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Parent Group Intervention with Child-Based Intervention for Promoting Playfulness in
Children with Disabilities

Author(s): Anita C. Bundy, Jitka Kolrosova, Sarah-Grace Paguinto, Paula Bray, Belinda Swain, Margaret Wallen and Lina Engelen

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Comparing the Effectiveness of a Parent Group Intervention with Child-Based Intervention for Promoting Playfulness in Children with Disabilities

Anita C. Bundy, Jitka Kolrosova, Sarah-Grace Paguinto, Paula Bray, Belinda Swain, Margaret Wallen, Lina Engelen

Key words: Parent education, mixed methods approach, pilot study, occupational therapy.

Abstract

Aim: The aims of this pilot study were: (a) to determine the effect size associated with a parent group intervention as compared with individual occupational therapy, for increasing children's playfulness; and (b) to explore parents' experiences of the group intervention. **Methods:** Families of 40 children aged 2 to 8 years were randomly assigned to two groups. Parents assigned to parent group intervention (n= 21) participated in activities designed to help promote play. Children assigned to individual intervention received therapy using play as a medium. The Test of Playfulness was the outcome measure. Nine parents from the parent group intervention participated in semi-structured interviews; resulting data were analyzed thematically. **Results and Discussion:** Small to moderate effect sizes were associated with the interventions: 0.15 for the parent

Anita C. Bundy, ScD, OTR, FAOTA, Occupational Therapy, Faculty of Health Sciences, The University of Sydney, Australia. anita.bundy@sydney.edu.au

Jitka Kolrosova, MOT(Hons), Occupational Therapy, Faculty of Health Sciences, The University of Sydney, Australia.

Sarah-Grace Paguinto, BAppScOT(Hons), Occupational Therapy, Faculty of Health Sciences, The University of Sydney, Australia.

Paula Bray, PhD, OT, Occupational Therapy, Faculty of Health Sciences, The University of Sydney, Australia. The Children's Hospital at Westmead, Westmead, Australia.

Belinda Swain, MA, BAppSc(OT), The Children's Hospital at Westmead, Westmead, Australia.

Margaret Wallen, PhD, MA BAppSc(OT), The Children's Hospital at Westmead, Westmead, Australia.

Lina Engelen, PhD, Occupational Therapy, Faculty of Health Sciences, The University of Sydney, Australia.

The Israeli Journal of Occupational Therapy, November 2011, 20(4)

group and 0.37 for individual intervention. Qualitative data from parent interviews revealed three themes: (a) Rethinking the value of play; (b) Promoting play; and (c) Parents helping parents. **Conclusions:** The small effect size associated with the parent group intervention may be the result of a number of factors that require further investigation. Parents' initial reluctance to participate in a group to promote playfulness suggests the need for reframing of the primary roles of occupational therapy with children. Further research is clearly needed.

Introduction

In recent years, pediatric occupational therapists have expressed increased interest in children's play and playfulness (e.g., Parham & Fazio, 2008). Playfulness has been associated with a number of benefits that may make it particularly important for children with a range of disabilities. For example, Guitard, Ferland, and Dutil (2005) argued that a playful attitude contributes to problem-solving skills and adaptability and to decreased frustration, deception and anxiety. They also associated playfulness with imagination, joy, creativity, pleasure and spontaneity. Other authors have found a positive relationship between playfulness and coping for preschoolers (Saunders, Sayer, & Goodale, 1999) and adolescents (Hess & Bundy, 2003).

Children with disabilities are known to have difficulties with play and playfulness that often, but not always, reflect the primary characteristics of the disability. For example, children with autism have difficulties with symbolic and social play (summarized in Lockett & Bundy, 2007) and their playfulness is generally decreased (e.g., Skaines, Rodger, & Bundy, 2006). Children with ADHD have playfulness profiles that suggest a lack of empathy but no difficulty remaining engaged (Cordier, Bundy, Hocking, & Einfeld, 2010). Children with physical disabilities but no cognitive limitations have been shown to have greater skill for playful mischief and teasing, which is perhaps a way of playing with ideas that compensates for difficulty playing with objects or moving about in space (Harkness & Bundy, 2001). However, unlike children with ADHD, these children with physical disabilities did have unexpectedly low scores reflecting reduced engagement in play. Perhaps this was because they often were not the decision makers in the play and thus may have been less highly motivated by particular activities selected for them.

Even given the importance of play touted by researchers and theorists, society as a whole does not always perceive its benefits. Parents of children

Comparing the Effectiveness of a Parent Group Intervention with Child-Based Intervention for Promoting Playfulness in Children with Disabilities

with disabilities may be even more prone than other parents to undervalue play, despite evidence that play and playfulness are affected negatively by disability. This may be because their children require greater time and effort to master basic and "more highly valued" skills.

Play is highly motivating to children and is often considered to be a window onto development. Thus, play is the primary medium for direct intervention in occupational therapy (Parham & Fazio, 2008) and is a common context for developmental assessment (e.g., Linder, 2008). Play is also a medium for intervention and assessment conducted by psychologists and psychiatrists, although these professionals focus on the psychosocial or psychoanalytic underpinnings of play (e.g., Axline, 1989).

Playfulness is responsive to change in the environment (e.g., Bundy et al., 2008) including such simple interventions as helping parents position their child so they can see one another, thus facilitating interaction (e.g., Okimoto, Bundy, & Hanzlik, 2000). Parents set the environmental context for play and may serve as valued playmates. They also have a fundamental role in determining how children spend their time. Intervening with parents, therefore, might be an ideal means for promoting play and playfulness in children.

Parent groups may be as effective for facilitating changes in playfulness as one-on-one interventions implemented directly with children. A group provides opportunities for parents to share their knowledge and challenge their beliefs about play together with other parents who share a similar family situation: having a child with a disability. Group interventions also promote parental feelings of competence and provide new play ideas (e.g., McConkey, McEvoy, & Gallagher, 1982).

While no studies exist in occupational therapy, substantial research in other fields supports parent group interventions for increasing play-related outcomes. Parent groups have been found to lead to gains in children's self-initiation and responsiveness (Moran & Whitman, 1985); to increase children's emotional engagement and sustained attention during play with objects (Love et al., 2005; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989) and to yield gains in development (Deutscher, Fewell, & Gross, 2006). Other studies addressing problem behaviors in children have used parent group interventions to promote positive parent-child interactions (e.g., Deutscher et al., 2006; McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005; Turner, Richards, & Sanders, 2007).

Not all researchers have found parent group interventions to be as successful as individual interventions (e.g., Chadwick et al., 2001). However,

the potential for multiple benefits and increased cost-effectiveness make parent group interventions an important topic for further investigation.

The format and purpose of group-based interventions vary widely. Parent or family support groups, where one or more members experience a particular condition (e.g., muscular dystrophy), are common. Such groups have primarily social and compassionate functions -- parents helping other parents. Parent support groups may meet (in person or via the internet) for many years. Other groups have a primarily educational focus with professionals using a more-or-less fixed curriculum as the basis for didactic lectures. Alternatively, educational groups may take the form of facilitated discussion. Groups with a primarily educational focus are generally relatively short-term. Still other groups are characterized by therapists coaching parents in techniques for imparting skills or changing behaviors in their children. These groups often involve both parents and children being present.

The lines between different types of parent groups often blur and many groups that have been reported in the literature reflect a mix of types, for example: coaching and didactic (Deutscher et al., 2006; McNeil et al., 2005; Turner et al., 2007); facilitation and didactic (Webster-Stratton et al., 1989). The groups reported herein had an educational focus; therapists provided materials that facilitated discussion -- parents teaching themselves and one another (Vella, 2001). The group discussions generated by those interactions sometimes added a compassionate function - parents helping other parents.

The aims of this pilot study were twofold:

1. To determine the effect size associated with a parent group intervention for promoting play as compared with individual occupational therapy (usual practice) for increasing children's playfulness. This was necessary in order to calculate the sample size needed to detect statistical significance in a full-scale trial to test the equivalence of these interventions.
2. To explore parents' experiences of the group intervention.

We were interested in parents' perceptions because groups of this nature are relatively unusual in occupational therapy. In learning about parents' experiences, we hoped to learn which aspects worked and in what ways we might alter the group experiences in future trials.

Methods

The research questions that prompted this study reflected the aims directly. How big was the effect of the two interventions on playfulness? And, how did

Comparing the Effectiveness of a Parent Group Intervention with Child-Based Intervention for Promoting Playfulness in Children with Disabilities

the parents involved in the group intervention describe their experiences? We hypothesized that the group would be at least as effective as individual intervention for increasing playfulness. This research was conducted at The Children's Hospital at Westmead, NSW, Australia. Ethical approval was obtained from Human Research Ethics Committees of The University of Sydney, The Children's Hospital at Westmead and Sydney West Area Health Service.

Participants

Participants were recruited through The Children's Hospital at Westmead and Auburn and The Hills Community Health Centres. Families were eligible for inclusion if they had children aged between 2 and 8 years who: (a) were receiving or waiting for occupational therapy services, and (b) had difficulties associated with play as a part of their referral (e.g., social difficulties, problems playing in an age-appropriate manner). Choosing a sample from a particular group thought to be appropriate for the intervention is known as purposive sampling.

All eligible families ($n = 69$) were invited to participate. As the purpose of this pilot study was to detect an effect size in preparation for a larger study, 40 participants were considered a sufficient sample. The first 40 families to consent were randomized with allocation concealment, following the pre-test, in blocks of 10. Randomization was completed over 2 years (June 2005 to May 2007) by a member of the hospital staff not involved in the interventions. Twenty-one families were randomized to the parent group intervention and 19 to the individual intervention. Nothing is known about families who chose not to participate.

Pre-test data were collected on all 40 children; post-test data were collected on 18 children from the parent intervention group and 17 from the individual intervention. Two families randomized to the parent group dropped out before beginning the intervention stating they preferred individual therapy. One child in the parent group and two children in the individual group were not available for post-testing.

Table 1 contains descriptive information. The families resided in western Sydney and most had more than one child. No data were collected on socioeconomic status or IQ. The educational status of the 11 children attending school (i.e., special or mainstream education) also is unknown. Although the children were randomly assigned, the parent-based intervention comprised a larger sample of children diagnosed with developmental delay than the group

receiving individual intervention. Parents were reimbursed \$20 per assessment for travel costs.

Table 1
Characteristics of Children and Mothers' Education for Each Intervention.

	Parent group	Individual
Female	6	6
Male	12	11
Mean age in months (<i>SD</i>)	52.3 (20.3)	51.4 (23.2)
Diagnosis		
ADHD		1
Autism	3	4
Developmental delay	11	5
Language delay	3	3
Motor delay	1	3
Cerebral palsy		1
School Status		
Attending school	6	5
Pre-school	15	14
Mothers' Education		
Primary school	1	
High school	4	5
Tertiary education	13	13

Instrument

The Test of Playfulness (ToP; Skard & Bundy, 2008) is an observation-based assessment developed to capture four elements related to playfulness: intrinsic motivation, internal control, freedom from unnecessary constraints of reality and framing (i.e., giving and reading social cues). The ToP is administered during free play in an environment supportive of play; a usual play environment is preferred. An uninterrupted period of 15 minutes is videotaped and scored by qualified raters. Twenty-nine items are scored on a 4-point (0 to 3) scale reflecting extent, intensity or skill of a play-related behavior. Higher overall scores indicate a greater degree of playfulness. Previous studies have

Comparing the Effectiveness of a Parent Group Intervention with Child-Based
Intervention for Promoting Playfulness in Children with Disabilities

provided evidence that the ToP yields reliable and valid data for both typically developing children and children with a range of disabilities (e.g., Bundy, Nelson, Metzger, & Bingaman, 2001).

Procedures

The ToP was administered before randomization and 4 to 6 weeks after completion of the 6-week interventions. Except for three children from the individual intervention group, all children completed both assessments with the same parent, usually their mothers. The ToP was administered in a large hospital room usually used for occupational therapy interventions. The room was not familiar to the children but was well equipped with toys popular with young children. In accordance with ToP procedures, parents were instructed to follow their child's lead in play. Radio microphones were placed on both child and parent to record their conversations for ease of later scoring. Parents and children explored the playroom without anyone else present for 15-minutes before the camera operator entered and began videotaping; the camera operator did not interact with the participants.

Interventions

Individual intervention. Children participated in six 1-hour sessions conducted by one of three experienced pediatric occupational therapists. In keeping with usual practice, goals for intervention were established collaboratively by parent and therapist. While all children had play-related difficulties, those were not always the focus of the intervention if they were not deemed to be the most pressing issue. Goals varied from participation in particular play activities to improved handwriting. In all cases, play was the primary means to address the goals. Therapists set up the environment to optimize play and engaged with the child in play activities designed to meet a part of the goal. Parents were present during the sessions and they chose how much to be involved. At the close of each session, therapists provided ideas for families to carry over at home.

Parent group intervention. The parent group intervention involved six 2-hour sessions over 6 weeks. Each group comprised four to six participants. Group members engaged in three or four group activities each session, covering topics such as defining play, describing the benefits of play, assessing play, illustrating play in which they engaged as children, and discussing videotapes of parent-child dyads playing together (their own as well as dyads

unknown to them). Each activity was introduced by a brief lecture, short written material, or videotape followed by discussion among the parents and then a discussion involving both parents and staff. A break for refreshments and informal conversation occurred midway through each session. Two experienced occupational therapists (AB and PB) planned the activities, provided materials and introduced the group activities.

At the end of each session, each parent created his or her own "take-home message" for the coming week. Parents were free to discuss their thoughts or to work alone as they created their message. Each parent shared his or her take-home message before the session ended. The subsequent session began with a report of the parents' experiences relative to the message from the previous week. In the final session, parents created a specific plan for promoting play with their child. The plan considered the child's motivations for play, types of play well-suited to the child and supports necessary for the play to succeed. Parents also saw examples of simple toys made from household items.

Follow-up interviews. During the final group session, parents received a letter inviting them to participate in follow-up interviews. Eight mothers and one father returned a form indicating willingness to participate. Due to budget constraints, no attempt was made to follow up with the other parents¹. Face-to-face semi-structured interviews, ranging from 20 to 55 minutes, were carried out individually 4 weeks after completion of the group by one of two trained interviewers who had not been part of the intervention. Interviews were audio-taped and transcribed verbatim. The interviewers asked parents to describe their experiences of participating in the parent group intervention, what they had learned and whether the group had affected their day-to-day routines or their beliefs about play.

¹ All parents were asked to provide feedback during their final group session for the purposes of altering future groups if needed. The feedback received during those sessions was overwhelmingly positive and no changes were made to group activities. Thus, it also seems possible that parents who did not return a form for interview considered that they had already provided all the feedback they had. However, it is unclear whether parents consenting to be interviewed differed significantly from those who did not.

Comparing the Effectiveness of a Parent Group Intervention with Child-Based
Intervention for Promoting Playfulness in Children with Disabilities

Data Analysis

Quantitative analysis. The video recordings of the play sessions were assessed by one of four trained and calibrated raters who were unaware of the purpose of the study. Overall ToP scores, expressed as logits, were obtained by entering item scores into a large ToP data set ($N > 2000$) and by subjecting the data to Rasch analysis using the Facets program (Linacre, 1987-2007). The scores gained in this way were analogous to scores gained from a test manual. The resulting scores were used to derive descriptive statistics, Cohen's d (effect size) and sample sizes needed to detect statistical significance for each intervention (Aron, Aron, & Coups, 2010). An effect size of up to 0.3 is considered small; 0.5 medium; and ≥ 0.8 large.

Qualitative data. Constant comparative analysis was used when coding data from the interviews into themes (Hewitt-Taylor, 2001). Initial codes were developed using coding families as suggested by Bogdan and Biklen (2003). Data and codes were revisited iteratively; related chunks were combined until the minimum number of mutually-exclusive thematic groupings had been identified. Each time data were re-coded or combined, changes were documented in an audit trail. One author (SGP) took major responsibility for coding the data in consultation with the first author. Discrepancies in interpretation were resolved through discussion.

Results

Table 2 summarizes the results from the quantitative analysis. While the mean ToP scores increased slightly for both groups, effect sizes, expressed as Cohen's d values, were small to moderate for both interventions. Entering those values into a sample size calculation with $\alpha = .05$ and power of 80%, the sample size required to detect a statistically significant difference is very large ($N = 264$) for the parent group but much smaller ($N = 44$) for the individual intervention. Thus our hypothesis that the parent group would be at least as effective as the individual intervention for increasing playfulness in children was not upheld.

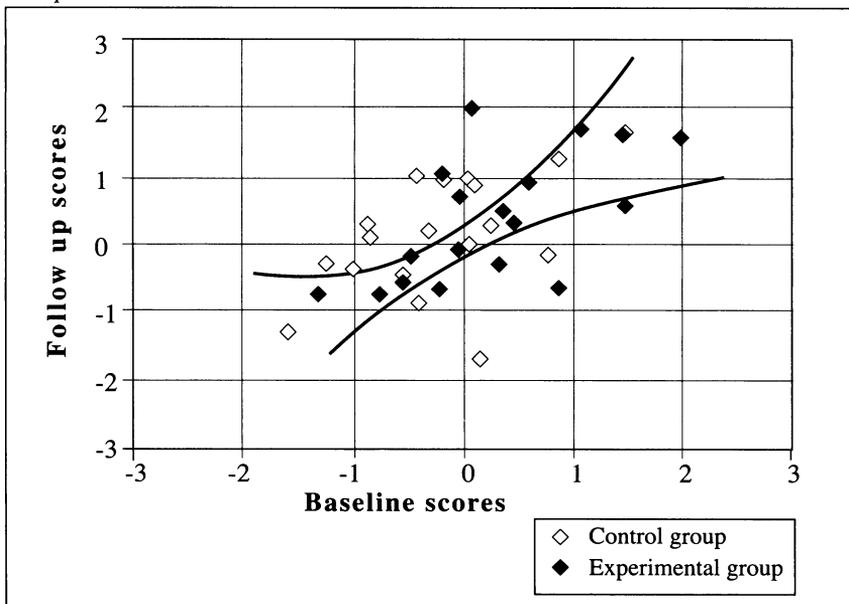
Table 2
ToP Scores, Effect Sizes and Sample Size Calculation by Group.

Intervention	ToP scores in logits		d	Sample size*
	pre-test <i>M (SD)</i>	post-test <i>M (SD)</i>		
Parent group	0.28 (0.9)	0.40 (0.9)	0.15	264
Individual	-0.16 (0.8)	0.14 (0.9)	0.37	44

*Sample size required to achieve a statistically significant result

As shown in Figure 1, when errors of measurement are considered, ToP scores of three children whose parents received the group intervention and eight children who received the individual intervention increased significantly. The scores of most children ($n = 11$) whose parents were in the group remained unchanged but those of only six who received individual intervention failed to change. Similar numbers in both groups decreased significantly.

Figure 1
Comparison of Pre- and Post-Test ToP Scores for the Two Interventions.



Note. Lines denote 95% confidence intervals created by adding and subtracting the error estimates associated with each data point and smoothing the lines.

Comparing the Effectiveness of a Parent Group Intervention with Child-Based
Intervention for Promoting Playfulness in Children with Disabilities

The ages and diagnoses of the children whose scores differed significantly between pre-test and post-test are shown in Table 3. Children whose ToP scores decreased significantly at post-test were more often diagnosed with developmental delay (DD) or syndromes characterized by DD or intellectual disability, such as Dravet's or Williams syndromes, than were children who reached significantly higher scores at the time of post-test. The scores of 13 of the 16 children with DD decreased significantly ($n = 6$) or remained unchanged ($n = 7$). The mean age of all children whose scores on ToP increased significantly was 54.7 months ($SD = 19.4$). That of those participants whose ToP scores decreased significantly was 42.5 months ($SD = 18.1$). The difference in mean ages between these two groups was not significantly different ($t = 1.3, p = 0.2$).

Table 3
Characteristics of Children with Significantly Different Scores at Follow-Up.

Group	Diagnosis	Gender	Age (months)
Higher Scores			
Parent (N = 3)	Autism	Male	70
	DD‡	Male	42
	Language Delay	Female	64
Individual (N = 8)	Autism	Male	63
	Autism	Female	69
	ADHD+	Male	99
	DD ‡	Female	42
	DD ‡	Male	48
	Language Delay	Female	45
	Motor Delay	Female	36
	CP ‡‡	Female	44
Lower Scores			
Parent (N = 4)	DD‡	Male	33
	DD‡	Male	24
	DD‡	Female	83
	DD‡	Female	42

The Israeli Journal of Occupational Therapy, November 2011, 20(4)

A. C. Bundy, J. Kolrosova, SG. Paguinto, P. Bray, B. Swain, M. Wallen and L. Engelen

Individual	DD‡	Male	43
(N = 3)	DD‡	Male	32
	Language Delay	Male	49

‡ DD - Developmental delay and associated syndromes

+ ADHD - Attention Deficit Hyperactivity Disorder

‡‡ CP - Cerebral palsy

Qualitative Findings. The qualitative findings were in marked contrast with the quantitative findings. One parent's words reflected a commonly-expressed belief, *"The group was fantastic, I really got so much out of it."* Three themes emerged to support this conclusion: Re-thinking the Value of Play, (b) Promoting Play, and (c) Parents Helping Parents.

Rethinking the value of play. Prior to the parent group intervention, parents viewed play as a medium for their child's learning. Parent 2 said, *"I used to think I always had to teach him something That was my main goal."* And Parent 10 echoed that sentiment. *"I wasn't focused on his play; I was focused on him achieving a goal. . . . There was always a mental checklist of stuff that they should be achieving."* Parent 7 realized, however, that *"There doesn't have to be an outcome for everything - play can just be play."* Many parents came to believe that the happiness and enjoyment their children derived from play was its most important benefit. Parents became more conscious of being a playmate to their children and enjoying the play themselves rather than viewing their own role as *"tutor," "referee,"* or *"security guard."* Parent 4 said she had learned *"to let go, to be a kid again."*

Promoting play. Parents found many new ways to promote play among family members. Some families restructured play spaces. Parent 7 said, *"I'll set up some craft or some drawing or some bits and pieces and then I'm not too far away."* Some parents changed daily routines. Parent 8 said, *"I've been a bit more conscious of playing more and jobs will wait."* Parents reported that allowing their children to lead meant play lasted longer and was more mature. Parent 11 said *"I am able to pull back a little bit more, which is really nice. He's actually able to persevere with particular activities longer than he was able to before;"* and *"he seems to have a little more of a story in the games that he plays."* All parents learned the value of giving and reading play cues. Parent 11 continued, *"It helped us [when we paid] more attention to the cues that he's giving, not just trying to push things to our agenda, but to see what he got out of his play, and following his lead."* Parent 8 was surprised to learn that her

The Israeli Journal of Occupational Therapy, November 2011, 20(4)

Comparing the Effectiveness of a Parent Group Intervention with Child-Based Intervention for Promoting Playfulness in Children with Disabilities

children also read her cues and that the expression on her face is important. She now smiles more, which she believes changed her interactions with all her children. Parents taught other family members about reading cues. Parent 8 explained, *"Teaching [the other children] to pay attention to the cues . . . makes life a lot more peaceful . . . It makes the household run smoother and therefore things for [my daughter who has a disability] are better."* Some parents suggested that the group should be accessible to all parents (and all family members) because play *"is very much a family issue"* and the group was a good *"reminder of what play is meant to be for our children."*

Parents helping parents. Parents felt comfortable with one another. Parent 6 remarked, *"When you're in a group like that with all the parents, then you're the same. . . . Being able to talk and understand each other's lingo. Yes, being on the same level playing field with everybody makes you feel good."* She contrasted the parent group experience with other interventions where the primary interaction was professional to parent. *"When you're a mother, especially when you're dealing with professionals all the time, they tend to look down at you. You're just a mother. And you're not, you're a person; you are equal with everybody."* Being comfortable together meant that parents could readily give and receive information and ideas. Group activities generated conversation about interactions one parent had with a child that another might try in her or his family. Parent 11 said, *"When we were watching other parents and their children in the video session that was a very good part of the program . . . Often the commenting included what you are doing or what could be done."* Every week, parents set goals; they reviewed their progress in the following session. *"We'd always have like some sort of take-home message which we wanted to work on and then bring back the next week and talk about. It allowed us time to put into place the stuff we were discussing each week."* Parents took that responsibility seriously and many commented on it in the interviews. Parent 8 said, *"Sometimes it was hard . . . but it was good."*

But it's not occupational therapy. A further observation from the parent interviews was that, despite the positive response to the parent group interventions, most parents did not view it as occupational therapy (OT). Parent 10 was not the only one to express this. *"Honestly, I didn't feel I got much OT out of it. . . . If I hadn't had the OT at the start of the group I'd be quite disappointed, just particularly because [my son] was so bad, I would be disappointed now that I didn't know these things, these tricks [that the therapist taught in direct intervention sessions]."*

The Israeli Journal of Occupational Therapy, November 2011, 20(4)

Additional analyses and findings

Because (a) so many parents set take-home messages related to their interactions with their children, and (b) so many parent interviews emphasized parent-child interaction, we examined pre-test and post-test videotapes of 18 randomly selected children (nine from each group) for evidence regarding parent-child interaction. Specifically, we observed who led the play transactions and who initiated new activities.

During pre-testing, parents from both groups led the play. They chose the play activities and sought to engage their children in those activities much of the time (65% for those in the parent group; 70% for those in the individual group). Following intervention, parents whose children received individual intervention continued to lead 60% of the time, but parents who participated in the group led only 35% of the time. Similarly, during pre-testing, whenever a child seemed unoccupied, his or her parent initiated a new activity; this was true in both groups (77% of initiations were parent-led in the individual intervention group; 73% for the parent group). At post-test, however, parents in the group were more likely to allow their children to initiate new play opportunities whenever the children chose; only 48% of initiations were parent-led. In contrast, 67% of initiations were parent-led in the individual intervention group.

Discussion

This study had two primary purposes: (a) to establish the effect size for two interventions in order to calculate the sample size needed for an adequately powered trial of those interventions, and (b) to examine parents' experiences of an intervention that was novel in terms of both content and delivery. And, seeking to understand more about the implications of our findings on practice, we re-examined some of the videotapes from each group, focusing on parent-child interactions.

The effect of individual interventions on children's playfulness, while only moderate, was substantially greater than that of the parent group intervention. The size of a sample required to detect statistically significant differences for the parent group would be about six times that required for the individual intervention. When considering individual change, ToP scores of most children whose parents received the group intervention did not change significantly while scores of nearly half of the children who received individual intervention increased.

Comparing the Effectiveness of a Parent Group Intervention with Child-Based Intervention for Promoting Playfulness in Children with Disabilities

The reason for these somewhat unexpected findings is unclear. The difficulty of affecting children's outcomes through parent interventions must be considered. Mahoney et al. (1998) found, that while intervention effects were unlikely to occur unless mothers modified their style of interacting with their children, only about 20% of the variance in child outcomes is due to interaction with parents. Perhaps more than 4 months (the time between pre-test and post-test) is required for changes in parents' attitudes and behaviors to filter down to changes in children's playfulness.

While participants were randomized into groups, a very high proportion of parents whose children had DD (11 of 16 total) were randomized into the group intervention. The effect of this difference between groups is unknown, in part because the children with DD were heterogeneous and no IQ testing was conducted. However, it is important to note that the scores of only three of the 16 children with DD increased significantly no matter the group. Future researchers might consider stratifying groups by diagnosis.

Although several factors may have contributed, individual interventions yielded greater change in children's playfulness than the parent group, even though the explicit goal of individual therapy was often to enhance a goal *other than* play. In a similar way, Chadwick et al. (2001) found that intervening directly with parents was more effective than parent groups for changing children's problem behaviors, even when techniques used in the two approaches were very similar. The individual interventions in the present study always included play as a medium and often involved modeling for parents. Further, the individual interventions were conducted by experienced and skilled therapists who valued play highly.

Were it not for the striking discrepancy between the quantitative and qualitative findings associated with the parent intervention, we would conclude that parent groups targeting play should be abandoned in favor of skilled therapists interacting one-on-one with children. However, parents involved in the group indicated that their values toward play and their abilities to promote it, increased markedly. Further, they described changes to their children's abilities to read cues, remain engaged in play and become involved in more complex play. They described changes to the entire family—not only the child with the disability. The parents who were interviewed were so clear that both they and their children played better as a result of the intervention that we are led to conclude that further research definitely is required.

Our findings also led us to conclude that such research should include formal measurement of parent-child interaction. A number of previous

researchers (e.g., Deutscher et al., 2006; McNeil et al., 2005; Turner et al., 2007) have found that parent group interventions promote parent-child interactions. Toward that end, we reviewed pre- and post-test videotapes from 18 randomly selected dyads (nine from each group). At pre-test, despite instructions to follow their child's lead, parents from both groups led most of the time. Following the intervention, however, parents who participated in the group followed their children's lead more often than not and allowed their children to choose play activities independently. In response, the children seemed to take more initiative. However, these changes were not sufficient to increase post-test ToP scores significantly. To the contrary, parents' willingness to let their children wander until they found an activity that engaged them may have had an unintended negative effect on ToP scores. Extended time exploring meant less time playing, possibly *decreasing* scores on items such as extent of engagement. We are left to conclude that while ToP scores did not always increase, parent child interactions may have been more positive. Clearly, that belief must be tested. In contrast to parents involved in the group, parents of children who received individual interventions frequently re-directed their children to new activities when their child appeared disengaged. Those parents may have been skillful enough at selecting engaging activities that their children's scores actually increased. The relatively novel play environment where the study took place may have compounded this effect.

One further point bears discussing. As enthusiastic as participants were in the end, it was difficult initially to recruit parents into the group intervention. In fact, two parents who agreed to participate dropped out when they were randomized to the group. Other researchers (Chadwick et al., 2001) also have found that parents prefer individual interventions over parent group interventions. Given comments made initially by parents assigned to the parent group, we suspect that an additional barrier was created by a group that expressly targeted play. Even parents enthusiastic about the group failed to associate it with occupational therapy despite multiple explanations that promoting play is an important goal of occupational therapy and that the group leaders were occupational therapists. Clearly, there is a need for therapists working with children and their families to define occupational therapy more clearly-for themselves as well as for others. Play is the primary occupation of children, not only a powerful medium for assessment and intervention. Alternatively, therapists might consider labeling parent groups differently - perhaps as groups targeting parent-child interaction.

Limitations. A number of limitations are associated with this study. Some have been discussed in depth earlier. Additionally, this study was designed to

Comparing the Effectiveness of a Parent Group Intervention with Child-Based
Intervention for Promoting Playfulness in Children with Disabilities

occur over 1 year. Originally we envisioned conducting only one group for all 20 parents. However, difficulties recruiting participants who met the study criteria meant that the study time doubled. In order to prevent parents having to wait long periods of time until a group was formed, we ran multiple small groups and sought participants from multiple agencies. Having a single small group rather than multiple small groups within a large group changed the nature of the whole group interaction and also meant that it was much less cost effective than originally envisioned. Future research should consider recruiting participants from a much larger pool.

Conclusions and Implications

The small effect associated with the parent group may be the result of a number of factors that require further investigation. Parents' reluctance to participate in a group to promote playfulness seems reflective of a societal undervaluing of children's primary occupation. This suggests the need for reframing of the primary roles of occupational therapy with children-and of the place of play. Such reframing may need to begin with therapists themselves. Play is the primary occupation of children, not simply a medium for assessment and intervention. Parents, and indeed the general public, are most likely to learn about the benefits of occupational therapy from encounters with therapists. Future research and further examination of the principal roles of therapy are clearly needed. Alternatively, therapists might rename their group interventions in such a way as to capture outcomes that families clearly understand.

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The Israeli Journal of Occupational Therapy, November 2011, 20(4)

A. C. Bundy, J. Kolrosova, SG. Paguinto, P. Bray, B. Swain, M. Wallen and L. Engelen

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The Israeli Journal of Occupational Therapy, November 2011, 20(4)

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