



AOTA Evidence Briefs

Children With Behavioral and Psychosocial Needs

**A product of the American Occupational Therapy Association's Evidence-Based Literature Review Project*

PSYCH 13

Peer treatment facilitates play, improves social skills, and decreases problem behaviors in maltreated preschool children

Fantuzzo, J., Sutton-Smith, B., Atkins, M., Meyers, R., Stevenson, H., Coolahan, K., Weiss, A., and Manz, P. (1996). Community-based resilient peer treatment of withdrawn maltreated preschool children. *Journal of Consulting and Clinical Psychology, 64*, 1377–1386.

Level: IA1b

Randomized controlled trial, 20 or more participants per condition, high internal validity, moderate external validity.

Why research this topic?

Reviews of the research literature on treatment of children who are victims of physical abuse and neglect identify two guidelines for future research: (1) It should address major methodological problems, and (2) it should be guided by conceptual models of how maltreatment affects child development. While preliminary findings demonstrated the efficacy of resilient peer treatment, those studies were conducted in a university-sponsored facility rather than a community-based center and were conducted as a “pull-out” as opposed to integrated program. It also does not include parents in the implementation of the intervention.

What did the researchers do?

Fantuzzo and his colleagues (1996), variously of the University of Pennsylvania (Philadelphia), the University of Illinois at Chicago, and the Department of Human Services (Chicago), designed a study that addressed the two guidelines by taking steps to avoid common methodological problems and by using a developmentally appropriate treatment. The study investigated the differences in social play between preschool children who had been maltreated and preschool children who had not been maltreated. Also, it evaluated the effectiveness of a resilient peer treatment (RPT) program for socially withdrawn victims of physical abuse and neglect.

The participants in the study were 46 socially withdrawn African-American children enrolled in a Head Start program. Nineteen were boys, and 27 were girls. The average age was 4.46 years. All were from low-income households. Twenty of the children had a documented history of physical abuse, physical neglect, or a combination of the two. They were selected for participation from a large metropolitan area's 10 Head Start centers with the highest density of physical abuse of preschool children.

The researchers randomly assigned the maltreated children and the nonmaltreated children to an RPT condition or an attention control (AC) condition. The resulting groups were maltreated RPT, nonmaltreated RPT, maltreated AC, and nonmaltreated AC.

RPT promotes development of social competencies in preschool children. It has three components: (1) Pairing of a “resilient peer (or play buddy)” with a target child for play sessions, (2) establishment of a special play corner for the two children during regularly scheduled free play, and (3) training of Head Start parent volunteers to serve as “play supporters.” In the study, play buddies were children from the target children's classrooms who were “particularly successful in promoting play interaction with socially withdrawn children” (p. 1381) as indicated by the Peer Play

Interactive Checklist (PPIC). The treatment involved 15 play sessions, 3 per week, spread over 2 months. Before every play session, the play supporter talked briefly with the play buddy about activities that typically resulted in positive interactions between the play buddy and the target child. During the play sessions, the play supporter observed the children from a distance. Afterward, he or she “made supportive comments to the target child and the play buddy about their interactive play” (p. 1381).

The AC condition controlled for the extra attention being given to the children in the RPT condition (pairing, a special play corner, etc.). In the AC condition, a participating child was paired with a classmate of average interactive ability as identified by the PPIC. The two children met in the same play corners as those in the RPT condition did for 15 sessions, but were only supervised by a play supporter, not prompted or encouraged by him or her.

The researchers were interested in the following outcome areas: *nonrelating activities* (nonplay and solitary play), *social attention* (awareness of what the other child in the pair was doing), *interactive play* (interacting with the other child but not adjusting to his or her behavior, or collaborating in play activity in a reciprocal way), and *negative play interactions* (hitting, pinching, insulting, or grabbing an object from the other child; all as measured by an observational coding system for interactive peer play); *social skills* (self-control, interpersonal skills, and verbal assertion) and *problem behaviors* (as rated by teachers using the Social Skills Rating System [SSRS]); *interactive peer play* (common behaviors that either facilitate or prevent positive play interactions; e.g., inviting and sharing, and starting fights and grabbing others’ things; as measured by teachers and classroom aides using the PPIC); and *family bonding* (as measured by the Family Adaptability and Cohesion Scales [FACES II]). The PPIC and the FACES II were administered before the intervention; the observational coding system, for 2 weeks before and 2 weeks after the intervention; and the SSRS, 2 months after the intervention.

What did the researchers find?

Before treatment, the maltreated children showed **significantly** (see *Glossary*) lower levels of interactive play than the nonmaltreated children, and they showed significantly higher levels of solitary play and social attention.

After treatment, the children in the RPT condition showed significantly higher levels of interactive play than the children in the AC condition. They also showed significantly less solitary play. Teachers rated the children in the RPT condition significantly higher than they rated children in the AC condition on the Self-Control and Interpersonal Skills subscales of the SSRS. On the Internal Problem Behaviors and External Problem Behaviors subscales, they rated children in the RPT condition as displaying significantly lower levels than children in the AC condition.

What do the findings mean?

For therapists and other providers, the findings suggest that resilient peer treatment is effective in facilitating play, improving social skills, and decreasing problem behaviors in maltreated and nonmaltreated preschool children. “On a small scale, this research demonstrates the potential of a Head Start, child protective services, and research university collaboration to develop effective, ecologically valid treatment services for young child victims of physical abuse and neglect” (p. 1385). On a larger scale, the findings have policy implications for considering Head Start as central to the development of successful community-based interventions for this population.

What are the study’s limitations?

The study has two limitations. First, the findings are not able to be generalized to children in other socioeconomic groups, in nonurban settings, or at educational levels above preschool. Second, the researchers conducted only one follow-up assessment, two months after the intervention. Thus the long-term effects of the intervention are not known.

Glossary

significance (or significant)—A statistical term that refers to the probability that the results obtained in the study are not due to chance, but to some other factor (e.g., the treatment of interest). A significant result is likely to be able to be generalized to populations outside the study.

Significance should not be confused with *clinical effect*. A study can be statistically significant without having a very large clinical effect on the sample. For example, a study that examines the effect of a treatment on a client’s ability to walk may report that the participants in the treatment group were able to walk significantly longer distances than

those in the control group. However, after reading the study one may find that the treatment group was able to walk, on average, 6 feet, whereas the control group was able to walk, on average, 5 feet. Although the outcome may be statistically significant, a clinician may not feel that a 1-foot increase will make his or her client functional.

This work is based on the evidence-based literature review completed by Mind-Hui Kuo, MS, OTR.

For more information about the Evidence-Based Literature Review Project, contact the Practice Department at the American Occupational Therapy Association, 301-652-6611, x 2040.



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