

Play Group Therapy: Processes and Patterns and Delayed Effects

V. Bell, S. Lyne, I. Kolvin*

The crucial question about the efficacy of psychotherapy with children is now being widely addressed by careful systematic research. The doubts and uncertainties surrounding psychotherapy were thrown into sharp relief in the 1950s with Eysenck's (1952) controversial claim that adult patients receiving psychotherapy were not better off than those receiving no treatment at all. Similar claims were made in relation to psychotherapy with children (Levitt, 1957; Levitt et al., 1959). Since then, the claims and counter-claims have resounded through the therapy evaluation literature. Yet clinicians continued to practice psychotherapy, guided presumably by their own experience within the context of therapy—if not by research findings—and thereby reassured that their activities were worthwhile. The last decade has thrown up confirmatory evidence for the clinician's assumptions (Kolvin et al., 1985, 1988a, b).

Much attention is now being directed to the processes of therapy, and this paper represents an attempt to explore processes and patterns of outcome over time in relation to play group therapy. For these purposes we utilize data from previous research as outlined in *Help Starts Here* (Kolvin et al., 1985) and a more recent community-based early secondary prevention project with deprived "at risk" Inner City Children (Bell et al., 1988).

Aims

In this paper we address ourselves to four interrelated themes: *first*, the processes of therapy and their implications for outcome; *second*, the crucial importance of long-term follow-up; *third*, the importance of collecting information using multiple measures from diverse sources at different points in time; and *fourth*, the question of sleeper effects.

* I. Kolvin is indebted to the Health Promotion Trust and the Mental Health Foundation for their support.

Background

The Newcastle School-Based Study (Kolvin et al., 1985)

These studies were undertaken with 547 children identified by screening procedures; individual information was gathered from parents, teachers, and individuals by group assessments. The children were randomly allocated by school class to the various treatment regimes, including a non-treatment regime. Major follow-ups were undertaken 18 and 36 months after the baseline assessments. The treatment regime is fully described elsewhere (Kolvin et al., 1985, 1988a, b). This included behavior modifications applied in senior schools, group therapy in both primary and secondary schools, and nurture work in primary schools.

Our play groups were based on the philosophy developed by Rogers (Rogers, 1952; Hall & Lindzey, 1970). The adaptation of the group-therapy technique to younger children was influenced by the work of Axline (1947), especially her eight principles that can be followed in practical play therapy. These include the development of a warm friendly relationship with the child, accepting the child exactly as he or she is, engendering a sense of permissiveness in the relationship, being alert to the expression of feelings in the child, maintaining of a deep respect for the child's ability to solve his or her own problems, having a non-directive attitude, exerting no sense of pressure, and finally confining limitations to those that are necessary to maintain the therapy in the real world. This allows the children to reflect their feelings through play. Nevertheless, in the model established in Newcastle, it was agreed it was necessary to establish some limit setting to allow the groups to function in the complex environment of the school while at the same time strengthening internal controls of some of the more impulsive children (Axline, 1947; Ginott, 1961).

The play groups were run by trained experienced social workers who had had an additional introductory training program. They were given continuous supervision over the period of the program. The children were withdrawn from the classes for the purpose of play therapy, which was undertaken in small groups and consisted of ten sessions over one term. The groups were of mixed sex, and problems consisted of a mixture of conduct,

neurotic, and educational. In the above research the processes of therapy have been described by Parker and Nicol (1981) and included monitoring of aggression, isolation, and attention-seeking behavior in any session over 17 groups.

Community-Based Early Secondary Prevention (Bell et al., 1988)

Introduction

The classical approach to prevention has been based on the work of Caplan (1964). 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 promote psychological adjustment (Sandford, 1965). Such primary preventive approaches do not focus directly on individual distress. 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 from becoming severe or overt. A prominent example of early prevention were the "Head Start" programs, which were designed to facilitate educational progress by providing deprived children with compensatory stimulation. These projects were reviewed by Bronfenbrenner (1974). He concluded that compensatory stimulation provided in the preschool years gives rise to substantial IQ gains while the program lasts, but that this trend reaches a plateau and that gains are rapidly eroded once help ends. There have been some recent reviews suggesting that these programs were not without useful long-term effects.

The Newcastle research findings outlined in *Help Starts Here*, on the other hand, indicated that short-term group therapy with older children or play group therapy with younger children who were at risk for maladjustment had impressive long-term outcome. The crucial difference between the above and the "Head Start" compensatory enrichment program was that in Newcastle a therapeutic component was added. Traditionally, enrichment is geared to the cognitive and social development of the child. Play group therapy includes this but in addition it attempts to promote emotional maturational and modify any associated behavioral problems.

The *Help Starts Here* project included a number of deprived infant school children 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 play group therapy has the potential for making a major contribution to counteracting the medium- to long-term effects of deprivation which is so widespread in our inner cities.

The Current Project

The intention of the Community-Based Secondary Prevention Project was to identify deprived infant school children and to evaluate the impact of play group therapy on them. Our hope in locating this project in the community was to make this type of prevention and intervention available in the future to a maximum number of children while causing little disruption to their lives. Inevitably, the deprived group of children included a high proportion of children who were maladjusted or at risk for maladjustment.

The project was conducted in Infant and Primary schools in an Inner City Educational Priority Area. Children in their second year at school, 5-6-year-olds, were screened using three criteria previously tested in the 1,000 Family Study (Kolvin et al., 1983, 1988a), and based on information likely to be known to the schools. These were unemployment of the breadwinner, free school meals (given to children from low-income families), and marital breakdown. During randomization, the children were matched for criteria of deprivation and sex in order to achieve a balance within the therapy groups and between these and the controls.

Each group contained 5 to 6 children, and play group therapy sessions were run over a 10-week period; these took place in schools. A total of 13 therapy groups were run. Sessions were conducted by occupational therapists, supported by a co-therapist. The previous experience of the occupational therapists included group and individual play therapy under clinical instruction and supervision. A specific training course was run for the co-therapists prior to the research project. All the therapists attended weekly supervision sessions with a psychotherapist during the course of the groups.

The assessment of the project and the collection of data has included the establishment of a baseline, followed by a short-

term follow-up at 6 months after baseline, an intermediate follow-up at 12 months after baseline, and a final long-term follow-up after 24-30 months. Assessments include teacher ratings of child behavior, social and behavioral data from the parents, and assessment of verbal and reading abilities.

Again, play group therapy was modelled on principles derived from Rogers and Axline with modifications tailored to meet the needs of deprived children. We have labelled this variation "Developmental Play Group Therapy" (Jeffrey, 1984) as it attempts to meet the child's physical, emotional, and social needs as expressed through their play. It was theorized that the non-directive play setting would allow the re-experience and satisfaction of developmental needs. We used small groups of children to facilitate social learning, and provided a range of play materials for different developmental levels to facilitate growth in all areas. The therapy sessions were carried out with the consent of the parents, but their active involvement was not required. Play therapy sessions were timed to run for 45 minutes. In the non-directive play time, the therapist aimed to create a permissive and accepting environment in which the children, in the safety of a therapeutic relationship, could express themselves freely at their true level of development. Through a sensitivity to varying maturational levels, the therapist aimed, through the use of simple reflective statements, to help the children to understand themselves. This was done with individuals in the group and with the group as a whole. Social difficulties were handled in the "here and now", using clarifying statements to help the children understand their own and others' points of view. Limits were set as they were required and centered around behavior that threatened the safety and equilibrium of the group or one of its members.

Changes in Play

Previous studies have examined openness of discussion and group cohesiveness in therapy as predictors of outcome (Truax et al., 1973), but these have not been confirmed (Kolvin et al., 1985). On this occasion, we studied processes during therapy as demonstrated through play, both as a study in itself and in an attempt to define patterns of short-term changes that may be helpful as indicators of long-term outcome. The measures of play are defined in the addendum. Reliability studies have been undertaken and are reported elsewhere (Bell et al., 1988).

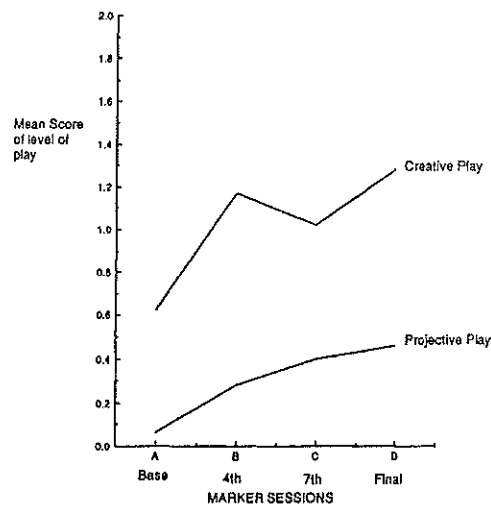


Figure 1. Changes in play (i): Increases. Play was rated on an ordinal scale (0 = none, 1 = little, 2 = some, 3 = much).

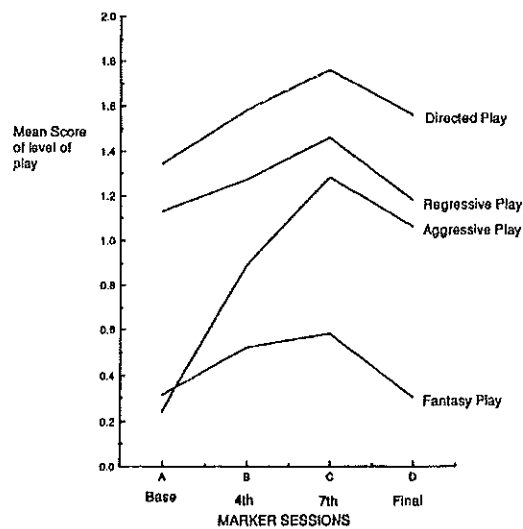


Figure 2. Changes in play (ii): Increases followed by decreases. Play was rated on an ordinal scale (0 = none, 1 = little, 2 = some, 3 = much).

The patterns are summarized in Figures 1-3. Figure 1 shows an upward trend in creative and projective play; this suggests to us a growth of self-esteem and a growth in imaginativeness. We interpret this as an improvement in the ability to use play at a more advanced level.

Figure 2 shows a pattern of increase followed by decrease; these are represented by regressive, aggressive, and fantasy forms of play. The regressive play possibly demonstrates the

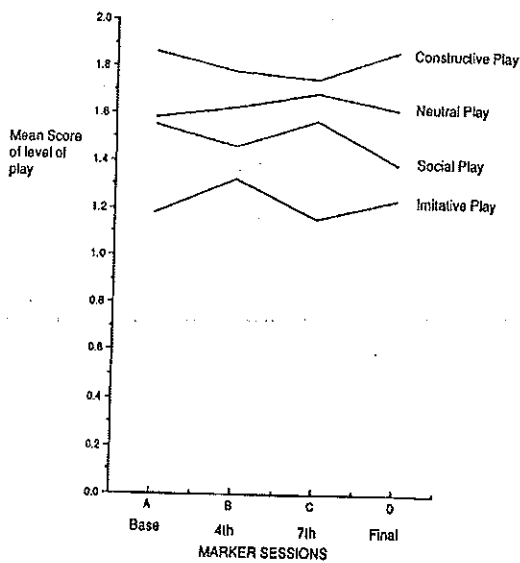


Figure 3. Changes in play (iii): Play which remains constant. Play was rated on an ordinal scale (0 = none, 1 = little, 2 = some, 3 = much).

need of some children to re-explore and transiently meet early developmental needs at the sensory/tactile and motor levels. The aggressive play perhaps indicates some of the emotional and physical tension released by these children in an environment that promotes health growth, e.g., Klein (1955), Ginott (1961), Woltmann (1955), and Salvson and Schiffer (1975). Other reasons for the rise in aggressive play were likely to be its use in challenging the boundaries of the play setting and in some cases an increased assertiveness in previously passive children.

In Figure 3 there is a representation of the type of play that remained constant. Constructive play proved to be common: It reflects the children's level of purposeful use of play materials, and we have speculated that it represents the novelty of their unrestricted availability. We would suspect that imitative and social play, which are less common but constant, will increase with the child's improved ability to socialize and to identify with the alternative adult models in their educational and play environment.

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

In conclusion, we address ourselves to the question: Is this application of play group therapy 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. From the monitoring of play there are indications of some short-term fluctuations occurring during therapy. While we do not rely on these as representative of improvement in itself, they may well be predictors of long-term outcome.

The Importance of Long-Term Follow-Ups

It is essential to monitor the rates of change and such changes can be compared using different formulae. First, by complex multivariate techniques such analysis of covariance (see Appendix 3 of Kolvin et al., 1985), which allow the monitoring of improvement, by which average *improvement* scores for each treatment group were compared for every measure separately at each subsequent follow-up. In addition, certain measures were summed, and the summed scores were again subject to analysis of covariance.

The second is a more simple method that calculates outcome in terms of percentages (as defined by Sainsbury, 1975, and

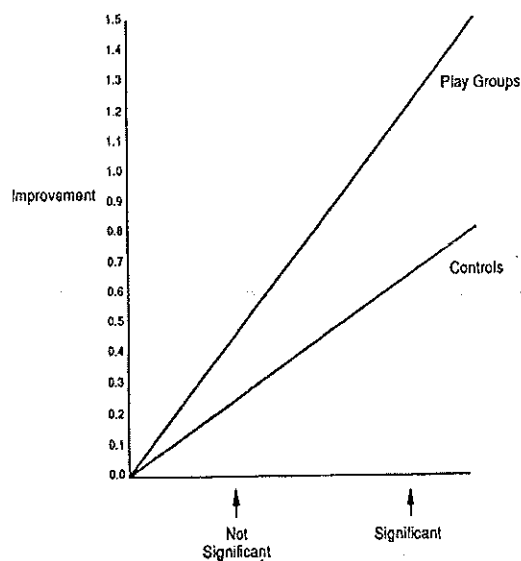


Figure 4. "Help Starts Here" (Kolvin et al., 1985): Juniors. The importance of long-term follow-up. Mean improvement in maladjustment (10 items). Here, we assume improvement is linear!

described in Appendix 2 of Kolvin et al., 1985). This allows for a calculation of the percentage who show good and moderate as opposed to poor outcome. It is notable that the overall trends for these very different types of analyses were remarkably similar.

In their school-based intervention study, Kolvin et al. (1985) report that, over time, behavior symptoms decrease slowly but inexorably in both treated and control groups. Because of this steady reduction in symptoms in untreated disturbed children, it is unwise to assume that change constitutes improvement. It is essential that appropriate controls be selected for simultaneous study. The Newcastle research demonstrated that four-fifths of the "at-risk" children who were given play group therapy showed a good/moderate outcome as compared to just over 45% of the controls. Figure 4 demonstrates that improvement continues over time and that such improvement looks linear. However, on the basis of analysis of covariance, the differences at 18 months were not significant, though those at 36 months were highly significant.

Multiple Measures and Long-Term Follow-Up

Another crucial message from the Newcastle work is the importance of collecting information using multiple measures and from diverse sources at different points in time. It is notable that changes occurred rather slowly, major changes appearing to occur quite a long time after therapy was complete. It seems that it is all too easy to look for the wrong things to be measured at the wrong point in time. For instance, there were some initial gains on measures of academic performance which appeared to wash out. After 18 months, there was significant improvement of only two measures (both at $p < .05$ level). In the long term, parent and teacher reports proved to be the most sensitive indicators of treatment effectiveness. Multiple measures showed significant improvement (mostly at $p < .01$ level) (Table 1). If, at the medium-term follow-up, only parent behavior scales had been employed, then the researchers could have concluded that there had been no improvement and abandoned the follow-up!

Table 1. Significant differences across time on school and home measures (paired comparisons).

Base to end of treatment	After 18 months	After 36 months
Not tested	DESB* Rutter School Scale Antisocial*	DESB** Rutter School Scale 1. Antisocial** 2. Neurotic** Newcastle Parent Scale 1. Antisocial** 2. Psychosomatic* Global measures 1. Neurotic: 5 measures* 2. Antisocial: 5 measures**

DESB = Devereux Elementary School Behaviour Rating Scale
Newcastle Parent Scale

* $p < 0.05$

** $p < 0.01$

The Question of Sleeper Effects

Despite its brevity, the effects of group therapy seem to continue for about 30 months or more, which is extraordinary in view of the many experiences the children must have had in their lives during this time. Why has this occurred? Perhaps psychotherapy merely brings forward improvement rather than actually producing change. If this were the case, we would have expected the controls to catch up. But they did not do so, and therefore we must conclude that intervention produced real change that would not otherwise have occurred. (This was not unique to our research; cf. Wright et al., 1976.) Indeed, this improvement continues and may only become evident after therapy has ceased; the mechanisms behind this are unknown, but we can advance several explanations. The first possibility is that the change is *linear*, and if we apply our measures too early, changes may be too subtle to be revealed by crude measures. Or that there is merely a non-significant trend. Unfortunately, in *Help Starts Here*, the assumed linearity may be an illusion based on the fact that we did not undertake our measures sufficiently soon after the end of treatment (Figure 5).

When we originally examined our data, we assumed that change was linear. This is a fundamental issue on both practi-

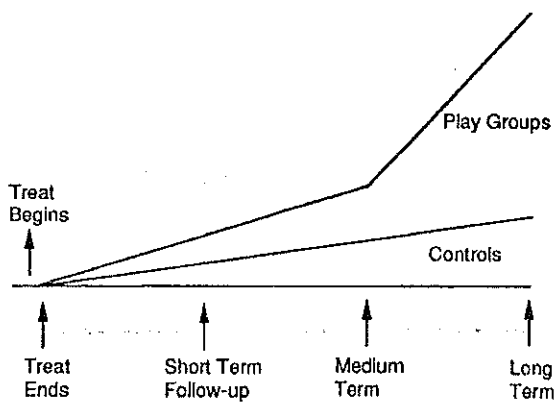


Figure 5. "Sleeper effects" (based on "Help Starts Here").

cal and theoretical grounds, and there are important questions about this. Indeed, if improvement is linear, then it should be possible to detect some trends or even significant differences at an earlier point in time. The *Help Starts Here* research (Kolvin et al., 1985) did not collect follow-up data sufficiently early to allow this question to be addressed.

In the current deprivation project using play group therapy with deprived primary school children living in our Inner City, we were able to address the question about short-term effects since we had teacher reports (Rutter B2 Scale) completed at 6 and 12 months after baseline (that is, after the initiation of the group therapy program). However, no short-term differences or even trends were identified, and under the circumstances the notion of sleeper effects begin to find favor (Figure 5).

The notion of "sleeper effects" holds considerable fascination for the therapist and researcher alike. What are sleeper phenomena—there is no problem with definition: They may be defined as delayed effects of therapy. Nor is there a problem with measuring these delayed effects. The problem for the therapist resides in understanding the *psychological processes* that precede the delayed effects, and for the researcher in how to *measure* these processes. On logical and theoretical grounds, we must assume the existence of the above psychological processes. One possibility is that over the 10 sessions of play group therapy, positive interactions between the child and peers could have resulted in greater degrees of group cohesiveness and this given rise to improvement of self-esteem, which in turn could have influenced the perceptions of that child by parents and teachers. A variation of this is that positive social interactions within the group may lead to a strengthening of relationships with peers, which may be reinforced by further contacts sub-

sequently with these peers. These experiences may be analogous to the "fresh starts" events which George Brown considers give new perceptions to individuals who can change the course of their life. It is often noted that underlying so-called spontaneous improvement of maladjustment may be some desirable chance events that may be the turning point in an individual's life.

A second possibility is that the child may acquire a new set of skills through interactional experiences that are not useful immediately but become so at a later point in time. For instance, they may help to prepare children to cope with later stressful experiences. A third possibility is that psychotherapy affects underlying central or structural aspects of personality functioning rather than overt behavior (Wright et al., 1976). Eventually, there may be subtle shifts in personality which, through feedback mechanisms, give rise to demonstrable change in behavior, or, alternatively, that intervention has set up some latent or even subtle changes in internal psychological structures that may change the way the child perceives the environment, by changing their cognitions or attributions, and these in turn eventually give rise to a change in behavior. Thus, in the early stages there may have been changes in latent psychological structures which are only later operationalized into measurable processes.

Bearing these three possibilities in mind, tests of variation between groups may be quite irrelevant to these subtle within-subject changes. Furthermore, our data suggest that therapists should not be deterred by lack of evidence of short-term overt behavioral changes. Nevertheless, they would be wise to seek confirmation of the presence of longer-term more durable effects. Finally, if therapy has a "sleeper effect," then therapists may have to conduct therapy regardless whether it is going to have an impact.

There remain two important qualifications, and they both relate to the second treatment program. The first qualification is that we have not as yet disentangled the behavioral and environmental classifications. It is as yet not clear whether our conclusions apply to the children who are both maladjusted *and* deprived, or merely to those who are deprived but not maladjusted. The second relates to long-term follow-up. We had hoped to provide data from a final statistical analysis, but because of technical delays in analyzing data, this information is not yet available.

We do not agree with the cynic who said: "To be well adjusted is marvellous. To help others to become adjusted is even better—and less trouble."

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Appendix

Play Definitions

NEUTRAL	Play used to build a therapeutic relationship.
REGRESSIVE	The child uses play at a level below that expected for his or her 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 feelings, fears, fantasies, etc.
FANTASY	Representational play using fantasy themes.
IMITATIVE	Representational play using themes that imitate adult activities.
SOCIAL	Cooperative play among children.
CONSTRUCTIVE	Use of toys or play materials purposefull.
CREATIVE	Child's unique influence on play materials.
DIRECTED PLAY	Structured use of the play situation by the therapist.