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Theraplay in the Chinese World: An Intervention Program for Hong Kong Children With Internalizing Problems

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The primary objective of this study was to evaluate the effectiveness of Theraplay on reducing internalizing problems among young children. Described as at-risk for developing internalizing disorders, 46 children were randomly allocated to either the Theraplay condition or the wait-list control condition. A standardized measure of internalizing symptoms was completed before and after an 8-week period. Results showed that children from the Theraplay condition showed significantly fewer internalizing symptoms when compared to the waitlist group. Qualitative feedback from mothers and children were gathered to further understand the experience of Theraplay activities on the participants. Limitations and suggestions for future research directions are discussed.

Keywords: Theraplay, internalizing problems, intervention, Chinese

Children's behavior problems can be broadly classified into two groups: externalizing behaviors and internalizing behaviors (Achenbach, 1991; Cicchetti & Toth, 1991). Externalizing problems encompass acting out behaviors, such as aggression and delinquent behavior, while internalizing problems include withdrawn behavior and somatic complaints. Unlike externalizing problems, whereby children's behaviors are covert, internalizing behavior problems often go unnoticed (Kauffman, 2001). Children with internalizing problems tend to be impaired in various social and school activities (e.g., Messer & Beidel, 1994; Silverman & Ginsburg, 1998). This impairment can also hinder children's readiness for learning (Pianta, 1997) and can increase the risk for suicide attempts (Lewinsohn, Rohde, & Seeley, 1998). Furthermore, these internalizing problems may intensify over time and are likely to develop into psychiatric conditions, such as depression and anxiety (e.g., Seligman & Ollendick, 1998). Hence, early intervention is important.

Internalizing problems among Hong Kong children have also reached an alarming level. A recent report released by the Health Welfare and Food Bureau of the Hong Kong Special Administrative Region (2002) estimated that about 5% to 10% of children were suffering from anxiety disorders while 2% were suffering from depressive disorders. Another study published by the Hong Kong Association for Careers Masters and Guidance Masters (2005) indicated that 75% of primary schoolchildren were unhappy. Their emotional problems were mostly on academic

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performance as well as on social relationship with others. Undetected internalizing problems at an early stage of life can lead to problems, such as depression or suicidal tendency (Centre for Suicide Research and Prevention, 2003). This may be particularly the case in Chinese children given the cultural endorsement of coping with personal distress through internalizing means (Chen & Swartzman, 2001). Hence, identifying effective interventions for helping these children is important.

There are many interventions that cater to reducing or preventing childhood internalizing problems. Examples include the Penn Optimism Program (POP; Jaycox, Reivich, Gillham, & Seligman, 1994) and the Coping Koala Program (Barrett, Dadds, & Rapee, 1996). Most of the interventions are cognitive-behavioral in nature. Ollendick and King (2004) commented that the existing criteria for reviewing empirically supported treatments rely too heavily on behavioral and cognitive-behavioral principles; hence, frequently practiced treatments of other orientations (such as play therapy) have not been evaluated sufficiently. In fact, play therapy has been indicated to be effective (Ray, Bratton, Rhine, & Jones, 2001) and is increasingly used in many different countries. There has been a growing recognition of the power of children's play as part of the intervention process (Shen, 2002), and play can be an important way to enhance children's socioemotional development. Relationship enhancement approaches represent another group of evidence-based interpersonally oriented practices for working with children's internalizing problems, especially depression. According to Mofson, Weissman, Moreau, and Garfinkel (1999), the Adolescent Coping with Depression (CWD-A) program is an empirically supported treatment for depression that emphasizes the interpersonal nature of depression and the effective strategies of using role-play to address issues relating to affect and social skills. Compared with a wait list control group, this study reported that adolescents who received interpersonal psychotherapy have a significantly greater decrease in depressive symptoms and an improvement in social functioning.

It seems that close relationship with significant others can be an effective therapeutic element for working with young children. It would be worthwhile to draw on the concept of attachment, an important component in the socioemotional domain for child development, in understanding effective therapeutic interventions for children. Theraplay (Jernberg, 1979; Jernberg & Booth, 1999) is one of the play therapy approaches that focuses on developing healthy parent-child relationship in addressing children's developmental needs.

THEORETICAL BACKGROUND OF THERAPLAY

Theraplay (Jernberg, 1979, 1993; Jernberg & Booth, 1999) is a playful, engaging, short-term treatment method that is intimate, physical, personally focused, and fun. It is "based on replicating normal parent-child interactions, which include a lot of physical contact, joyfulness, and fun" (Munns, 2000, p. 9). Theraplay is derived from attachment theory, which proposes that the first relationship children have is the most important one in their life. In Theraplay, the quality of this first relationship forms the prototype for all other relationships. According to Theraplay, the simple act of making a funny face at a baby set into motion a reciprocal series of

behaviors in which each player in the drama significantly influenced the other (Lewis & Lee-Painter, 1974). Such an interaction helps both participants understand how each feels about the other. This understanding eventually generalizes into a view of the world as a "fun, caring, and loving place" (Jernberg, 1979, p. 5). Healthy interactions allow both to experience the comfort of intimacy and to develop self-confidence. If that relationship is not a positive one, children may experience difficulties in relating to others in later life.

Theraplay uses interaction strategies that are modeled on the characteristics of a healthy mother-child relationship. In an ideal situation, mothers show behaviors that nurture, engage, structure, and challenge the child during their interactions, which includes play interactions. According to Jernberg and Booth (1999) and Munns (2000), Theraplay uses four core elements in some forms for all activities including:

1. *Structuring* activities that limit, define, forbid, outline, name, label, clarify, confine, hold, or restrain. Structuring activities are meant to be part of the explicit limits and boundaries the mothers set to ensure children's physical safety and emotional security. Examples of this type of activity include games like "Simon Says" and "Mother May I."
2. *Challenging* activities that include teases, dares, encouragement, making noises for imitating, and wiggling a finger for catching. The purpose of these activities is to challenge the child to take a step forward and to enhance feelings of competence. Challenging activities include thumb wrestling, pillow fights, and different types of balancing challenges.
3. *Engaging* activities that include tickles, bounces, swings, and surprises. The purpose of this type of activities is to increase a child's experience of her or himself as a unique individual. Examples of this type of activity include clapping games and games that involve hiding cotton balls on the child's body.
4. *Nurturing* activities that include rocking, holding, feeding, cuddling, and hugging. Nurturing activities are those that provide a calming, soothing, reassuring effect on the child. They help children meet their needs for physical contact and caring in a positive context. Examples of nurturing activities include feeding, lotioning, and powdering.

In an ideal situation, all children would experience appropriate nurturing, engaging, structuring, and challenging interactions in their relationships with their parents or other primary caregivers. Many children, however, grow up in circumstances that are less than ideal. According to Jenberg (1993), the absence of nurturing, engaging, challenging, and structuring in parent-child interaction leads children to exhibit behaviors that are maladaptive. Without the presence of these elements as healthy parent-child relationship, children are likely to encounter difficulty forming secure attachments with others and will frequently display aggressive, overly demanding, or socially withdrawn behavior (Sroufe & Fleeson, 1986).

Increased self-esteem leads to children and parents feeling valued and important. Once parents start feeling good about themselves, they are more ready to be sensitive to the cues of others and to be in affective attunement with each other.

This responsiveness on the part of the parents is crucial for their children to develop an inner sense of a strong, competent self; feelings of worth; and secure attachment to their caregivers (Jernberg & Booth, 1999; Stern, 1995). It is commonly agreed that effective intervention with young children must address the environment of the child. According to Eyberg (1988), it is a philosophy in Theraplay that problem behaviors can be intensified by certain interaction patterns between a parent and a child.

In Theraplay, these experiences of oneself and of adults are encountered in a more direct way, using preverbal interactions instead of relying on the discussion at the cognitive level. From the developmental perspective, Theraplay, which focuses on improving parent-child relationships, could be an effective tool in dealing with childhood problems.

EFFECTIVENESS OF THERAPLAY ON CHILDREN WITH INTERNALIZING PROBLEMS

Research suggests that Theraplay has clinical validity. Morgan (1989) found that after receiving Theraplay, two thirds of the study's subjects had increased in measures of self-esteem, self-control, and self-confidence, as evaluated by parents, teachers, observers of the program, and the therapist. Munns, Jensen, and Berger (1997) demonstrated decreased aggression for children receiving Theraplay. Zanetti, Matthews, and Hollingsworth (2000) used Theraplay activities to reduce children's negative behaviors. Although results on objective measures (i.e., Connors Parent Rating Scale-48) failed to reach a statistically significant level, the change for most subjects was in the hypothesized direction. Talen (2000), in a study involving the use of Theraplay in primary health care centers, suggested that Theraplay activities played a role in facilitating interventions for the physical and behavioral health needs of children. A recently published "Multi-Centre-Study" that evaluated 205 children who received Theraplay (Franke & Wettig, 2003) also indicated that Theraplay had a significant and positive impact on children who exhibited shyness.

APPLICATION OF THERAPLAY WITH CHINESE CHILDREN

Very few studies related to research on Theraplay have been done in the Chinese population. However, it was expected that Theraplay would be appropriate for Chinese children based on the following rationale. First, the emphasis of Theraplay on attachment and interdependence is consistent with traditional Chinese collectivist cultural values. In fact, it's the author's impression that mother-child bonding in Chinese societies has been usually tighter, although not necessarily healthier, than in Western society. Compared with the Western culture, Chinese parents generally have higher academic expectations of their children and exert more pressure on them to work hard and to achieve (Pagani-Tousignant, 1992). These pressures might lead to problems including self-criticism and lowered self-esteem if children fail to achieve as expected (Csikszentmihalyi, 1997). Addressing

these affective issues can help Chinese parents better understand the source of emotional problems, and Theraplay can be an appropriate approach to achieve this.

Second, given that the Chinese are generally less expressive when talking about their problems, an approach with more focus on activity than talk may suit their cultural characteristics. Theraplay is an approach that focuses more on activity than talk. In line with this argument, as there is less demand in Theraplay for language to express complex thoughts and feelings, it can be effective in working with children.

Although there has been limited research regarding the effectiveness of Theraplay in the Chinese culture, Manery (2000) demonstrated the effectiveness of Theraplay in treating a withdrawn preschooler. In that case, the parents' persistence in intellectualizing their child's experience by asking questions seemed to dampen the child's spontaneity and enjoyment of activities. Theraplay treatment focused on responding to the child's needs by encouraging and modeling engagement in activities and discouraging question asking. The girl was later reported by the therapist to be more verbal and more willing to share her feelings with adults.

The major purpose of this study was to evaluate the effectiveness of Theraplay in reducing children's internalizing symptoms. Internalizing scores of children who received Theraplay was compared with those who do not receive Theraplay (i.e., a wait list control group). It was hypothesized that internalizing scores of children who received Theraplay would show a greater decrease from pre- to posttest than would internalizing symptoms of children who did not receive Theraplay.

METHOD

Participants

Participants were 46 children, 25 boys and 21 girls, from an elementary school in an urbanized area. The mean age for children in the Theraplay group ($n = 22$) was 7.84 ($SD = 1.36$), and the mean age for children in the waitlist control ($n = 24$) group was 7.89 ($SD = 1.32$). Females composed 56% and 54% of the treatment and waitlist groups respectively. Mothers of these children also participated in the study. The mean age of mothers in the Theraplay group was 37.36 ($SD = 4.20$) while the mean age for the waitlist control condition was 39.81 ($SD = 3.12$).

One criterion for children being included in the study was that they had reached at least the cutoff point for internalizing problems as measured using the Child Behavior Checklist (CBCL; Achenbach, 1991). The raw score for clinical cutoff of CBCL-Internalizing was 16 (T score = 63). In this sample, the mean raw score was 16.76 ($SD = 1.43$), with the mean T score at 64.58 ($SD = 3.25$). In addition to the CBCL-internalizing score, participants had to meet the following criteria in order to join this study: (a) neither the mother nor the child was currently receiving any form of counseling or psychotherapy; (b) the child's intellectual level was at least within the normal range (as reported by teachers); and (c) the mothers signed a consent form allowing their children to join the intervention program.

Measure

Child Behavior Checklist (CBCL)

The CBCL (Achenbach, 1991) was chosen to measure internalizing problems because it is a commonly used and well-validated behavioral rating scale (Achenbach & Edelbrock, 1983; Leung & Wong, 2003; Lochman & Dodge, 1998). The CBCL was designed to quantify a broad range of clinically relevant behavioral and emotional problems. It contains 113 items related to child functioning and problem behaviors in a variety of contexts. Parents indicate the degree or frequency of each behavior in their child as described in the CBCL items and rate their child on a scale of 0 (*not true*), 1 (*somewhat or sometimes true*) or 2 (*very true or often true*). By summing 1s and 2s on all items, scores on the eight narrow-band syndromes were created. These syndromes were *Withdrawn*, *Somatic Complaints*, *Anxious/Depressed*, *Thought Problems*, *Social Problems*, *Attention Problems*, *Delinquent Behavior*, and *Aggressive Behavior*. Symptoms on *Withdrawn*, *Somatic Complaints*, and *Anxious/Depressed* were combined to form a composite score on *Internalizing*, while symptoms on *Delinquent Behavior* and *Aggressive Behavior* formed a composite score on *Externalizing*. For the purpose of this study, only items related to the composite score on *Internalizing* were used. For this composite score, raw scores of *Internalizing* from 13 to 16 ($T = 60-63$) were identified as within borderline clinical range. Hence, children whose *Internalizing* score were at or above 13 were considered as "high risk" for having internalizing problems. The Chinese version of the CBCL has demonstrated an internal consistency of 0.89 on Total Problems in a Mainland Chinese sample (Liu et al., 1999) and 0.72 to 0.90 on various subscales in a Taiwanese sample (Yang, Soong, Chiang, & Chen, 2000). The CBCL was translated into Chinese and a Hong Kong norm was established (Leung, Ho, Hung, Lee, & Tang, 1998). The clinical cutoff point for *Internalizing* identified from Leung et al. (1998) in the Hong Kong norm for CBCL was similar to that from the original CBCL. Hence, in the present study, children with *Internalizing* score at or above 13 in the CBCL were considered as high risk for having internalizing problems.

Procedure

Mothers of children between grades two to four in the target school were asked to complete the CBCL. Those children whose CBCL internalizing score reached at least the cutoff point were invited to participate in this study. Mothers were invited to come for a briefing session on the introduction to Theraplay. For those who agreed to participate in the study, children were randomly assigned into the two conditions, the Theraplay group and the waitlist control group.

Group sessions were conducted once a week by certified Theraplay therapists. The content for the intervention group was based on the Group Theraplay activities (The Theraplay Institute, 2000). Activities incorporated a high degree of physical interaction, playfulness, and a strong sense of connection among participants. As suggested by Jernberg and Booth (1999), each session would begin with an opening

Table 1. Pre- and Post-Intervention Scores for All Participants

Scales	Treatment group		Control group		Eta-squared	Effect of group Univ <i>F</i>
	(n = 22)		(n = 24)			
	Pre	Post	Pre	Post		
CBCL-internalizing <i>T</i> -score	64.68 (3.40)	57.68 (2.37)	64.50 (3.18)	64.16 (2.89)	0.26	15.46**

Note. The values in the Pre and Post columns represent mean behavior scores on the CBCL-internalizing, with *SD* in parentheses. Pre = pre-intervention; Post = post-intervention.

song, followed by some "check-up" activities (e.g., "Let's see whether you brought those strong muscles you had here last week"); then move into some lively, surprising, engaging activities; slow down for some soft, gentle, calming activities; build up to a lively, perhaps competitive crescendo again; and end, possibly, with food sharing and a good-bye song. Three simple rules were reviewed with the children as often as necessary. The rules for children were "stick (stay) together," "no hurts," and "have fun." The fourth rule, which applies to the adult only, is "the adult is always in charge." There were eight weekly sessions for the intervention group; each lasted for about 40 minutes. The rationale of the approach in helping children was explained to the mothers, who joined in the early sessions as observers. The sessions were videotaped and feedback regarding the child's behavior was discussed with the mothers at the end of each session. Mothers were encouraged to practice the activities done in the group with their own child. These mothers were asked to join the latter sessions as participants in the group.

When all the Theraplay sessions were completed, mothers were again asked to complete the CBCL. The CBCLs were distributed through the class teacher and were returned to the school for later collection by researcher. The researcher helped to remind mothers to complete and send in the CBCLs. After all sessions were completed, mothers and children who were in the Theraplay condition were invited to provide qualitative feedback on treatment satisfaction.

RESULTS

Changes in Children's Behavior: Pre to Postintervention

Scores on the CBCL-Internalizing scale were calculated, using preintervention scores on each scale as covariates. The results on CBCL-internalizing, as shown in Table 1, revealed a statistically significant but small association between the combined dependent variable and the combined covariates, $F(1, 43) = 15.46$, $p < .01$ (Eta-squared = 0.26). The results of the univariate analyses of covariance revealed significant group difference on the score for CBCL internalizing, indicating that the mean scores of the intervention group decreased significantly more from pre- to postintervention than those of the control group, even with the effects of preintervention score controlled. The effect size, as measured using eta-square, was in the large range (Tabachnik & Fidell, 2001).

Treatment Satisfaction

Participants in the Theraplay condition were interviewed after all the sessions were held. Theraplay received positive evaluations from parents and children alike. On a 10-point scale with 1 as *very dissatisfied* and 10 as *very satisfied*, the parents' mean overall evaluation of the program was 8.07 ($SD = 1.04$). The mean rating of parents' recommendations of the program to others was 7.48 ($SD = 1.08$). Sixty-four percent of parents indicated that they tried out Theraplay activities at home while 54% indicated that they would continue with the Theraplay games in future. With regard to how enjoyable Theraplay was, 68% of children rated the activities as "fun" and 72% rated them as "happy."

Mothers' Reports About Enjoyment of Sessions

Participants were interviewed after all the sessions were held. Among the comments given by mothers, 90% of the mothers said that they had fun time with their children. The games reminded them of the fun of being "playful" with their children. There was a variation in the responses for the games of different dimensions. With respect to *Structuring* games, 60% of mothers indicated that there was "nothing special" about those games as they were so used to playing those types of games with their children. As for *Nurturing* games, there were two distinct types of responses from mothers. Sixty-eight percent of mothers stated that nurturing games reminded them the importance of basic needs on children and that feeding and "babyish stuff" were sometimes good for enhancing relationship. Twenty-eight percent of mothers commented that these games were too childish and they seldom played like this since their children were getting older. For games in *Challenging* and *Engaging* dimensions, 60% of mothers found that they got insight to their daily parenting through these games. Some mothers mentioned that *Challenging* games did remind them about setting up appropriate expectations for children and said it was important for children to see how much they achieve. Among all the games, the "cotton ball" series, that is, the "cotton ball blow" and the "cotton ball fight" were nominated as the most enjoyable games from the mothers who participated in the Theraplay condition.

Children's Reports About Enjoyment of Sessions

As for the children who participated in the Theraplay condition, most of them reported that they enjoyed the sessions. Ninety percent of the children said that they were happy playing the games with their mothers, while the remaining 10% of children indicated that it was "odd" that mothers played with them that way. All children enjoyed this kind of session as there were no "assignments" given in class – only games. Seventy-seven percent (i.e., 17 children) indicated that they enjoyed all the giggling and laughing in the games. Sixty-three percent of children indicated that "balloon between two body parts" and "cotton ball blow" as their favorite games.

DISCUSSION

The major aim of this study was to evaluate the effectiveness of Theraplay in reducing symptoms of internalizing problems (as reported by mothers). Results of data analyses suggested that Theraplay was effective in showing positive improvement for children who are "at risk" for developing internalizing problems. There was a significant difference between the Theraplay group and the wait-list control group on CBCL-internalizing scores, with the Theraplay group's scores being lower than control group's scores. The results of this study, together with previous studies (e.g., Franke & Wettig, 2003), indicate that Theraplay is an effective intervention for children.

Theraplay can also enhance mother-child relationships, as it gives more opportunities for mother-child dyads to interact and have fun through playful activities. Such fun, playful relationships are dependent on the child's feeling of being loved and valued, and Theraplay nurturing activities are especially important in creating a sense of unconditional acceptance for children. When children feel accepted just for being who they are, they may not be that dependent on academic achievement to "gain acceptance" from their parents. The pressure on the child to work hard and to achieve (as described by Pagani-Tousignant, 1992) in order to meet high academic expectations from parents can be reduced.

Children with internalizing problems tend to keep things to themselves and are less verbal in talking about their problems. The positive attention given to children through Theraplay could help to create a perception in children that they are lovable and valued; and in turn, this sense of feeling importance may be an essential element in building children's general self-esteem. When children feel valued, it might be easier for them to talk to adults about their own difficulties and less chance for them to turn their emotions inward. This might indirectly reduce children's internalizing problems.

Results of this study also imply that Theraplay works well for Chinese children and their families. Interpersonal harmony is an important characteristic of Chinese communication. Emotional restraint and indirect communication as opposed to confrontation are often preferred (Huang, 1994; Smith & Wang, 1996). Chinese people are more reluctant to express themselves verbally or emotionally. Moreover, they see family problems as "secrets" and it would be shameful for the whole family if these problems are brought up to a third party for help. As Theraplay is an action-based type of therapy and its focus is more on activities than talk, Chinese people may find this approach less "intrusive." In addition, the collectivist cultural values that emphasize "togetherness" of the Chinese coincide with Theraplay's core focus on attachment and interdependence. Because Chinese parents put relatively high emphasis on their children's academic achievement, issues relating to school performance often lead to poor parent-child relationships. Theraplay provides a means for parents and children to put schoolwork aside and be "playful" and have fun together. In Theraplay, especially in nurturing activities, children are unconditionally accepted and are made to feel valued and loved. This is important for building one's self-esteem. When a child feels accepted just for being whom he or she is, the sense of self is less dependent on other achievements.

Limitations of the Study and Directions for Future Research

There were several limitations in the current study. First, children's internalizing problems were only based on mother's report. Information from fathers, teachers, or significant others may provide different perspectives on understanding children's behavior and on reducing bias in reporting of internalizing problems. Second, observations of the interaction patterns between mothers and their child were not included in the assessment procedure. A formal measure to assess parent/child interactions for Theraplay, the Marschak Interaction Method (MIM; Jernberg, 1991), could be used to compare relationship patterns at pre and postintervention. The results of the MIM could highlight the components of Theraplay that contribute to reducing children's internalizing problems. Third, the sample size for the current study was small and this could have an impact on the external validity of the conclusion. Future studies with larger samples would allow further exploration of treatment outcome moderators that could affect the impact of Theraplay on children.

With reference to the design of the study, future studies of similar nature could consider including an attention control placebo condition (e.g., academic tutoring) or other less-commonly used therapeutic activities (such as doing art work) to see how different activities could help to reduce children's internalizing behavior. In addition, 1- and 6-month follow-up measurements would help to determine further the effectiveness of Theraplay (a relationship-based intervention) on Hong Kong children across time.

In conclusion, this study adds to a growing body of data suggesting that Theraplay is an effective treatment for childhood internalizing problems. The effectiveness of Theraplay is further supported by the design of this study of using randomized assignment for conditions. The results should be replicated in other centers/schools by other researchers to determine if Theraplay can be extended to Chinese children from different samples as well as with different severity levels of internalizing problems.

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