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The Effectiveness of Play Therapy and Role Playing in Reducing Children's Aggressive Behavior

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This study aims to determine the effectiveness of play therapy and role playing in reducing children's aggressive behavior. The research method used was quasi-experimental research with three-factor factorial designs. The independent variables were play therapy, role playing and gender. The subjects of the study were 90 preschool children who were divided into experimental groups (EG); 30 children as EG1 with play therapy, 30 children as EG2 with role playing and 30 children as a control group (CG). The measurements were made before the treatment (pre-test) and after it (post-test). The data analysis was completed using two paths ANAVA with a significance level of F = 0.01 and HSD test (Honestly Significant Difference). The result shows that play therapy and role playing can reduce children's aggression behavior while play therapy is more effective. Moreover, girls have greater control of aggression compared to boys and there is no difference in children's aggressive behavior due to the influence of interaction with gender.

Key words: *Play Therapy, Role Playing, Aggressive Behavior, Children.*

Introduction

The problems and challenges in the development of education and culture in the period 2015-2019, especially for the early childhood education has been described in the Strategic Plan of the Ministry of Education and Culture for 2015-2019 (Kemendikbud, 2015). The government succeeded in increasing PAUD participation by 17.89%, one village one PAUD programs increased from 50.21% in 2010 to 68.10% in 2014. As a form of government commitment to sustainability PAUD was issued through Presidential Regulation Number 60 of 2013 which concerns the development of Holistic-Integrative Early Childhood and aims to ensure moral-

emotional development facilitation so that children can grow and develop optimally according to age group.

The existence of this Presidential Regulation become a platform for educators, especially in the PAUD domain, to further early childhood education quality improvement according to the child development stages. Santrock (2012) explained that as they children gain age, educators should pay attention to social-emotional development. It is important considering that children will begin to learn to establish relationships outside themselves for example, with brothers and sisters, friends and even people they have just met.

The factors in child social development are very important to note. This is because if it disturbed, it will affect emotional developmen and vice versa. According to Wade, Travis and Garry (2016) emotions are subjective reactions expressed by a person and are usually associated with physiological changes and behavior. According to Wade and Travis (2007), factors that influence emotions include family and social factors. Therefore, the family has a very important role as it is where children learn to feel their feelings, respond to other people's feelings and express their feelings to others. The social environment is like the school environment and the playground which has influence on a child's emotional development. The development of children's socio-emotional affects their responses as adolescents.

Given the importance of growing a positive socio-emotional in children from an early age, it encourages researchers to investigate the effectiveness of potential treatment for reducing child aggression. The research aims to analyze the effectiveness of play therapy and role playing to reduce children's aggressive behavior. The implications of this research can be used to provide additional information for practitioners who make efforts to reduce aggressiveness towards children.

Aggression

One approach that must be developed in reducing negative emotional behavior is the development of social relations (Roper, Johnson, & Bostwick, 2017). Emotions are divided into several types including happy, sad, angry and afraid. Various forms of emotions are manifested in different behaviors. One form of angry emotions is the emergence of aggressive behavior. Aggression behavior includes all forms of behavior that aim to hurt or make other people displeased that can be seen and observed directly (Roper et al., 2017). Aggression is not automatically formed in children but results from the influence of innate factors and environment (Japar & Purwati, 2015). Self-encouragement is very influential in shaping the child's personality. Sexual and aggressive encouragement is the main impulse in shaping the personality in a developmental stage (McRae & Lowe, 1968).

The forms of aggression behavior are divided into 2: verbal and physical. Various forms of aggression are often carried out by preschoolers such as disturbing friends, screaming, crying and rampaging. All of these forms of behavior are caused by anger. The thing that needs to be highlighted is that some impulsive behaviors such as hitting can be considered aggressive behavior but are in the normal category (Kamini, 2017). This condition can occur because the child may want to maintain or perform a mechanism to overcome a problem. Therefore, it is very important to be able to consider the situations that conclude in aggressive behavior as not all aggressive behavior is an indicator of behavioral irregularities.

According to Roper et al. (2017), boys demonstrate higher aggression than girls. Aggression behavior can continue to increase if children are friends with a group of children who play in a poor environment and conversely, the behavior of child aggression will comply if they are in an environment with positive friends (Pronina & Gerasimova, 2018). An aggressive behavior that occurs in childhood will continue developing to the next development stage if not directed. (Pronina & Gerasimova, 2018). On the other hand, the existence of a good relationship between children and parents can divert the urge of child aggression towards acceptable behavior (McRae & Lowe, 1968). This becomes important to note considering that in this phase of children, parents and educators are easier to redirect towards expectations while children are building character. Therefore, a special approach is needed in providing education about good behavior so that a child achieves it (Wilson & Ray, 2018).

Play therapy

Communicating weaknesses in children in terms of expressing what they feel, meeting needs, self-exploration and children's expectations of adults make it difficult for adults to capture and respond to what children mean well and effectively. This makes the delivery of information verbally imperative so that children can have optimal modelling (Landreth & Bratton, 2013). Therefore, to reduce the communication gap, children can be trained to communicate through a structured game with a dynamic approach. The approach is in the form of play therapy.

Play therapy is a therapy through play which creates a connection between therapist and child. Children try to exclude and explore what they feel as expressed to the therapist through the tools used to play without their awareness (Landreth & Bratton, 2013). More specifically, Blanco, Ray, and Holliman (2012) explain that play therapy is something that is very closed and attached to children and it is very easy for educators to reduce aggression in children by using this approach. Child-Center Play Therapy (CCPT) can be an alternative to reduce the aggressive behavior of children and that special way is by play therapy. Through CCPT, a therapist can give moral messages to children without dictating or instructing them so that the CCPT is effective in reducing children's aggression behavior (Wilson & Ray, 2018).

Blanco et al. (2012), further pose that CCPT can suppress the emergence of aggression in children and involvement between parents and teachers strongly supports success in this intervention so that the school and family contribute in eliminating aggression in children. Furthermore, Blanco et al. (2012) explain that play therapy besides being able to hone a child's physical abilities, can also be used to develop the child's social and emotional development stage. Another benefit of the play therapy method is to train children's social skills. The existence of rules that must be obeyed when playing and involving other people will train children to learn to control themselves and control emotions (Flasch, Taylor, Clauber, & Robinson, 2017).

Role playing

Another way that can be used to reduce aggression behaviour is a role-playing technique, an approach that is able to reduce the intention of aggressive behavior in children (Corsini, 2018; Ivory, Nisa, & Lestari, 2017). The role-playing technique provides emotional experiences to children when they are asked to portray certain characters. The emotional experience is then able to provide insight to children when they are faced with situations that are suitable for situations when role-playing (Murjiatik, Supriyo, & Setyowani, 2015). Khairina and Efendi (2018) assert that role-playing is one method of learning to teach behavior and social problems by playing a role.

The role-playing method can increase imagination and develop a child's appreciation because they are directly and actively involved in the process. Role-playing by a child can help to appreciate and express their needs in terms of expressing emotions through the words that come out of their mouths. There are many words and sentences containing emotional messages, expressing both positive and negative values, during role-playing. This study has 2 interesting themes to be considered scientifically: (1) being a good student, and (2) being a good teacher. Both of these themes are very close to the lives of PAUD children, so the results of this study are expected to be used to reduce child aggression. Interaction and conversation will train responsibility for children because they are required to be able to play within the perameters that have been agreed upon.

Hypotheses

Based on the Literature Review, the following research questions were formulated:
H1: Play therapy and role-playing can reduce a child's aggressive behavior
H2: play therapy is more effective in reducing the behavior of aggression
H3: there are sex differences in the decrease of heightened aggression

Research methods

The research method used was quasi-experimental with three-factor factorial designs, experimental research which has 3 independent variables. The first independent variable is play therapy, the second variable is role-playing, which is a learning model that is applied to children who behave aggressively by arranging themes that must be played by children, gender is the third variable. The dependent variable of this study is the aggressive behavior of children.

Research subject

The research subjects met the following criteria: (1) enrolled in kindergarten (TK) aged up to 6 years, (2) an aggressive score above the mean number based on the teacher report form (CTRF) caregiver, (3) and students willing to be the subject of research by showing evidence of parental informed consent and child assent. There were 90 children with moderate and high aggression categories from kindergartens in Magelang who were research subjects in this study. The results of grouping child aggression based on data from CBCL and CTRF were then randomly entered into 3 groups: the experimental group (KE) divided into 2 treatments: KE1 30 children treated with play therapy and KE2 30 children were given role-playing treatment, and a control group of 30 children. The appointment of children in each child aggressive category was random to ensure diversity in each treatment group and the control group.

Research Ethics

Before the research was conducted, researchers compiled informed consent for the subjects as part of research ethics. Informed consent was filled out by parents of children who stated that parents were willing for their child to be the subject of research and the children's approval was gained through child assent. Informed consent sheets were distributed by researchers to parents who had children with aggressive behavior tendencies as provided from accompanying teacher information available. The completed informed consent sheet was returned to the researcher as required by permit and research ethics. Further, the accompanying teacher was given a CTRF sheet to complete according to the subject's behavior, emotions and social-emotional stage.

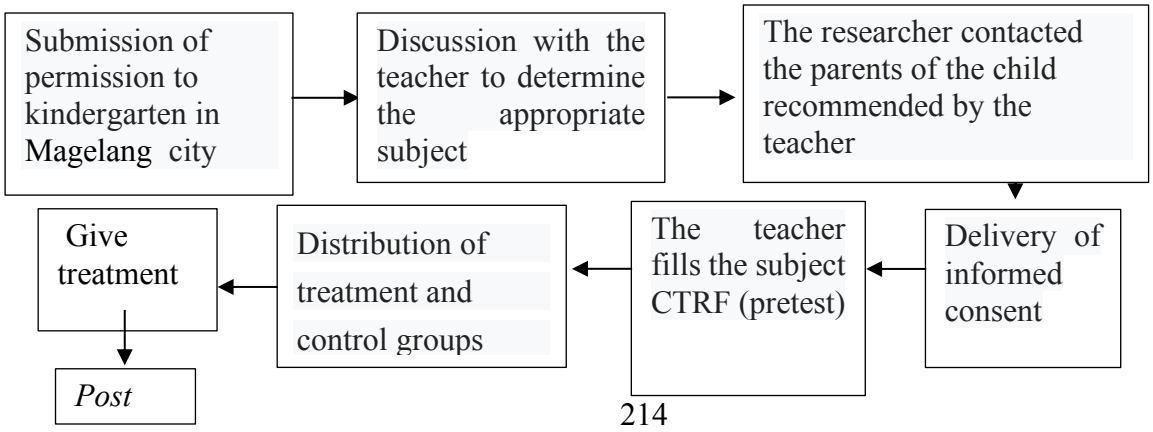
Data retrieval instrument

The instrument used by researchers in detecting the level of child aggression is the CTRF is intended for teachers or teachers of the subject. The CTRF form was filled in by teachers in the school. The two types of forms were then collected by the class teacher who becomes the contact person and submits the collected data to the researcher. The following, in Table 1 below, is part of the CTRF form that must be filled in by the school teacher.

Table 1: Components of CTRF

No.	Section	Component
1.	Part 1: Child identity	1. Full name 2. Age 3. Date of birth 4. Gender
2.	Part 2: Identity of parents and teachers	1. Type of work of parents 2. Relationship with the subject 3. The intensity of time when meeting a subject 4. Long-time to know the subject 5. Teacher experience while educating the subject
3.	Part 3: Quality of the relationship between the teacher and the subject	Consists of 6 items that reveal the quality of the relationship between the teacher and the subject
4.	Part 4: Item that can describe the behavior of a subject	Consisting of 100 items with 3 answer options, namely 0 for behavior that was never encountered on the subject, 1 for behavior that sometimes appears, and 2 for behavior that often or always appears on the subject.
5.	Section 5: uncovering conclusions and suggestions are given on the condition of the subject	Consisting of 3 items with an open question model that can describe the subject and what suggestions for the subject

Procedure



Treatment

The treatment given to the subject is divided into 2, in the form of both play therapy on KE1 and role-playing on KE2. The treatment was administered for 12 sessions, 2 weekly meetings of 1 hour duration per session. The number of sessions for both play therapy and role-playing is the same. Treatment is delivered to the subject by experienced counselors and therapists in the field of therapy and each treatment involves 2 counselors and 2 therapists. There are some responses that therapists can use in providing play therapy, reflecting feelings, reflecting the content, tracking behavior, facilitating decision making, facilitating creativity, encouraging, facilitating relationships and setting boundaries (Ray, Armstrong, Balkin, & Jayne, 2015).

Delivery of the second treatment to the subject is carried out in a room that has the same conditions and times, namely in a relatively quiet room and the temperature is at 27 degrees Celsius. Play therapy treatment is accompanied by the provision of toys that can describe the child's aggression behavior, such as plastic toy knives, plastic swords, handcuffs and keys (Ray, Stulmaker, Lee, & Silverman, 2013). Role-playing treatment is administered to the subject through invitation to play a role by using the storyline of a student who behaves aggressively towards his friends and gets behavioral results in the form of unpleasant behavior that must be accepted by students. The second flow is a positive path, that is, students are invited to play roles that tell the other students how they can hold back their anger and control their emotions towards friends and obtain the results of pleasurable treatment for these students (Gading, Nisa, & Lestari, 2018; Ray et al. , 2013).

Data analysis

Calculation of scores from the CTRF form was completd using SPSS based on the raw score. Scale reliability measurements using Cronbach alpha. The subject analysis was carried out by t-test. The data analysis in this study used two-way variance analysis with the F test at the 0.01 significance level with the help of SPSS. Two-way ANAVA technique is used to test a hypothesis that states the average difference between sample groups whether using treatment by level design in experimental research and causal-comparative research (Kadir, 2017). Two-way ANAVA test was carried out in this study because researchers wanted to test whether there were differences in the attitude of aggression based on therapy given and those who did not receive treatment and whether there were differences in aggressive behavior between men and women before being given treatment and after being given treatment. Further, analysis of variant 2 paths was used to see whether there are interactions between factors in forming an attitude of aggression in children. If there are differences regarding the approach to early intervention, the test was continued with the Tukey-HSD test.

Results

The following are the results of assumptions, namely the normality test and homogeneity test:

Table 1: Normality Test Results

Groups	Sig	Information
Pre-test KE1	0.290	Normal
Postest KE1	0.284	Normal
Pre-test KE2	0.808	Normal
Post2 KE2	0,440	Normal
Pre-test KK	0.544	Normal
Postest KK	0.368	Normal

Based on Table 1 above, the results of the normality test using the Smirnov Kolmogorov test, it can be seen that the significance value of the tests conducted shows that the distribution of data in each group is normally distributed.

Table 2: Homogeneity Test Results

	F_{count}	df1	df2	Sig.	Information
Results at pre-test	1.113	5	84	0.360	Homogeneous
Results at post-test	0.312	5	84	0.905	Homogeneous

Table 2 above presents results of homogeneity tests which indicate that the significance value at pre-test is 0.360 and at post-test is 0.905, which is greater than 0.05 ($p > 0.05$). Thus it can be concluded that the variance in each value of each treatment group is homogeneous.

The pre-requisite test results show that the data is normal and homogeneous, so data analysis can be conducted using analysis of variance 2 roads as depicted in Table 3 below.

Table 3: Results of Descriptive Analysis

Treatment	Sex	Mean	Std. Deviation	N
KE1	Male	40.06	2,609	17
	Female	39.62	1,938	13
	Total	39.87	2,315	30
KE2	Male	40.53	2,322	17
	Female	39,92	2,100	13
	Toal	40.27	2,212	30
KK	Male	40.41	1,938	17
	Female	39.77	3,004	13

	Total	40.13	2,32	30
Total	Male	40.33	2,269	51
	Female	39.77	2,334	39
	Total	40.09	2,301	90

Table 4: Anava Results for Prestet Values

Source	**Sum of Square**	**df**	**Mean Square**	**F**	**Sig.**
Corrected Model	9,687[a]	5	1,937	0.353	0.879
Intercept	141802,899	1	141802,899	25804,586	0,000
Treatment	2,299	2	1,150	0,209	0,812
Gender	7.032	1	7.032	1.280	0.261
Treatment * Gender	0.166	2	0.083	0.015	0.985

[a]. R Squared = 0.021 (Adjusted R Squared = -0,038)

Based on Table 4 above, 3 conclusions can be drawn:

1. The significance value of the treatment is 0.812 (p> 0.05) and the calculated F value is 0.209. The Ftable value for df1 = 2 and df2 = 84 with a significance level of 5% at 3.105 (F count <Ftable). Thus it can be concluded that there is no difference in the average value of the pre-test based on the treatment group.
2. In addition, seeing the significance value of the treatment, the researcher notes that the significance of their sex obtained 0.261 and the calculated F value of 1.280. Ftable values for df1 = 1 and df2 = 84 with a significance level of 5% of 3.955. As the significance value obtained is greater than 0.05 (p> 0.05) and the value of Fcount <Ftable, it can be concluded that there is no difference in the average value of the pre-test by sex.
3. Based on the results of the influence of the interaction between the treatment groups and the sex obtained a significance value of 0.985 and the calculated F value of 0.015. The significance value obtained is greater than 0.05 (p> 0.05). It can be concluded that there is no difference in pre-test values based on the interaction between treatment groups and sexes.

Table 5: Results of Descriptive Statistics (Post-test) Analysis

Treatment	**Sex**	**Mean**	**Std. Deviation**	**N**
KE1	Male	19.18	1,286	17
	Female	17,23	1,739	13
	Total	18.33	1,768	30
KE2	Male	23.06	1,435	17
	Female	21.77	1,481	13
	Total	22.50	1,570	30
KK	Male	25.35	1,367	17

	Women	25.00	1,732	13
	Total	25.20	1,518	30
Total	Men	22,53	2,901	51
	Female	21,33	3,608	39
	Total	22.01	3,262	90

Table 5 above shows that:

1. The average value of KE1 post-test is 18.33, the average value of post-test KE2 is 22.50 and the average post-test score of KK is 25.20.
2. The average value in each treatment group where the post-test means value in male sex with KE1 treatment is 19.18. Female gender has an average of 17.23, then for the post-test mean value of male sex with KE2 treatment of 23.06 while in female sex it is 21.77. The post-test means the value of male sex in KK was 25.35 while in female sex it was 25.00.

Table 6: Anava Results for Post-test Values

Source	**Sum of Square**	**df**	**Mean Square**	**F**	**Sig.**
Corrected Model	759,079[a]	5	151,816	67,865	0,000
Intercept	42519,083	1	42519,083	19007,038	0,000
Treatment	726,641	2	363,320	162,413	0,000
Sex	31,616	1	31,616	14.133	0,000
Treatment *Gender	9,441	2	4,720	2.110	0.128

[a] R Squared = 0.802 (Adjusted R Squared = -0,790)

Based on Table 6 above, some values can be drawn in conclusion:

1. The significance value of the treatment group is 0,000 and the calculated F value is 162,413. The value of Ftable for df1 = 2 and df2 = 84 with a significance level of 5% is 3.105 and the significance value obtained is smaller than 0.05 (p <0.05) and the value of Fcount> Ftable, it can be concluded that there are differences in average post-test value based on treatment group.
2. Based on the results of the post-test mean values of male and female sex with a significance value of 0,000 and a calculated F value of 14.133. The Fable value for df1 = 1 and df2 = 84 with a significance level of 5% of 3.955, and the significance value obtained is smaller than 0.05 (p <0.05) and the value of Fcount> Fable., it can be concluded that there is a difference post-test value based on sex.
3. Based on the results of interaction's influence between the treatment groups and the sex obtained a significance value of 0.128 (p> 0.05) and the calculated F value of 2.110, it can be concluded that there are no differences in post-test values based on interactions between treatment groups and sexes.

To find out more about what treatment is most influential in decreasing children's aggression, the researchers tested the data with post hoc analysis. The following results, presented in Table 7, are the results of a post hoc analysis of the three treatments:

Table 7: Results of Post Hoc Analysis

(I) Treatment	**(J) Treatment**	**Mean Difference (I-J)**	**Sig.**	**95% Confidence Interval**	
				Lower Bound	Upper Bound
Play therapy	Roleplaying Control	-4.17 * -6.87 *	0.000 0,000	-5.09 -7.79	-3.25 -5.95
Role-playing	Play therapy Control	4.17 * -2.70 *	0,000 0,000	3.25 -3.62	5.09 -1.78
control	Play therapy Role-playing	6.87 * 2.70 *	0,000 0,000	5.95 1.78	7.79 3.62

* *The mean difference is significant at the 0.05 level*

Based on Table 7, it can be seen that the significance value between groups is 0,000. This means that there are differences in post-test values between all groups.

Discussion

The purpose of this study was to determine the effectiveness of play therapy and role-playing in reducing students' aggression behavior and the results of the data analysis above show that play therapy and role-playing can reduce students' aggression behavior. Students who receive play therapy and role-playing treatment have lower aggression behavior scores than students who do not receive treatment in the form of play therapy and role-playing This is consistent with the results of research that play therapy and role-playing can reduce students' aggressive behavior (Chotim, Affifah, & Dewi, 2016; Corsini, 2018; Muro, Muro, Rose, Webster, & Allen, 2017) .

Another finding obtained in this study is that play therapy is more effective in reducing aggression behavior than role-playing with a gain score of 21.54 for play therapy and 17.77 for role-playing. This difference can occur since, in the process of giving treatment in the form of play therapy, children feel like they are in their daily world, whereas when role-playing is administered, children may feel awkward in playing the roles agreed upon in the group. In addition, play therapy is a recognized model and has been proven as an easily used approach

An interesting finding based on the results of the observations in this study is that boys have a higher score of aggressive behavior than girls. These results are in line with research from Japar

and Purwati (2015) which shows that there are differences in aggression between boys and girls. This is because boys have an active behavior tendancy compared to girls (Roper et al., 2017). In addition, boys habitually imitate peer behavior which who can also influence a child's aggressive behavior (Pronina & Gerasimova, 2018).

Conclusion

Based on the results of the research and discussion it can be concluded as follows:

1. Play therapy and role-playing can reduce a child's aggression behavior.
2. Play therapy is more effective in reducing aggression behavior than role-playing with a gain score of 21.54, while the role therapy gain score is 17.77. This shows that play therapy is more effective in reducing the intensity of aggression in children.
3. Girls have greater control of aggression compared to boys who are given play therapy (22.39 in girls and 20.88 in boys) and role therapy (17.47 in boys and 18.15 in girls).
4. There is no difference in aggression based on the interaction between treatment groups with gender.

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