COGNITIVE BEHAVIORAL PLAY THERAPY (CBPT) AND AGGRESSIVE BEHAVIOR AND CONDUCT DISORDERS: A SINGLE CASE STUDY

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INTRODUCTION

Cognitive Behavioral Play Therapy (CBPT) is an integrated psychotherapy model based on CBT (Knell, 1993, 1998) and the therapeutic powers of play (Shaefer, 1999). The strategic use of play within the therapeutic context, makes it possible to apply CBT even to very young children (2½ - 8 years). At the moment the most commonly used CBT interventions for the treatment of aggressive behaviors and conduct disorders include the Coping Power Program (Lochman and Wells, 2002) and the Cool Kids Program (Rapee, R.M. et al., 2006). All these approaches are directed primarily to children with age range 7-16 years and do not require use of play therapy. Conversely, the integration of a play therapy paradigm with cognitive and behavioral techniques appears to be more appropriate for young children and to offer a structuring of sessions that has proven effective in the treatment of different disorders (Knell, Dasari, 2011).

METHODS

An 8 years-old child with aggressive behavior and conduct problems underwent 20 sessions of CBPT in a 6 month period and was assessed at three time points: pre-treatment (T0), post-treatment (T1) and 12-month follow-up (T2). At each assessment parents and teachers' completed the Child Behavior Checklist (Achenbach e Rescorla; 2001) and the Conners Rating Scales (Conners, 2001). Furthermore, data on the monitoring baseline of aggressive behavior and conduct problems frequency were collected.

The intervention was developed following the S. Knell model (1999) phases: introduction/orientation, assessment, middle and termination. The CBT interventions used are: modeling, role playing, bibliotherapy, psychoeducation, contingency management, positive self-affirmations and problem solving. Play therapy activities (Kaduson, Schaefer, 2002) were used to improve problem solving and emotional literacy and regulation through the use of puppets, storytelling and expressive arts.

OBJECTIVE

Aim of this study was to verify the effectiveness of CBPT treatment on the reduction of problem behaviors and on the development of coping skills aimed at managing aggressive behaviors and conduct problems.

RESULTS

Result show that at baseline the child showed high frequency of: (1) denigrate others, (2) amplify the truth, (3) polemical and aggressive reaction to no, (4) insistence and blackmail to get something, (5) do not listen to the parents' requests, (6) destroy objects. From the seventh CBPT session until T1, the number of these behaviors gradually decreases and remains partially unchanged even at T2 follow-up (The "denigrate others" does not appear only in 18, 19 section and at T1) (Figure 1). Furthermore, the results of the CBCL and CONNERS scales showed an improvement that is maintained over time exclusively at school (Figure 2a/b and Figure 3a/b).

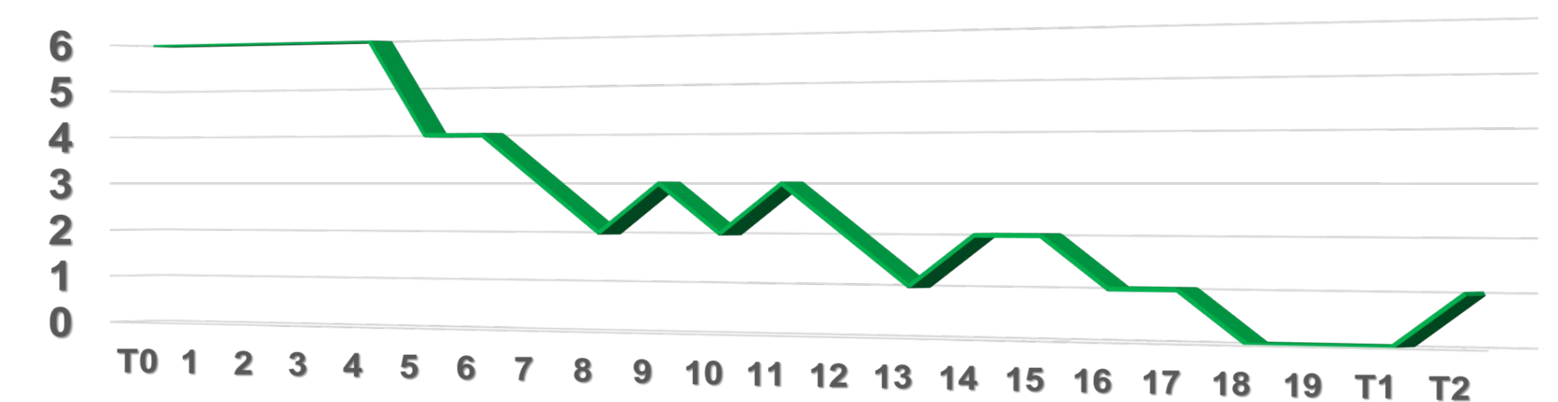

Figure 1. Frequency of problem behaviors from T0 across each session to T1 and T2.

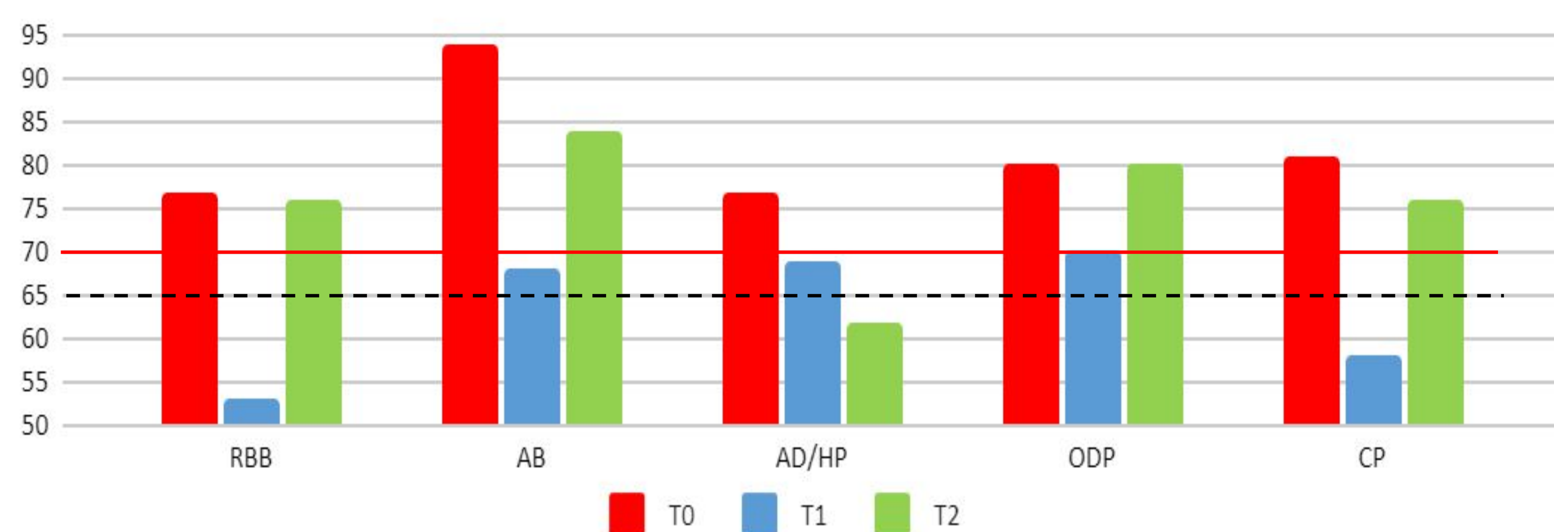

Figure 2a. Parents CBCL at each assessment times (T0, T1, T2)

CBCL SCALES

RBB: Rule-Breaking Behaviour
CA: Aggressive Behaviour
AD/HP: Attention Deficit/Hyperactivity Problems
ODP: Oppositional Defiant Problems
CP: Conduct Problems

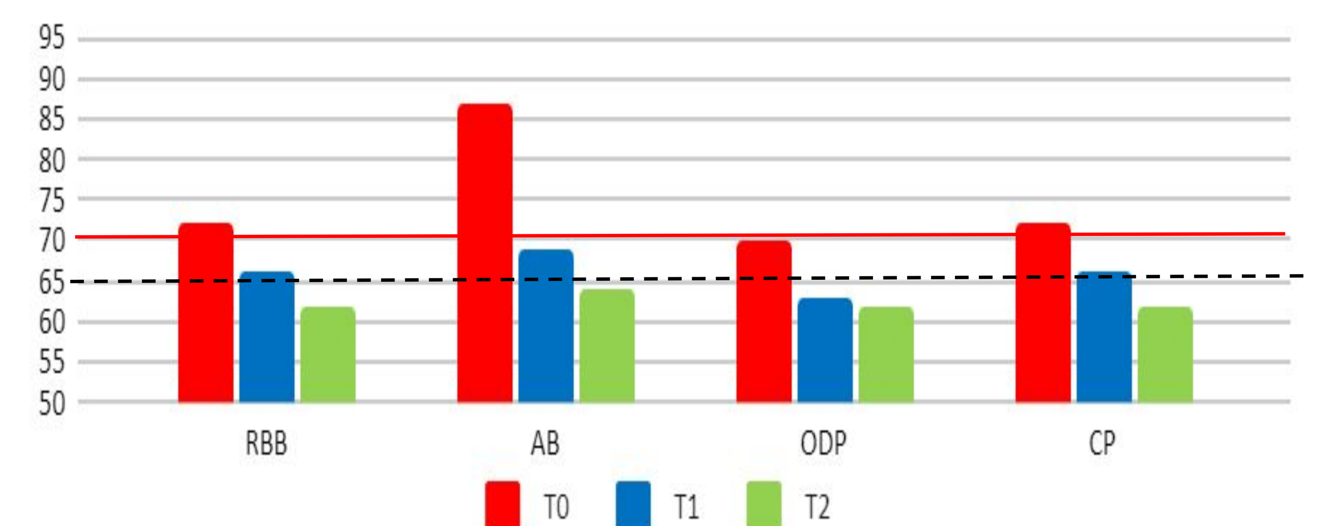

Figure 2b. Teachers CBCL at each assessment times (T0, T1, T2)

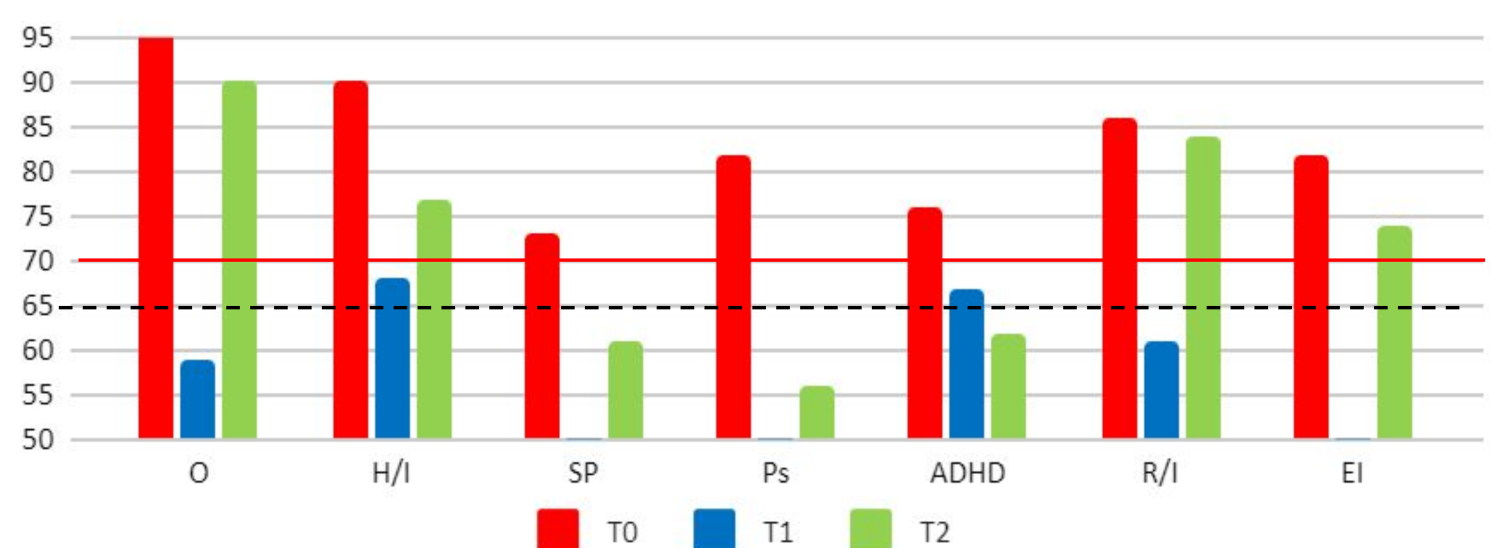

Figure 3a. Parents Conners scales at each assessment times (T0, T1, T2)

CONNERS SCALES

O: Oppositional
H/I: Hyperactivity/Impulsivity
SP: Social Problems
Ps:Psychosomatic
ADHD: ADHD Index
R/I: Restless-Impulsivity
EI: Emotional Lability

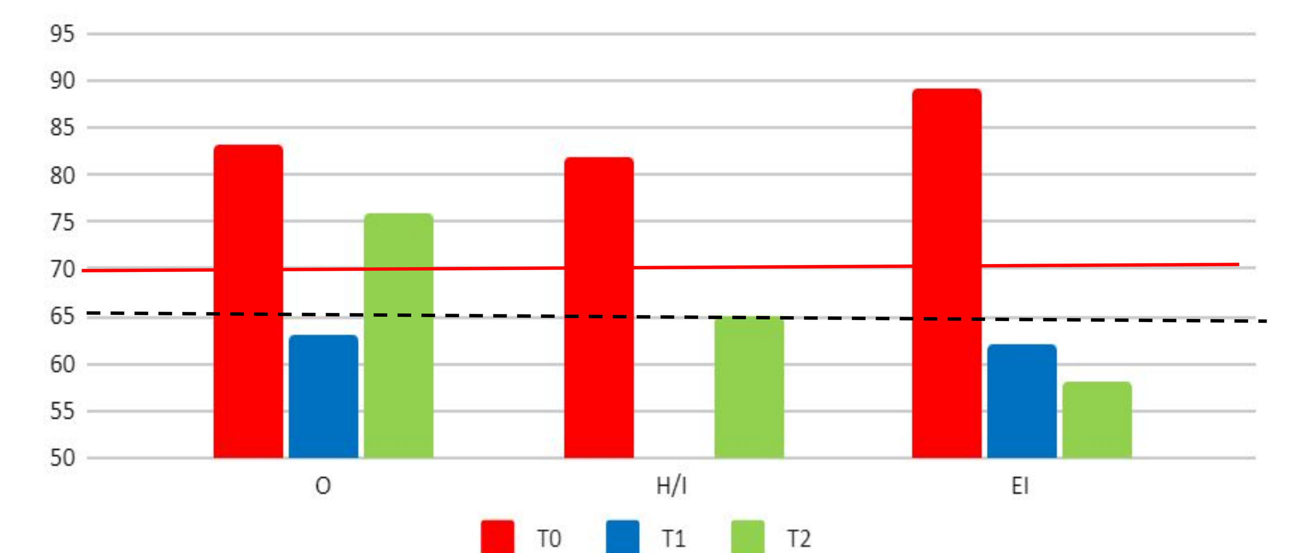

Figure 3b. Teachers Conners scales at each assessment times (T0, T1, T2)

DISCUSSION AND CONCLUSIONS

The results of this study demonstrate the effectiveness of CBPT in the post-intervention phase (T1) in both family and school settings. These data support the hypothesis that adapting CBT to younger children through play therapy activities can facilitate behavior regulation and belief change. Regarding maladaptive behaviors, measured at baseline, we witnessed the extinction of all maladaptive behaviors with the exception of "Denigrating others" at T2. The results of the CBCL and Conners scales at T2 remain out of clinical range for school behaviors. However, the subscales of both were within the clinical range for home behaviors. It should be noted that the scores were even lower than those at T0. We could justify this as the consequence of a mismatched parental intervention. This means that the intervention was effective in reducing aggressive behaviors due to conduct problems within the school setting, but not completely in the home setting. We can speculate that restarting the parenting skills intervention, which had yielded excellent results at T1, may improve the results at the next follow-up.

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