	6	-2.5	-1.5	0.0	<b>0.046</b>
		> 10	13	-3.0	-2.0	-1.0		Female	17	-2.0	0.0	1.0		No	24				



جامعة النجاح الوطنية

كلية الدراسات العليا

فعالية برنامج العلاج باللعب في الحد من اضطرابات السلوك لدى

أطفال المؤسسات السكنية

إعداد

رؤى ماهر عبد القادر تكروري

إشراف

د. عدنان سرحان

قدمت هذه الرسالة استكمالاً لمتطلبات الحصول على درجة الماجستير في علم النفس الإكلينيكي، من كلية الدراسات العليا، في جامعة النجاح الوطنية، نابلس- فلسطين.

2024

# فعالية برنامج العلاج باللعب في الحد من اضطرابات السلوك لدى أطفال المؤسسات السكنية

إعداد

رؤى ماهر عبد القادر تكروري

إشراف

د. عدنان سرحان

## الملخص

**الخلفية:** يُعدّ الحرمان من الأسرة من أصعب التجارب التي قد يمر بها الإنسان، فالأطفال المحرومون من البيئة الأسرية والمقيمون في المؤسسات السكنية يعانون من أضرار نفسية كبيرة قد تنعكس على سلوكهم وتؤدي إلى ظهور اضطرابات سلوكية لديهم.

**الهدف:** هدفت هذه الدراسة إلى التعرف على انتشار اضطرابات السلوك بين الأطفال المحرومين من البيئة الأسرية والمقيمين في المؤسسات السكنية، ودراسة تأثير العلاج باللعب على هذه الاضطرابات.

**المنهج:** تم استخدام تصميم شبه تجريبي في هذه الدراسة، حيث شملت العينة مجموعتين: مجموعة ضابطة ومجموعة تجريبية. تم تقييم المشاركين باستخدام النسخة العربية من مقياس بيركس لتقدير السلوك، كما تم تحليل البيانات باستخدام الحزمة الإحصائية للعلوم الاجتماعية (SPSS) الإصدار 24، بالإضافة إلى تطبيق برنامج العلاج باللعب.

**النتائج:** أظهرت النتائج فعالية العلاج باللعب في تقليل حدة اضطرابات السلوك لدى الأطفال المقيمين في المؤسسات السكنية.

**الخلاصة:** وُجد أن اضطرابات السلوك شائعة بين الأطفال المقيمين في المؤسسات السكنية. وتبيّن أن التدخلات الفعّالة مثل العلاج باللعب تسهم في تقليل هذه الاضطرابات. لذلك، يجب التركيز على زيادة الوعي في المؤسسات السكنية والمعاهد والمدارس حول اضطرابات السلوك وكيفية التعامل مع الأطفال الذين يعانون منها، من خلال تنظيم ورش عمل ومحاضرات ودورات تدريبية تعتمد على العلاج باللعب.

**الكلمات المفتاحية:** اضطرابات السلوك عند الأطفال، المؤسسات السكنية، العلاج باللعب.