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CREATING AWARENESS AND BENEFITS OF PLAY THERAPY IN CHILDREN BETWEEN 5 TO 12 YEARS AGE WITH BEHAVIOR PROBLEM

Paediatrics

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ABSTRACT

The aim of the present study to evaluate the effect of applying play therapy on children with behaviour problem: 1) Assessing and diagnosis the children's inattention, hyperactivity, impulsivity, and other behaviour problem before applying play therapy. 2) Evaluating the effect of play therapy on children's inattention, hyperactivity, impulsivity, and other problem after applying play therapy. 3) Parenting counselling and guidance for understanding children emotional concepts, behaviour therapy and other management. Sample for the study includes 84 school going children from different school from Nagpur (48 boys, and 36 girls) between the age group of 6-12 years, referred by doctors from NKPSIMS and Lata Mangeshkar Hospital from central India Nagpur. The present study shows statistically significant differences in all areas of emotional and behaviour areas at the level of <0.05. Study also shows statistically significant differences in all behaviour domain areas after ten months play therapy, behaviour modification, Parenting Counselling, training, communication, through Play Therapy, significant at <0.05 level. Study shows that play therapy helps to resolve those issues as well and reduces the overall number of challenges the child is facing. Together with Parenting Counselling, training, communication, games play with children. Through Play Therapy, children learn to communicate with others, express feelings, modifying/ shaping behaviour, develop reasoning, problem-solving skills, communication and learn a variety of ways of relating to social areas. Play provides a safe psychological distance from their problems and allows expression of thoughts and feelings on paper and play appropriate to their development.

KEYWORDS

Child behaviour checklist (CBCL), Play therapy, behaviour modification, parent counselling and guidance.

INTRODUCTION

Parenthood can be a constant worry. They feel your child is not performing well at school; is constantly anxious or unhappy; doesn't play with others or is unable to communicate; has a physical , mentally, academic difficulties; is exhibiting disruptive behaviours; or may be inattentive to others and their environment.

Play is commonly misconceived as 'frivolous fun', something that should be given to children as a break between learning. However, for children, play **is** learning. Play is a child's universal right and it is how they gain an understanding of who they are and how they can make sense of the world.

Play is essential for the development of language and communication skills; logical and creative thinking; fine and gross motor skills; and also has many therapeutic benefits. Play Therapy can enable children to gain an understanding of themselves and the world around them, helping them overcome behavioural, emotional and social issues. It can aid social interaction, encourage communication, sadness, anxiety and help towards better social integration, growth and development, leading to a full and happy adult life.

Day by day educational burden ,tough competition, high parenting expatiation, home atmosphere , relationship with peer group or social and stressful events in life Play can be used as a medium to help therapist and parents interact with children and help them express their feelings and emotions. Due to its focus on the developmental needs of young children, play therapy is widely used as an intervention for children's emotional and behavioural problems. Play therapy has been specifically designed to be developmentally appropriate for children and is based on the idea that children communicate and express inner conflicts and feelings through play. Children generally don't have any experience or not taken any counselling and guidance for undo or fix unhealthy habits. Although children who have been through inordinate amounts of stress will have some fixing to do, the majority of our work will be focused on building child's self-creating self-respect and social respect. Play therapy gives your child the glorious opportunity to get it right the first time, to forge a healthy emotional foundation that will last a lifetime.

Play Therapy is a form of psychotherapy that uses play, a child's natural mode of communication, to help them resolve their issues. Traditional forms of therapy may be very intimidating for a child and can cause added stress rather than actually resolving the issues that your child may be facing. Play Therapy provides a safe place for your child to explore and learn about the world without judgement, offering a mode of expression that is familiar and more comfortable for the child. The psychologist or therapist works to form a strong bond with your child who provides them with a feeling of safety - a secure base from which they can work to explore and resolve, or at the very least manage, whatever may be troubling them.

Through the therapeutic alliance, the child's inner resources are enabled and their trust and confidence will grow as they begin to independently explore the world, engaging more creatively in play, working through their issues, developing an understanding of the problems they are facing and learning how to come to terms with them.

Play Therapy holds child with unconditional positive regard and will always work to bring out their strengths, enabling them to reach their full potential, regardless of any hindering issues that they may have. Within the Play Therapy room, your child will begin to understand the world, how to cope and how to respond, and this will in turn transcend into the outside world, leading to a full and healthy life.

Benefits of Play

For children with behaviour difficulties this is particularly useful as psychologist and therapists help them to better understand themselves and the situation they are in. With their play therapist they can learn to understand difficult ideas and reconcile emotional frustration. This allows them to discover what physical and emotional strengths they have in relation to their difficulties. Behavioural problems, such as anger management, sadness, somatic pain, crisis and trauma, and disorders, such as anxiety, depression, ADHD, autism, and developmental problems, can all be helped with effective therapeutic play.

For best effect it is recommended that a parent, caretaker, or family member is actively involved and understanding the treatment process. Most importantly, a safe relationship must be built between the psychologist, therapist/ parents and child, one where the child can freely and comfortably express anything they like or find unpleasant. This will allow them to better express themselves and resolve their problems. Play therapy has many benefits for children coping with difficulties, it can help them process complex issues, understand themselves and their difficulties, and develop a stronger more confident idea of who they are. A further benefit of Play Therapy is that when a child gets used to this parents accepting children emotions,

begins to feel more comfortable expressing them to the other adults in their life.

Aim of the study

This study aimed to evaluate the effect of applying play therapy on children with behaviour problem:

- Assessing and diagnosis the children's inattention, hyperactivity, impulsivity, and other behaviour problem before applying play therapy.
- Evaluating the effect of play therapy on children's inattention, hyperactivity, impulsivity, and other problem after applying play therapy.
- Parenting counselling and guidance for understanding children emotional concepts, behaviour therapy and other management.

Research hypothesis-

- The current study was hypothesized that applying play therapy has a positive effect on paying attention, decreasing hyperactivity, controlling impulsive behaviour, and other behaviour problem of children.

MATERIALS AND METHODS

The present research was purposed to examine the effects of Play Therapy on children with behaviour problem in 6-12 years aged male and female children.

The total sample of this study will be (N 84) boys and girls whom were selected randomly via simple sampling procedure from children who were identified and diagnosed in NKPSIMS and Lata Mangeshkar Hospital Nagpur. Children with diagnose ADD, ADHD, Depression, anxiety, somatic, oppositional defiant problem, conduct problem was involved in play therapy for ten session (every month). The research conducted during March 2017 to August 2018 (One year five months).

Assessment – The present study based on interview and child behaviour assessment author interview all the subjects and parents counselling and follow-up. The intake proforma for each subject (Age, Gender), family history (Economic background, urban/rural area, Parents education, and any family history), and Schooling history (grads, repeated class, behaviour problem, learning disorder, fear).

SUBJECTS AND METHODS

Study Design: Cross sectional study (Questionnaire Based Study)

Inclusion criteria - Children with behaviour problem and don't taking any medication or therapy before, children's age ranged from 6-12 years, and from both genders.

Exclusion criteria - School going children (boys and girls) with behaviour problem, at different schools from central India Nagpur.

TOOLS USED:

Child Behavior Checklist for Ages 6–18 (CBCL/6-18; Achenbach and Rescorla 2001) The 113 items on this measure are rated as Not True (0), somewhat or sometimes True (1), or Very True or Often True (2). Validity and reliability are excellent, and extensive normative data are available for children ranging from 6 to 18.

EVERY MONTH PLAY THERAPY SESSION LIST

Play therapy sessions processed for children diagnosed for ADD, ADHD, Depression, anxiety, somatic, oppositional defiant problem, conduct problem**:**

March session: Drawing/painting (house, tree), puppet play, Art and craft, role play, puzzles solving and parents counselling and guidance.

April session: Time bond activities , Painting with shaving cream, Mud play, sand play, clay activity, Storytelling, chair and song game, puzzle solving, word repetition, make friend with for making drawing, reward chart , healthy communication talk and parents counselling and guidance.

May session: Maze learning, Mud game, Knock/clock game, picture storytelling, , sand play ,puzzles solving, dot/line extension drawing, puzzle, vision training cards, and parents counselling and guidance.

June session: Storytelling, book, Reward chart, token-economy, dot/line extension drawing and colouring, vision training cards, dart and circle play, mind mapping learning, soft toys, kitchen set communication game and parents counselling and guidance.

July session: Storytelling, token receiving counting, clay game, make a story cards, nut and screw game, straw drawing, Motor coordination game, bits games, and parents counselling and guidance.

August session: Storytelling, token receiving counting, rewards chat, finger painting, house building game with blocks, balloon game, and parents counselling and guidance.

September session: Storytelling, playing with animals, token receiving counting, online, memory game, words searching game, judgment game and parents counselling and guidance.

October session: Storytelling, words searching game, puzzle solving, snake and ladder game, clay play, token receiving , reward chart, magnetic sand game, block- design, gym ball activity, and parents counselling and guidance.

November session: Storytelling, sharing activity, reward, win/lose game, puzzle solving, making masks, wish list and parents counselling and guidance.

December session: Storytelling, animals sounds, puppet play, puzzle solving, swing game, bits play, objects setting game, picture puzzle and parents counselling and guidance.

PROCEDURE OF DATA COLLECTION

For collection of data from NKPSIMS and Lata Mangeshkar Hospital Nagpur was chosen. By keeping age and gender requirements in mind the subjects were selected more than the required then the test of Child behavior checklist 6/18(CBCL) who referred by doctors for behaviour difficulties. N 84 subjects have been selected randomly from different school going children's, which consists 84 school going students (boys 48 and 36 Girls).

First of all, checklist of trails was administered on the subjects to get their original viewpoint. The subjects were randomly selected sample in NKPSIMS and Lata Mangeshkar Hospital Nagpur, school going children (boys 48 and 36 Girls) and done Child behavior checklist 6/18(CBCL), each subjects took about 40 min to respond on the entire above tools. A period of one year five months was devoted for the data collection.

STATISTICAL ANALYSIS

The obtained data was statistically analyzed by applying descriptive (Mean, Standard Deviation, Paired t-test) of significance of mean differences in term of various variables. We have entered all data and further Statistical Analysis was done with the help of IBM- SPSS-25 software.

RESULT

Table 1 revealed that the mean age of children was 6 to 7 years, fathers 10% are 10th pass, 12% are 12th pass, 36% are gradate, 31% are post-graduate and 12% other (vocational Course), mothers 21% are 10th pass, 24% are 12th pass, 45% are gradate, 7% are post- graduate and 2% other (vocational Course) .Meanwhile, 71% and 44% of families their socio-economic condition was moderately. See table no.1.

Table No.1: Distribution Of The Families Of Studied Children With Behaviour Problem To Their Socio- demographic Characteristics

Areas			
	Gender Count	Male	Female
		48 (57%)	36 (43%)
Age range			
	6-7 Years	27 (56%)	21 (58%)
	8-9 Years	15 (31%)	9 (25%)
	10-11 Years	6 (13%)	5 (14%)
	12-13 Years	0 (0%)	1 (3%)
Parents Education Level			
	Education Base	Fathers	Mothers
	10th Pass	8 (10%)	18 (21%)
	12th Pass	10 (12%)	20 (24%)
	Graduate	30 (36%)	38 (45%)
	Post-Graduate	26 (31%)	6 (7%)
	Other (Vocational Course)	10 (12%)	2 (2%)

Social economic Condition			
	SEC	Male	Female
	Low	2 (4%)	6 (17%)
	Moderate	34 (71%)	16 (44%)
	High	12 (25%)	14 (39%)

%- Percentage

Table 3 - revealed that half of the studied children (74%) were social problem like organizations, participation, make friends , behaviour with others, and play alone.(67%) children showed school related issues , and activities –(49%) showing low performance , not enjoying , low level of hobbies, and low participation in school sports activities or group activities. See table no.3

Table No.2: Distribution Of The Studied Children With Behaviour Problem According To Their Prenatal, Natal And Postnatal Histories

AREAS	COUNTS AND PERCENTAGE	
CHILD DELIVERED AS		
	Pre-term	16 (19%)
	Full Term	60 (71%)
	Post term	8 (9%)
DELIVERY TYPE		
	Normal Vaginal Delivery	30 (36%)
	Caesarean Delivery	54 (64%)
COMPLICATIONS FOR CHILD DURING BIRTH		
	Delayed neonate crying	22 (26%)
	Decreased oxygenation	9 (11%)
	Low birth weight	36 (43%)
TYPE OF INFANT FEEDING		
	Breast feeding	52 (62%)
	Spoon Feeding	17 (20%)
	Bottle Feeding	15 (18%)

Table 3 - revealed that half of the studied children (74%) were social problem like organizations, participation, make friends , behaviour with others, and play alone.(67%) children showed school related issues , and activities –(49%) showing low performance , not enjoying , low level of hobbies, and low participation in school sports activities or group activities. See table no.3

Table No.3: Distribution Of The Studied Children With Behaviour Problem According To Their Social Problem, School Related Issues,and Activities Wise Average And Percentage

AREAS	MALE	FEMALE	COUNTS AND PERCENTAGE
SOCIAL PROBLEM			
	37 (77%)	25 (69%)	62 (74%)
SCHOOL RELATED ISSUES			
	34 (71%)	22 (61%)	56 (67%)
ACTIVITIES			
	18 (38%)	23 (64)	41 (49%)

Figure No.1 shows that all of the studied children (100%) were nervous before applying play therapy. Study had founded that 34 (40%) of children were having hyperactivity behaviour 23 (48%) boys and 11 (31%) girls, 50 (60%) of children were having aggression behaviour 34 (71%) boys and 16 (44%) girls, 26 (31%) of children were having conduct problem behaviour 18 (38%) boys and 8 (22%) girls, 19 (23%) of children were having anxiety problem 12 (25%) boys and 7 (19%) girls, 28 (33%) of children were having depression features 10 (21%) boys and 18 (50%) girls, 65 (77%) of children were having somatization problem 34 (71%) boys and 31 (86%) girls, 48 (57%) of children were having attention problem 35 (73%) boys and 13 (36%) girls, 68 (81%) of children were having learning problem 40 (83%) boys and 28 (78%) girls, 34 (40%) of children were having rule breaking behaviour 26 (54%) boys and 8 (22%) girls, and 55 (65%) of children were having withdrawal behaviour 36 (75%) boys and 19 (53%) girls.

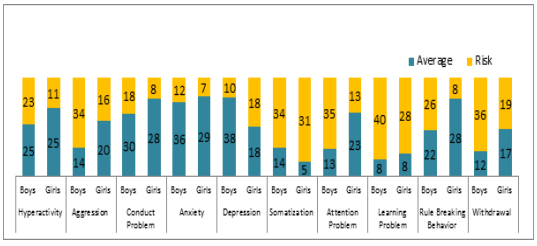

Figure No. 1: Distribution Of The Studied Children Regarding Their Emotional & Behavioral Disturbances Average And Risk Factors

Table No.4: Distribution Of The Studied Children Regarding Their Emotional & Behavioral Disturbances As Reported By Their Parents Pre & Post Play Therapy

Paired Samples Statistics						
			Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Depressive	Pre-Test	49.79	84	9.948	1.085
		Post Test	36.19	84	12.800	1.397
Pair 2	Anxity	Pre-Test	55.24	84	10.218	1.115
		Post Test	35.23	84	12.788	1.395
Pair 3	Withdrawn Behavioir	Pre-Test	46.08	84	8.214	.896
		Post Test	36.26	84	11.830	1.291
Pair 4	Somatic Complain	Pre-Test	54.79	84	9.752	1.064
		Post Test	39.36	84	14.866	1.622
Pair 5	Though Problem	Pre-Test	49.48	84	9.472	1.034
		Post Test	32.85	84	10.094	1.101
Pair 6	Attention-deficit hyperactivity disorder (ADHD)	Pre-Test	64.32	84	11.528	1.258
		Post Test	35.18	84	11.658	1.272
Pair 7	Rule Breaking Behavior	Pre-Test	52.88	84	9.950	1.086
		Post Test	32.65	84	10.411	1.136
Pair 8	Aggressive Behavior	Pre-Test	58.26	84	13.381	1.460
		Post Test	33.31	84	10.662	1.163
Pair 9	Oppositional Problem	Pre-Test	44.90	62	9.066	1.151
		Post Test	33.53	62	11.290	1.434
Pair 10	Conduct Problem	Pre-Test	49.37	84	11.089	1.210
		Post Test	32.58	84	10.243	1.118

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Depressive - Pre-Test/Post Test	13.595	13.448	1.467	10.677	16.514	9.266	83	.000
Pair 2	Anxity - Pre-Test/Post Test	20.012	14.519	1.584	16.861	23.163	12.632	83	.000
Pair 3	Withdrawn Behavioir - Pre-Test/Post Test	9.821	13.228	1.443	6.951	12.692	6.805	83	.000
Pair 4	Somatic Complain - Pre-Test/Post Test	15.429	16.694	1.822	11.806	19.051	8.470	83	.000
Pair 5	Though Problem - Pre-Test/Post Test	16.631	14.163	1.545	13.557	19.705	10.762	83	.000
Pair 6	ADHD - Pre-Test/Post Test	29.143	18.523	2.021	25.123	33.163	14.420	83	.000
Pair 7	Rule Breaking Behavior - Pre-Test/Post Test	20.226	13.201	1.440	17.361	23.091	14.042	83	.000
Pair 8	Aggressive Behavior - Pre-Test/Post Test	24.952	17.796	1.942	21.090	28.814	12.851	83	.000
Pair 9	Oppositional Problem - Pre-Test/Post Test	11.371	13.476	1.712	7.949	14.793	6.644	61	.000
Pair 10	Conduct Problem - Pre-Test/Post Test	16.786	16.324	1.781	13.243	20.328	9.424	83	.000

As it shown in table 4 -Mean score for Depressive features in the pre-test (Mean 49.79; Std. deviation 9.948) and in the post test (Mean 36.19; Std. deviation 12.800) (t value 9.266) there exist significant differences between Pre-test and Post-test group in children with Depressive features and Mean score for Thought Problem in the pre-test (Mean 49.48; Std. deviation 9.472) and in the post test (Mean 32.85; Std. deviation 10.094) (t value 10.762) there exist significant differences between Pre-test and Post-test group in children with Thought Problem . Present study shows during every month session therapist seen the children are actively participation in every activities and enjoying, sleep properly mixing and enjoying social activities. According to Birmaher B, Brent D, et al (1998) study shows psychotherapy can be useful as initial therapy for children and adolescents with mild to moderate depression and as an adjunct to medications for children with more severe depression.

Mean score for Anxiety features in the pre-test (Mean 55.24; Std. deviation 10.218) and in the post test (Mean 35.23; Std. deviation 12.788) (t value 12.632) there exist significant differences between Pre-test and Post-test group in children with Anxiety features. After play therapy children with behaviour problem shows low fear with social, phobia, separation anxiety, nervousness all positively come down .Jager and Ryan (2007) study showed better results in reduction of symptoms of anxiety disorder and worries after play therapy.

Mean score for Withdrawn Behaviour in the pre-test (Mean 46.08; Std. deviation 8.214) and in the post test (Mean 36.26; Std. deviation 11.830) (t value 6.805) there exist significant differences between Pre-test and Post-test group in children with Withdrawn Behaviour .Depression/ withdrawn behaviour/ anxiety is most often caused by a child being out of touch with their awareness of them. For example, child may sad, or showing angry feeling, hidden deep down, but the idea of expressing them seems scary. Depression is a common, natural mechanism that results from the mind's attempt to repress frightening, sad, and angry feeling. Children are completely unaware of all this going on. Child depression/ withdrawn behaviour/ anxiety treatment through play therapy, parenting counselling, gives children conscious awareness of their troubling emotions, allowing them to process and resolve it, and the present study shows the positive impact. Our findings support the earlier work made in this area -Harrist and colleagues (1997), Hymel, S., Bowker, A. & Woody, E.(1993) and Ladd and Burgess (1999). Present study noted earlier, the withdrawn children in our research had problems in social skills, peer group, shy nature, won't talk to others and don't take participant in sports activities, low or no friend in school, family relationship.

Mean score for Somatic Complain in the pre-test (Mean 54.79; Std. deviation 9.752) and in the post test (Mean 39.36; Std. deviation 14.866) (t value 8.470) there exist significant differences between Pre-test and Post-test group in children with Somatic Complain. Before play therapy session 77% showed somatic issues like headache, abdomen pain, vomiting issues, pain in chest, joint pain after therapy present study shows positively impact of play therapy and many studies performed in children have shown a relationship between somatic complaints and impaired emotional functioning. Emotional problems such as in creased level of stress, excessive experience of negative emotions, and symptoms of depression or feeling of fear co-occur with an increase in somatic complaints (Compo st al., 1994; De waal MV, Arnold, Eekhof, & Van Hemert, 2004).

Mean score for attention-deficit hyperactivity disorder (ADHD) in the pre-test (Mean 64.32; Std. deviation 11.528) and in the post test (Mean 35.18; Std. deviation 11.658) (t value 14.420) there exist significant differences between Pre-test and Post-test group in children with attention-deficit hyperactivity disorder (ADHD) . In the present study play therapy are effective for ADHD children for improving attention, decreasing impulsiveness, and self-control. Play therapy reduces ADHD symptoms and it could be used as a treatment method for children with ADHD. Conclusions from Cantwell's (1996) meta-analysis spanning ten years of research about ADD indicate that a combination of psychotherapy and psychosocial interventions play a major role in successful treatment. In 2013 study Ebrahim Abdollahian, Naghmeh Mokhber, Atena Balaghi, Fatemeh Moharrari- found that cognitive-behavioral play therapy showed a significant decrease in hyperactivity in children who had been diagnosed with ADHD.

Mean score for Rule Breaking Behavior in the pre-test (Mean 54.79; Std. deviation 9.752) and in the post test (Mean 39.36; Std. deviation 14.866) (t value 14.042) there exist significant differences between Pre-test and Post-test group in children with Rule Breaking Behavior and Mean score for Conduct Problem in the pre-test (Mean 49.37; Std. deviation 11.089) and in the post test (Mean 32.58; Std. deviation 10.243) (t value 9.424) there exist significant differences between Pre-test and Post-test group in children with Conduct Problem .In the present study shows positively impact of play therapy, like not cruel to animal, don't destroy toys or other things ,follow the rules, not using bad language . Many researchers applying cognitive behavioral therapy focuses on interpersonal-problem solving and social cognition to help in the treatment of peer problems in children with conduct disorder -Van De Wiel N, Matthys W, Cohen-Kettenis P, Van Engeland H (2002). Ritzi, Rochelle M.,Ray, Dee C.,Schumann, Brandy R. (2017). study showed both parents and teachers indicated that children with externalizing behaviors who received intensive child-centered play therapy (CCPT) showed a significant decrease in those behaviors. Davenport and Bourgeois (2008) inform us through theory and empirical research that they learn that play is an essential childhood activity, which the field of play therapy has built its foundation.

Mean score for Somatic Complain in the pre-test (Mean 54.79; Std. deviation 9.752) and in the post test (Mean 39.36; Std. deviation 14.866) (t value 12.851) there exist significant differences between Pre-test and Post-test group in children with Aggressive Behavior . In the present Study shows play therapy was effective in reducing the level of aggression in examinees. According to Axline VM.(1947) study showed that Playing is a natural way for children to express themselves, and it will provide them with an opportunity to gradually release suppressed emotions and tensions, disappointments, feeling of insecurity, aggression, and fear of confusion.

Mean score for Oppositional Problem in the pre-test (Mean 44.90; Std. deviation 9.066) and in the post test (Mean 33.53; Std. deviation 11.290) (t value 6.644) there exist significant differences between Pre-test and Post-test group in children with Oppositional Problem. According to DSM-5 - Oppositional defiant disorder (ODD) is listed in the DSM-5 under Disruptive, impulse-control, and conduct disorders and defined as "a pattern of angry/irritable mood, argumentative/defiant behaviour, or vindictiveness" in children and adolescents. Parents are usually an important part of a child's treatment. The level of involvement, participate, or if the goal is to work on family issues, the parents may be directly involved in the play therapy. The present study noted parent's positive feedback about treatment goals and child progress.

CONCLUSION

Children with behaviour problem often have other overlapping issues, including depression , anxiety, oppositional defiant behaviour, somatic complain, though problem, attention-deficit hyperactivity disorder (ADHD), rule breaking behaviour , oppositional problem conduct problem, educational , social and more. Present study shows that play therapy helps to resolve those issues as well and reduces the overall number of challenges the child is facing. Together with Parenting Counselling, training, communication, games play with children. Through Play Therapy, children learn to communicate with others, express feelings, modifying/ shaping behaviour, develop reasoning, problem-solving skills, communication and learn a variety of ways of relating to social areas. Play provides a safe psychological distance from their problems and allows expression of thoughts and feelings on paper and play appropriate to their development.

LIMITATION -

The results of this study were the significant but short-term. In order to study the long-term effects of play therapy on children with behaviour problem, difficulties to obtained results for a more extended population.

Parents' cooperation in this research was very limited. As this research was conducted in children with behaviour problem, the researcher had limitations of place and proper time to hold sessions.

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CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

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