Playgroup Therapy with Deprived Children: Community-Based Early Secondary Prevention

by

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This article describes research into a method of intervention in and prevention of the effects of multiple deprivation on inner-city infant schoolchildren and discusses some short-term effects. It covers the research background preceding the project and its aims to evaluate the impact of playgroup therapy on this section of the population. The methodology of setting up and assessing the study is explained, including the monitoring of play used during therapy. The therapeutic model — Developmental Play Therapy — is described, with attention given to the therapeutic relationship, the non-directive play setting and the use of various developmental frameworks. The article also describes how this technique can be used in a small group setting. A profile of the children included in the study is given and some short-term outcomes as seen through changes in play.

INTRODUCTION

Deprivation, its worrying extent and the process of transmissions have been the focus of our attention over the last three decades.[1-4] However, this was mere head-count research; here we address ourselves to intervention and prevention.

The classic approach to prevention has been based on the work of Caplan.[5] Such phrases have been coined as 'Cure is costly — prevention priceless'. The most influential ideas developed in the 1960s and 1970s stated that primary preventive activities are important because they attempt to prevent the development of subsequent disorder by attacking its presumed origins and simultaneously promoting psychological adjustment.[6] In Newcastle, there has been particular interest in early secondary preventive activities, which try to identify children who are considered to be at grave risk of developing abnormally and to prevent dysfunction becoming severe or overt. Prominent examples of early prevention were the Head Start programmes, which were designed to facilitate educational progress by providing deprived children with compensatory stimulation. The projects were reviewed by Bronfenbrenner.[7] He concluded that compensatory stimulation provided in the preschool years gives rise to substantial IQ gains while the programme lasts, but that this trend reaches a plateau and gains are rapidly eroded once help ends.[8,9] Some recent reviews have suggested that these programmes were not without useful long-term effects,[10] but the hope that programmes started early in life would give rise to great and enduring gains has not been widely substantiated.

In contrast to these findings, the Newcastle research outlined in *Help Starts Here*[11] indicated that group therapy of short-term duration (10 sessions) given to children who were at risk for maladjustment had an impressive long-term outcome, with widespread improvement in adjustment 3 years later. The project included a number of deprived infant schoolchildren, merely because maladjustment was so often inextricably interwoven with deprivation. However, the numbers of deprived children were not sufficient to enable a specific check of efficacy to be undertaken. If such efficacy can be demonstrated, then playgroup therapy has the potential for making a major contribution to counteracting the medium-term to long-term effects of deprivation which are so widespread in our inner cities.

The crucial difference between the Newcastle research and the Head Start compensatory enrichment programme was that in Newcastle a therapeutic component was added to the compensatory stimulation. Traditionally, enrichment is geared to cognitive and social development of the child. Play therapy includes this but, in addition, it attempts to promote emotional maturation and to modify any associated behavioural and emotional problems.

Also in Newcastle, research into the use of therapeutic play techniques by occupational therapists was being carried out. A subsequent paper by Jeffrey[12] looks at the application of an assessment and therapeutic technique, Developmental Play Therapy. This provides a comprehensive model for assessment and treatment. The work forms the theoretical basis for the current research, which attempts to answer questions posed by both *Help Starts Here*[11] and Jeffrey's thesis.[13]

AIM

The intention of the current project was to identify deprived infant schoolchildren and to evaluate the impact of playgroup therapy (PGT) on them. Inevitably, the deprived group includes a high proportion of children who are maladjusted or at risk for maladjustment. The treated group is compared with a control group of deprived children not receiving this form of help. In due course, the specifics of PGT could be taught to a variety of already trained professionals and this could be linked with supervised training. Our more precise aim was to test the following hypotheses:

(i) Treatment (PGT) is more effective than no treatment.
(ii) Treatment will differ in effectiveness according to the main type of deprivation which the children have experienced (that is, poor quality of mothering and poor social, economic or material circumstances).
(iii) Treatment will differ in effectiveness according to the severity of deprivation which the children have experienced.

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METHOD

Setting: The research was confined to primary and infant schools in an inner-city educational priority area.

Identification of deprived children: Research into the transmission of deprivation over generations, based on the 1000 families study,[3,4] identified seven cardinal criteria of family, social, environmental and educational deprivation. All these were examined with a view to establishing their utility in the current study. They were explored in the school setting and, on the basis of a pilot study, a screen was devised to identify deprived children based on information likely to be known to schools. The following three factors fulfilled this criterion: unemployment of breadwinner, free school meals and marital breakdown. It is interesting to note that the rate of free school meals was approximately 75% and that of unemployment approximately 60%. On subsequent interview, the above screen gave rise to no false-positives but there was inevitably a small pool of false-negatives.

Sample size: The deprived children were randomly allocated to therapy (n=72) and to a control group (n=70). The progress of a further small sample of 33 children who were apparently not deprived was similarly monitored.

Age of children: Five to six years.

Therapy groups: During randomisation, the children were matched for criteria of deprivation and sex in order to achieve a balance within the treatment groups and between these and the controls. A total of 13 therapy groups were conducted within the schools, with 5 or 6 children in each group. The groups ran for 10 sessions. The principal therapists (all occupational therapists) were all trained and skilled in playgroup therapy. The co-therapists comprised social workers and occupational therapy students. Additional specific training was provided for co-therapists before the programme started. All therapists attended supervision sessions with a trained psychotherapist while the groups were in progress.

Assessment procedures: The assessments included the following items.

1. The baseline was provided by (a) teacher ratings of child behaviour, (b) assessments of verbal and reading ability and (c) social data collection.
2. During therapy, play and behaviour were monitored.
3. Short-term follow-up, 6 months after the start: teacher ratings were made of child behaviour.
4. Intermediate follow-up, 12 months after the baseline: a repeat of baseline assessments was conducted.
5. Long-term follow-up after 2 years: a repeat of baseline assessments was done, including an assessment of self-esteem.

All the above procedures consist of objective measures of child functioning, with the exception of monitoring during therapy which includes some subjective impressions of behaviour and outcome.

Reliability of play measures: We wished to monitor the types of play that occurred during each play session. These were selected from a range of play types used in the preceding study on play.[13] Here, play had been rated categorically (present or absent). In the current research, it was decided to rate play on a four-point scale for frequency and intensity. Definitions of play types are given in Appendix 1.

To check the reliability for this research, videotaped vignettes of play therapy were rated by 10 experienced therapists and 14 recently trained therapists. There was some variation but, overall, the pattern of agreement showed little difference between the recently trained and the experienced therapists. The data were analysed using two statistical techniques: percentage agreement and Kappa which is a chance corrected measure for categorical data.[14] The results are likely to be robust because they are based on a large number of comparisons; for instance, the percentages are based on over 2500 comparisons of pairs of therapists (see Appendix 2).

All the Kappas were significantly different from zero. Nevertheless, it was concluded that only aggressive, social, imitative and projective play could be measured with satisfactory reliability; another four (constructive, creative, regressive and fantasy play) had moderate reliability; and finally, despite the Kappas being significant, the reliability is evidently poor for neutral and directed play. However, in the last, if the ratings are confined to experienced therapists, reliability is slightly improved.

THE THERAPEUTIC MODEL

The therapeutic model used was that of Developmental Play Therapy,[12] with some variation to take into account the group experience provided and the setting in which it took place.

Jeffrey[12] described the model as one which used a variety of developmental theories, offering a framework through which the type of play used by the child in a therapeutic setting can be understood, and which provides an indication of the child's emotional level initially and as therapy progresses. Within the context of this developmental framework, relationship therapy and non-directive play provide an opportunity for satisfactory experience and growth.

Within the setting described in this article, the therapeutic experience provided for the child thus comprised four main elements: the developmental framework; the relationship between the children and the therapists; non-directive play; and the relationship that the children had with each other. These four elements are considered in greater detail below.

The developmental framework

Developmental theory assumes that the skills that a child acquires in all behavioural domains are progressive, and that satisfactory experience at each stage provides a firm foundation for the next. Within a therapeutic setting, children whose emotional needs have been inadequately or inappropriately met in the past may need to regress and re-experience earlier phases of emotional growth before they can mature to an appropriate developmental level. In recognition of this, toys and play materials were provided that were suitable for different ages and stages of development, that is, from 2-6 years, allowing the child to regress in a socially acceptable way.

The various theories of development found to be most useful in constructing a multidimensional view of a child's development include the psychophysical model,[15] a model of social play,[16] a model of emotional development[17] and a psychosexual model.[18]

The therapist/child relationship

Two therapists were used in each group. This enabled any needs expressed by the children to be met more immediately, and reduced the intensity of the therapeutic relationship between children and therapists. The technique is advocated in the treatment of emotionally deprived children.[19,20] This is an experiential form of therapy, both in the non-directed nature of play activity and in the quality of the relationship with the therapist. The therapists accepted feelings and behaviour presented by individuals or the group as a whole, thus allowing conflicts to be expressed openly. Clear reflective statements were given to the children to clarify their actions, feelings and conversations, but no deep interpretation was given and care was taken not to express judgement in what was said. This reflection and clarification engenders a feeling of acceptance and understanding, allowing the child to explore potential new solutions to his/her problems and facilitating moves towards more mature functioning.

Non-directive play

Axline[21] states that play is the child's natural medium for self-expression: in a non-directive setting, the child is given permission to use materials as he wishes and to express himself freely without direction, intrusion, disapproval or expectation on behalf of the therapist; he is accepted at whatever level he chooses to function. The therapists within the groups did not initiate play but became involved if invited to do so by the children. The non-directive play context allowed the therapists to observe different areas of development to establish a

baseline and to observe and monitor changes over the 10-week period.

The basic purpose of permissiveness in group therapy is to enable children to express themselves without guilt or anxiety, but it is a planned and controlled technique. If acting-out behaviour threatens the safety, security and equilibrium of the group or individual, then intervention may be necessary, especially with younger children. Jeffrey,[13] in looking at the therapeutic play used by psychologically disturbed children, showed that those in the antisocial/conduct-disordered group persistently chose aggressive play themes and that, the longer that the therapy continued, this play escalated. This type of play was therefore limited, with the direction of individual children or, if necessary, of the whole group into more structured activities when aggressive acting-out behaviour occurred. In addition, a decision was made not to have play materials present which definitely or overtly suggested aggressive themes, such as toy guns. All sessions were planned to finish at morning break or lunch, so that the children were not returned to class with an excess of excitable behaviour which might have been generated by the therapy. In addition, the last 10 minutes of the session were structured by story telling, broadly for the same purpose.

The use of the group

The use of a group introduces the element of the children's relationship with each other. This provides opportunities for social learning and development within a supportive atmosphere, and for the sharing of experience with peers in working out mutual problems. It also provides an increased number of experiences of permissions and acceptance by the therapist. This results in increasing the facilitating atmosphere of the group while making the child/therapist relationship more dilute than in a one-to-one setting.

By widening the therapeutic experience to include a peer group, opportunities are provided for the children to present and explore the potential problem areas of sharing, rivalry, competition and cooperation with each other.

A PROFILE OF THE CHILDREN

From recorded data and other observations, a descriptive profile of the children has been compiled in terms of their physical and psychological appearance.

Physical appearance: The ratings in Table 1 were recorded independently by the therapists and co-therapists. One in four of the children was poorly clothed but fewer were poorly nourished or unwashed.

Table 1. Physical appearance

	Therapist	Co-therapist
Poorly nourished	14.3%	16.7%
Poor body cleanliness	17.1%	13.9%
Poor neatness of clothes	21.5%	23.6%
Poor quality of clothes	22.9%	22.3%

Psychological profile: This concerns how the children related to the therapists, how they related to each other within a group setting and how they played. Overfriendliness was defined as showing exuberant behaviour compounded of being superficial in their response, familiar in their conversation and attention seeking. Many appeared unused to shared activity with an adult. On the other hand, contrary to expectation, only a small group of children sought physical warmth and closeness and were overaffectionate; this most commonly took place during the story-telling time, with a child seeking to sit on a therapist's knee.

In their *social relationships,* many children played at an isolated or parallel level. Cooperative play was seen only between a small number of children who appeared to have age-appropriate social mechanisms.

Some of the children had marked difficulties in relating to one another. Low social competence was demonstrated either in their use of aggressive coping mechanisms, such as fighting and verbal rejections, or by timorous and passive behaviour. The children's partial involvement with one another made the existence of a group atmosphere and identity fragile; it did exist, however, and was enhanced by the directed ending of the sessions when everyone gathered together for a common purpose.

Playing in a non-directive setting posed many difficulties for the children. Some did not initially explore the playroom but found one or two activities which they remained with for several sessions before extending their play. Their difficulties in how to spend their time were made obvious by the frequency with which permission was sought about the use of play materials.

In observing their play, a number of children were found to be continuously and intently involved in basic play with sensory tactile materials. Play at a more mature level, involving representational themes, was predominantly unelaborate and unsustained. For instance, a child would dress up as a policeman but only for a few moments and without playing out the character at all. Tizard and colleagues[22] have described this latter feature in a study with preschool children as 'partial play'.

Table 2 shows that overfriendliness, poor social competence and poor autonomy were common features among our sample of deprived children. Overaffectionate behaviour, often seen in clinical cases, was uncommon.

Table 2. Psychological profile

Overfriendly	30%
Overaffectionate	10%
Poor social competence with peers	32.8%
Poor autonomy	32.9%

RESULTS

At the time of writing, follow-up data are incomplete. However, from monitoring of play and behaviour there are indications of some short-term changes occurring during therapy. Although we are not relying on these as indicators of the long-term outcome, they enable us to examine processes that have taken place so far.

Changes in play

The results are summarised in Figs 1-3 (see Appendix 1 for definitions of play). Fig.1 shows a pattern of upward movement. Creative play has a large rise which may suggest increased self-esteem and growth of imagination at a concrete level. Projective play is low and may indicate a limited ability

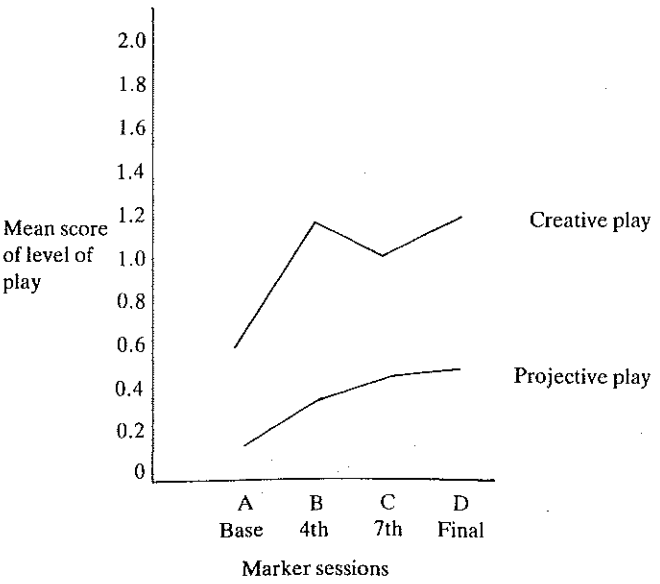

Fig.1. Changes in play: increases. (Play was rated on an ordinal scale: 0 = none; 1 = little; 2 = some; 3 = much.)

to use abstract themes. The increase shown is perhaps as a result of the facilitatory elements of the non-directive play setting.

Fig. 2 shows a pattern of increase followed by decrease, and these are represented by regressive, aggressive, fantasy and directed forms of play. The regressive scale possibly demonstrates the needs of some children to re-explore and meet early developmental needs transiently at the sensory/tactile and motor levels. The aggressive scale perhaps indicates some of the emotional and physical tension being released by these children in an environment that promotes healthy growth, for example, Klein,[23] Ginott,[24] Woltmann[25] and Slavson and Schiffer.[26] We suggest that other reasons for the rise in aggressive play were its use in challenging the boundaries of the play setting and in some cases may represent increased assertiveness in previously passive children. Directed play was used by the therapist to help contain excesses of behaviour which seemed to threaten the equilibrium of the group from time to time, and also to calm excited children at the end of a session. Its pattern of use is similar to those of the aggressive and regressive scales and further suggests that these latter two types of play allowed a transient demonstration and release of feelings. Fantasy play is low on the graph, indicating again a very limited use of abstract themes among these deprived children. Its increase is perhaps due to the facilitatory effects of the setting and its decrease reflects the ease with which newly experienced play forms are disrupted by stress, in this case the terminating of the play sessions.

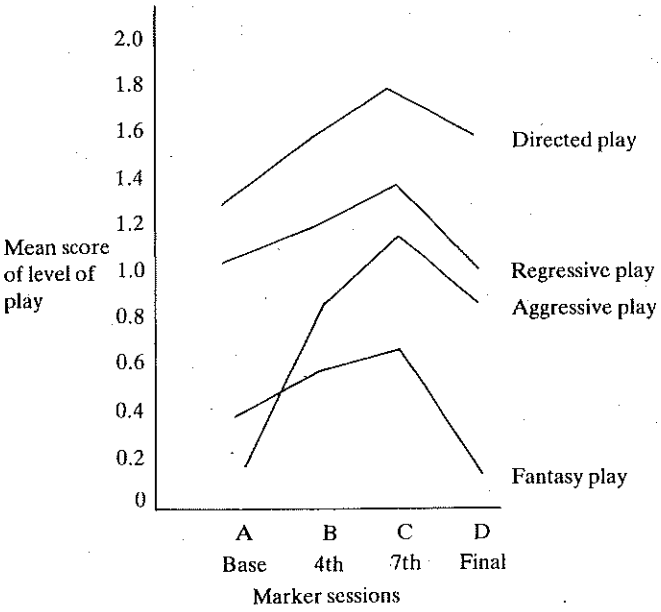

Fig.2. Changes in play: increases followed by decreases. (Play was rated on an ordinal scale: 0 = none; 1 = little; 2 = some; 3 = much.)

Fig. 3 shows the types of play that remained constant. Neutral play, which is used by children to build a relationship with the therapist without revealing very much of themselves, proved to be common. Constructive play has a similar pattern, reflecting the children's level of active involvement in the play materials and the novelty of their availability.

We would suspect that imitative and social play, which are less common but constant, will increase with the children's improved ability to socialise and to identify with alternative adult models in their educational and play environment.

Changes in types of behaviour

Major changes in 10 weeks are small and are seen in only one in four children. Finer degrees of change are less impressive and only hard change that is clearly observable is being reported.

There are some minor fluctuations which tend to obscure major changes in a small percentage of cases. For instance, looking at the curve of social play, little change occurs, but looking at individuals starting with problems in cooperative play, one in four improves substantially.

Overall, marked or moderate change in symptomatic improvement occurred in 43% of the children and positive dynamic change was seen in 36%.

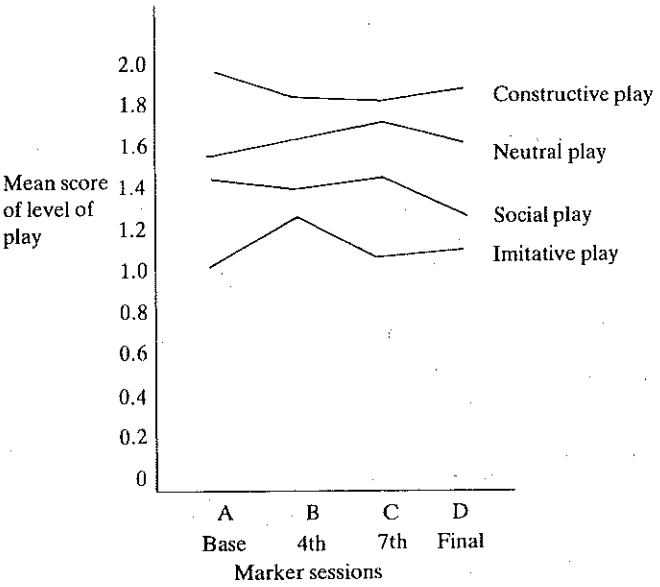

Fig.3. Changes in play: play which remains constant. (Play was rated on an ordinal scale: 0 = none; 1 = little; 2 = some; 3 = much.)

CONCLUSION

In conclusion, we ask whether developmental playgroup therapy is helpful. There appear to be some immediate effects, as reflected in changes in creative and projective play and facilitatory changes as seen in aggressive and regressive play. The medium-term and long-term effects of the therapy are not yet available. However, a fuller account of the issues is provided elsewhere.[28]

Another important question is: what are the advantages of this type of intervention? Firstly, it is community-based rather than clinic-based, so has the potential of being available to a larger number of children in need; secondly, it is a relatively inexpensive form of short-term group therapy; and lastly, parents in deprived circumstances may not have the resources, enthusiasm or motivation for participating in a therapeutic programme. Our programme is dependent on parental permission but not on their participation. Therapy is given directly to the children in their everyday environment. However, whenever possible, complementary programmes for parents should be encouraged.

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Appendix 1. Play definitions

NEUTRAL	Play used to build a therapeutic relationship.
REGRESSIVE	The child uses play at a level below that expected for his chronological age and intellectual endowment which satisfies an emotional need in the child.
AGGRESSIVE	Activity used to express aggression.
PROJECTIVE	Play used by the child to communicate, for example, feelings, fears and fantasies.
FANTASY	Representational play using fantasy themes.
IMITATIVE	Representational play using themes which imitate adult activities.
SOCIAL	Cooperative play between children.
CONSTRUCTIVE	Use of toys or play materials purposefully.
CREATIVE	Child's unique influence on play materials.
DIRECTED PLAY	Structured use of the play situation by the therapist.

Appendix 2. Reliability of ratings of play measures

Type of play	Percentage agreement		Percentage overall agreement	Kappa
	Absence of that play type	Presence of that play type		
Neutral	9	55	64	0.09
Regressive	20	48	68	0.32
Aggressive	31	54	85	0.69
Imitative	15	63	78	0.42
Fantasy	11	68	79	0.38
Projective	27	43	70	0.39
Social	33	39	72	0.45
Constructive	39	29	68	0.35
Creative	27	41	68	0.34
Directed	11	61	72	0.26

The data in the table are based on 10 play extracts contained on videotape with each play session rated by 23 or 24 raters. This gives rise to over 2500 pairs of ratings in relation to each type of play. The average agreement between raters was calculated in relation to absence of each play type, presence of each and also percentage of overall agreement.

Each individual Kappa proved to be significantly different from zero, although their magnitude indicates only mediocre reliability on most.[27] On the basis of the data, including an examination of Z values, it was concluded that only four of the play types (aggressive, social, imitative and projective) could be measured with satisfactory reliability. Another four (constructive, creative, regressive and fantasy) could be measured with moderate reliability. Finally, the reliability of neutral and directed play is evidently poor. In the latter, if the ratings are confined to experienced raters, the Kappas are marginally higher, namely 0.16 and 0.37 respectively.