THIRD EDITION

Theraplay

Helping Parents and Children Build Better Relationships Through Attachment-Based Play

PHYLLIS B. BOOTH
ANN M. JERNBERG

THERAPLAY

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JOSSEY-BASS
A Wiley Imprint
www.josseybass.com

Published by Jossey-Bass
A Wiley Imprint
989 Market Street, San Francisco, CA 94103-1741—www.josseybass.com

Library of Congress Cataloging-in-Publication Data

Booth, Phyllis B., date.
Theraplay : helping parents and children build better relationships through attachment-based play / Phyllis B. Booth, Ann M. Jernberg. –3rd ed.
p. cm.
Includes bibliographical references and index.
ISBN 978-0-470-28166-6 (pbk.)
1. Play therapy. 2. Family psychotherapy. I. Jernberg, Ann M. II. Title.
RJ505.P6J47 2010
618.92'891653 —dc22
2009029081

Printed in the United States of America
THIRD EDITION
PB Printing 10 9 8 7 6 5 4 3 2 1

To Ann Jernberg, Theraplay's pioneering genxius, who had the courage and foresight to put attachment theory into practice.

And to all the playful people who are using Theraplay to bring joy to the lives of parents and children throughout the world.

Contents

Preface to the Third Edition

When the first edition of this book was published in 1979, Theraplay® was a ten-year-old, innovative, highly successful treatment method. Because of our confidence in it, we were eager to introduce it to a wider group of people than could be reached through word of mouth, films, personal observation, or our local training courses. Ann Jernberg wrote the 1979 edition, with contributions, case studies, and research help from the small group of Theraplay therapists working in the Chicago area. From the beginning, the book was well received. It was translated into Japanese in 1986 and into German in 1987; it remained in print for twenty years. The second edition, written after Ann Jernberg's death and published in 1999, reflected many of the changes that had occurred in our practice and our understanding up to that point. It was also translated into Finnish in 2003 and into Korean in 2005.

This third edition is a synthesis of new insights based on ten more years of practice by talented clinicians all over the world. It is also based on the latest research into the nature of attachment. This new research has given us more information about the ways in which the parent-infant relationship affects brain development, and the importance of touch and play in healthy development. Some of this research strongly confirms the work we have been doing, some of it has led us to refine our practice. As our teaching and practice adapted to this new information, we realized that we needed a new edition to reflect these changes. We also wanted to report on the growing number of research studies that demonstrate the effectiveness of Theraplay and to give a picture of the many innovative ways in which Theraplay is being used throughout the world.

Theraplay® is a registered service mark of The Theraplay® Institute.

The following is a summary of some of the new developments we address in this third edition. The first four points do not reflect changes in our approach but rather are basic elements of Theraplay that are now more strongly supported by research. The rest of the points reflect subtle or not-so-subtle changes that have occurred in our work:

- **Meeting children's younger needs**. From the beginning, we used activities from the repertoire of parents with their young children and geared our interactions to the level of the child's emotional development rather than to his chronological age. The new understanding of brain development and of the effects of trauma on the brain supports the value of addressing the younger emotional and developmental needs of the children with whom we work.
- **Using touch**. Because a secure attachment relationship depends on appropriate, nurturing touch, Theraplay has always considered touch as essential to effective treatment. In this new edition we reaffirm the importance of touch.
- **Valuing play**. Play remains the cornerstone of our Theraplay approach. As today's children spend less and less time in play, there is an increasing awareness of the negative effects of lack of play. This has led to a call for bringing play back into the lives of children. Theraplay's playful approach can be part of the effort to redress the imbalance.
- **Intervening early**. As we learn more about the developmental importance of the early interactive relationship between a child and his parents, there is an increasing awareness of the need for early intervention. At the same time, many therapists are unprepared to treat young children. Because it is designed to meet early emotional needs, Theraplay has long been an ideal model for early intervention.
- **Working with families with adopted or foster children**. Increasing awareness of the depth of the problems faced by adoptive and fostering families has led to a great deal of interest in how Theraplay can help. Theraplay brings the child and the parents together to practice the interactions that are needed for a child to form a secure attachment. With our years of experience now supported by new research, we are able to present a much

more detailed description of how we help families with foster and adopted children.

- **Focusing on attunement and regulation**. As a result of extensive research into the effect of the mother-child relationship on the development of the brain, attachment and regulation have become almost synonymous. The attuned parent constantly co-regulates her interactions with her baby, leading to the later capacity for self-regulation. We now place a stronger emphasis on attunement and regulation in our sessions and on helping parents regulate their playful interactions with their children.
- **Increasing parental involvement in treatment**. New understanding of the importance of parents' attitudes toward attachment and of their capacity to reflect on their own and their child's experiences leads to an even stronger emphasis on the role of parents in Theraplay treatment, more time spent preparing them for their role in treatment, and consequently greater detail in this edition in describing how we work with them.
- **Redefining structure.** In our early work we emphasized the importance of parents' taking a strong parental role, which we often defined simply as, "taking charge." We are now articulating a more nuanced view of structure as the provision of a reliable, supportive presence that guides and regulates the child's experience and maintains safety while responding to the child's needs.
- **Redefining resistance.** Any attempt to create change may lead to resistance at some point in treatment. We now discriminate very carefully between resistance that comes from a reluctance to give up old patterns and resistance that stems from panic or fear. As we increase our sensitivity to the child's state of arousal and anxiety, we encounter fewer episodes of out-of-control behavior. Our basic approach is to provide the level of containment and calming that can keep the child safe. In order to calm a frightened child, we reduce stimulation, make sure he *feels* safe, and we stay close by in order to remain sensitively connected.
- **Treating complex trauma**. We now know more about the neurological effects of neglect, abuse, and trauma. This helps us to be more responsive and effective with children who have

suffered complex trauma. Theraplay's use of hands-on, rhythmic, soothing activities that help a child form a secure relationship with his caregiver can be the first step toward helping the child process the trauma.

- **New examples**. Finally, in this third edition we provide many new examples of the application of Theraplay to a wider range of problems and an increasing number of settings throughout the world.

Over the years, Theraplay has gained increasing acceptance throughout the world as an effective application of attachment theory to the treatment of relationship problems. It is now being used in twenty-nine countries by people who have received Theraplay training: Australia, Austria, Argentina, Bosnia, Botswana, Canada, England, Finland, Germany, Hong Kong, Indonesia, Ireland, Israel, Japan, Kazakhstan, Kenya, Kuwait, Latvia, the Netherlands, Philippines, Russian Federation, Singapore, Slovakia, South Africa, South Korea, Spain, Sweden, Tanzania, and Wales. Our hope for this new edition is that it will provide up-to-date guidance and support for the practice of Theraplay as it becomes even more widely and effectively used.

ACKNOWLEDGMENTS

We remain grateful to those who made the first edition possible by developing Theraplay: Ernestine Thomas, whose exuberant spirit and intuitive wisdom, together with her concern for excellence, led all of us to pursue the search for Theraplay perfection; Charles West, whose enthusiasm and compassion guided his coworkers as much as they helped the children he treated and who continues to serve Theraplay as chairman of The Theraplay Institute's board of directors; Terrence Koller, who continues to provide sound advice and encouragement; and Theodore Hurst, longtime president of Worthington, Hurst, and Associates, whose interest and support were steady over the years. He died in 2001; we all miss him.

As with the first two editions, this third edition is the product of the dedicated efforts of many valued friends and colleagues, Theraplay therapists, and trainers, who responded to my request for help in revising the book. Although several people contributed specific chapters—and I give my heartfelt thanks for their very important

contributions—this is not an edited book in the usual sense in which individual chapters represent different points of view. Instead the entire book is a collaborative effort with many people contributing ideas as well as text in order to present a unified point of view throughout. It is the distillation of the wisdom of the whole Theraplay family. We thus have many people to thank for their contributions.

I give special thanks for this new edition to the following colleagues, friends, and family:

- Sandra Lindaman, whose calm support and wise guidance have been available at all stages of the writing. Her ideas about the theoretical bases of Theraplay were essential to the development of Chapter Two. She also wrote the chapter on autism as well as parts of the chapter on adoption and foster care.
- Jukka Mäkelä, who has brought his broad knowledge of psychiatry, developmental theory, and clinical practice to articulating what makes Theraplay effective. He and his devoted Finnish colleagues are using Theraplay in imaginative ways in many settings and are making a major contribution to research into the effectiveness of Theraplay.
- Karen Searcy, an early Theraplay therapist, who made valuable contributions to the chapter on autism.
- Reva Shafer, who gave her time, energy, and expertise to the development of the chapter on autism.
- Graham Thompson, who contributed basic ideas to the chapter on working with adolescents and whose generous support of Theraplay over the years is greatly appreciated.
- Jean Crume, who was always available to read a draft, to suggest a better organization, and to be a steady support.
- Vicky Kelly, past president of ATTACh, who gave generously of her time to share her expertise about the effects of trauma on the brain and on how to work with children who have been sexually abused. Her thoughtful and eloquent suggestions were invaluable in making sure our explanations were correct.
- Gayle Christensen, Theraplay's superb executive director, who keeps The Theraplay Institute on an even keel.

- Kathie Booth Stevens, who has spent endless hours using her amazing editing skills to organize and edit the manuscript at all stages of its development.
- Both my daughters, Alison Booth and Kathie Booth Stevens, who have provide encouragement, moral support, and the pure comfort and joy of their presence in my life.

Finally, my thanks to the many friends and colleagues throughout the world who have contributed to the book by reading the manuscript at various stages, by providing case examples, and by sharing insights and helpful suggestions.

Kathy Atlass, Chicago, Illinois; Susan Bundy-Myrow, West Seneca, New York; Ishtar Beetham, Albany, Western Australia; Eadaoin Bhreathnach, Belfast, Northern Ireland; Rand Coleman, Phoenixville, Pennsylvania; Elke Furhmann, Konstanz, Germany; Donna Gates, Gurnee, Illinois; Brijin Gardner, Parkville, Missouri; Tracy Hubbard, Mansfield, Nottinghamshire, Great Britain; Emily Jernberg, Ann Arbor, Michigan; Heather Lawrence, Brampton, Ontario; Elaine Leslie and Nancy Mignon, Rockford, Illinois; Margaret Mackay, Fergus, Ontario; Evangeline Munns, King City, Ontario; David Myrow, West Seneca, New York; Linda Ozier, Winona Lake, Indiana; Margie Rieff, Fairview, Oregon; Mary Ring, Houston, Texas; Saara Salo, Helsinki, Finland; Angela Siu, Hong Kong; Mary Talen, Chicago, Illinois; Kirsi Tuomi, Hyvindää, Finland; Juan Valbuena, Chicago, Illinois; Cheryl Walters, Lancaster, Pennsylvania; and the following members of the staff at Chaddock: Karen Buckwalter, Thomas Donavan, Michelle Robison, and Marlo Winstead, Quincy, Illinois. Many more people responded generously to my call for case studies, but I have been unable to include them all in the book.

I was fortunate to have the help of Marie McDonough, a talented, efficient, and well-organized graduate student at the University of Chicago, who organized my files, typed transcripts of videotaped Theraplay sessions, copyedited the manuscript chapter by chapter, prepared reference and Theraplay publication lists, and was always there when I needed her. John Davy, also a graduate student at the University of Chicago, gathered a mountain of important library materials about attachment, the development of the brain, autism, and many other topics to help me update the background material.

Our special and warmest thanks go to the many children and families from whom we have all learned so much. To preserve the confidentiality of the families represented in the case studies throughout this book, all names have been changed and the details of their lives disguised.

I am grateful to Ann Jernberg, who dared to try out new ideas and explore new ways of working with children. Without her, Theraplay would never have existed. Theraplay has become my lifelong passion and commitment and I present this collaborative third edition with confidence in the continuing strength and vitality of the Theraplay approach. With its life-affirming capacity to bring joy and meaning to people's lives, it has truly connected me to a worldwide Theraplay community. I look back over the past forty years with pride in our achievement and I look forward with hope for the future of Theraplay: a force for good, for peace, and for family happiness. I have faith in the new and growing generation of the Theraplay family to continue to connect hands and hearts around the world.

Chicago, Illinois
September 2009

Phyllis B. Booth

The Authors

Phyllis B. Booth, LCPC, LMFT, RPT/S, is clinical director of The Theraplay Institute in Chicago. She was awarded an MA in human development and clinical psychology from the University of Chicago in 1966.

In 1969–70 she spent a year at the Tavistock Clinic in London, England, where she studied under John Bowlby, D. W. Winnicott, and Joyce and James Robertson. In 1981 she completed a two-year training program in family therapy at the Family Institute of Chicago. She spent a year (1992–93) at the Anna Freud Centre, London, England.

Booth began her career as a nursery school teacher. She and Ann Jernberg taught together at the University of Chicago Nursery School in 1949–50. In 1967 she was among the first group of psychological consultants to the Head Start program in Chicago, where she began her long collaboration with Jernberg in developing the Theraplay method. She was a consultant to Head Start programs, state pre-kindergarten programs, and special programs for autistic children. A major commitment in recent years has been to the training and supervision of Theraplay therapists. She has presented Theraplay trainings throughout the United States and Canada, England, Finland, South Korea, and Sweden.

Ann M. Jernberg, PhD, was clinical director of The Theraplay Institute in Chicago from its inception in 1969 until her death in 1993. Born in Germany, she came to the United States in 1939. Jernberg was awarded the PhD in human development from the University of Chicago in 1960. From 1960 to 1967 she was senior staff psychologist at Michael Reese Hospital in Chicago where she worked with Austin DesLauriers and Viola Brody. For many years, beginning in 1967, she developed and supervised psychological services to the Chicago Head Start program, Title XX Day Care, and Parent-Child Center programs

serving some five thousand children annually. She also served as chief psychologist at the LaPorte County Comprehensive Mental Health Center in Indiana. She made presentations and conducted training in the Theraplay method throughout the United States and Canada.

Jernberg's writings include numerous articles and papers on a variety of topics, including parent-child relationships, psychosomatic medicine, anorexia nervosa, the psychologist as consultant, adoption, the role of the paraprofessional, and Theraplay techniques. She directed three films: *It Can Be Done, There He Goes*, and the award-winning *Here I Am*.

THE CONTRIBUTORS

Rand Coleman, PhD, is a licensed clinical psychologist specializing in neuropsychology and a certified Theraplay therapist and trainer; he serves on The Theraplay Institute's research committee. He developed an outpatient clinic for children and adults with disabilities. He and his wife have provided both emergency and long-term foster care for children. He has training in attachment-based parenting, attachment therapy, and EMDR and is certified in Cognitive-Behavioral Therapy (CBT). For several years, he worked as the unit clinician in the Devereux Foundation's residential program for children with severe autism, mental retardation, and dual diagnoses. Currently in private practice, he does neuropsychological testing, provides Theraplay and parent training, and consults for various schools and the Devereux Foundation.

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Annie Kiermaier, LCSW, RN, is a certified Theraplay therapist and trainer. She has had a lifelong passion for helping parents and their young children have healthy, joyful attachment relationships. She provides home-based Theraplay and parent consultation in mid-coast Maine, to families who have children from birth to five years old.

She trains mental health clinicians in the use of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0–3R)*.

Dafna Lender, LCSW, is training director for The Theraplay Institute, and a certified Theraplay therapist, supervisor, and trainer. Her focus is on helping children develop a secure attachment with their caregivers while resolving issues in their traumatic history. She has studied Dyadic Developmental Psychotherapy (DDP) with Daniel Hughes and uses it in combination with Theraplay. She has worked with children in foster care and group homes within the child welfare system; she has also worked with children adopted from foreign orphanages and with children who were prenatally exposed to alcohol and drugs. She has published articles about Theraplay and DDP. She has provided Theraplay training throughout the United States, England, Israel, and Spain.

Sandra Lindaman, MA, LCSW, is the senior training advisor for The Theraplay Institute, and a certified Theraplay therapist, supervisor, and trainer. She is also a licensed speech and language pathologist. She has been with The Theraplay Institute since 1990, and served as executive director from 1993 to 1999. Her special interests are the development of the Theraplay training curriculum and working with children who are adopted or in foster care, and with children with autism spectrum disorders. She has published a number of chapters and articles about Theraplay and has been involved in the training and supervision of professionals in the Theraplay model throughout the United States, Canada, England, Finland, Japan, South Korea, and Sweden.

Jessica Mroz Miller, LCSW, is practicum manager at The Theraplay Institute, and a certified Theraplay therapist, supervisor, and trainer. She maintains a private practice in the Chicago area. Her primary interest is in helping families with children who have attachment and trauma-related difficulties. She has studied Dyadic Developmental Psychotherapy with Daniel Hughes, and she uses it in combination with Theraplay. She has worked with children in foster care and group homes within the child welfare system, with children adopted internationally, and with children who were prenatally exposed to alcohol and drugs. She developed and implemented specialized training for foster parents interested in adopting older children. She has published articles about Theraplay and DDP. She has provided Theraplay training throughout the United States and England.

Phyllis B. Rubin, CCC-SLP, PsyD, is a licensed speech and language pathologist, a licensed clinical psychologist, and a certified Theraplay therapist, trainer, and supervisor, a Group Theraplay trainer, and an affiliate of The Theraplay Institute. She maintains a private practice and has used Theraplay with children and parents in public school special education classrooms, Head Start, and with her private clients. She specializes in working with children with attachment problems, foster and adopted children, and children within the autism spectrum. She has studied Dyadic Developmental Psychotherapy (DDP) with Daniel Hughes, and uses it in combination with Theraplay. She is also trained in Eye Movement Desensitization and Reprocessing (EMDR). Phyllis is coauthor of *Play with Them: Theraplay Groups in the Classroom,* as well as other publications on Theraplay and on DDP. She has provided training in Theraplay and Group Theraplay throughout the United States, Australia, England, Germany, and Sweden.

Introduction

Theraplay is an engaging, playful, relationship-focused treatment method that is interactive, physical, and fun. Its principles are based on attachment theory and its model is the healthy, attuned interaction between parents and their children: the kind of interaction that leads to secure attachment and lifelong mental health. It is an intensive, relatively short-term approach that involves parents actively in sessions with their children in order to create or fine-tune the parent-child relationship. The effectiveness of Theraplay springs from the use of attachment-based play to meet the needs of troubled families. Theraplay is uniquely suited to address these needs.

As I was preparing this book I was struck by the many media laments about the challenges facing children and families today. On the one hand, they say that in affluent and middle-class families there is too much material indulgence, too many choices given, too much micromanaging of children's experience, too great an emphasis on intellectual achievement, too few opportunities for face-to-face interpersonal contacts, not enough support from a wider community of adults, and not enough time for play. In our inner cities, on the other hand, the challenges are crime, poverty, and drugs. Many children are growing up in neglectful, poverty-stricken, drug-affected families where they are left to their own devices: hungry, unloved, and miserable. For both groups the world as seen on television is a violent, frightening place: families are bombarded with scenes of war and natural disasters.

Children in both settings are missing the opportunity to relax in Dad's lap as he reads to them from their favorite book, to play rough-and-tumble games with Mom, to cuddle with Grandma while she feeds them cookies and milk. When can a child find a quiet moment to share her fears, sadness, or her joy in the arms of someone dear to her? Where can a child safely join the neighborhood

kids climbing trees and digging holes for forts and hideouts? Children are missing the whole magical world of childhood.

Although the two groups of children have, on the surface, very different experiences, there is an underlying common denominator: in both cases the parents, for very different reasons, are unable to value, nurture, and support the development of the child's true self. The busy, driven parent responds to the picture he has in his mind of the child as a successful career adult. In his pushing and organizing and hovering, he does not see and is not mindful of the needs of the unique child he should be nurturing and allowing to grow under his care. He does not see the child for who she is now or is capable of becoming.

The parent of the neglected child is also, because of her own struggles and limited resources, unable to see her child for who he really is. Lacking support and respect for his needs, the child becomes prematurely self-reliant, disconnected, and untrusting. He doesn't know how to play, and he is not open to learning in the way he should be able to be.

WHAT THERAPLAY HAS TO OFFER

Theraplay's relationship-based approach is uniquely designed to help these troubled families reconnect and fully engage with each other. Its playful interactions help parents and children become physically and emotionally close. Its emphasis on attunement and empathy makes it possible for families to form a true and sensitive connection through which they come to know and care about each other and are able to love and cherish each other. In the attuned, empathic interactions the child gains a true sense of herself and the parent sees the child for who she is.

Theraplay helps parents respond to their child's needs rather than imposing their own view of what those needs might be. We help parents provide the guidance, sense of security, and regulation that lead to safety and trust. We help them respond to their child's need for comfort, nurture, and support in order to create a secure base from which the child can be launched into the world, fully equipped with the skills to navigate that world, always certain that he can return for comfort and refueling to his home base when he needs it. And finally, we encourage the kind of play between parents and children that nurtures a lifelong capacity to relate to others in harmony and joy.

This early parent-child play prepares the child to find her place in the world of relationships. She learns the important skills of taking turns, adapting to the other person's rhythms, cooperating, and making friends. She learns that the world is an exciting place to explore. She develops a sense of awe and wonder about the world and is free to explore and learn.

How Theraplay Began

In 1967, Ann Jernberg accepted the daunting task of becoming director of psychological services for the newly instituted Head Start program in Chicago. Her mandate was to identify children in need of psychological services and refer them to existing treatment centers. During the first year of Head Start, she and her team found nearly three hundred children who needed help. When we looked for treatment resources in the Chicago area, we discovered that finding effective treatment for even a few children was impossible. Child psychotherapy, when available, was expensive, took a long time, and the few existing treatment centers were located far from the families who needed them.

We faced a crisis. We had the responsibility to find treatment for these children, but none was available. It was immediately apparent that we would have to create a program of our own, one that would take treatment directly to the child and be quickly effective. Furthermore, because of the urgency of the need, it had to be easily understood and used by relatively inexperienced mental health workers. It made sense, therefore, that it should use the playful patterns of interaction that come naturally to adults who care about and enjoy children. Ever resourceful, Ann Jernberg took healthy parent-infant interaction as her model and borrowed elements from the work of Austin DesLauriers (1962, DesLauriers and Carlson, 1969) and Viola Brody (1978, 1993) to develop the new approach.

In his treatment of children with autism, DesLauriers incorporated ideas from John Bowlby's newly published work on attachment (1969). He emphasized vigorous engagement and intimacy between child and therapist through direct body and eye contact, while focusing on the here-and-now and ignoring fantasy. In her work with emotionally disturbed children, Viola Brody emphasized the nurturing relationship between therapist and child, including touch, rocking and singing, and physical holding. As the work developed,

Ernestine Thomas, an early student of Viola Brody, contributed one of the most important aspects of Theraplay: a strongly affirmative and hopeful emphasis on the child's health, potential, and strength.

With this attachment-based model in mind, we gathered everyone we could find who had experience in working with children, including Head Start mothers, college students, and professionals in the field of child psychotherapy. We looked for people with a lively, playful ability to engage children and a strong commitment to helping them realize their full potential. We trained and carefully supervised a group of mental health workers to go into the schools to work individually and intensively—two or three times a week—with children who needed help. It soon became clear that what we were doing was working. Sad, withdrawn children became livelier; while acting out, angry, aggressive children became calmer and more cooperative.

When we ran into resistance to our unorthodox ways of working—from principals, teachers, social workers, and other Head Start staff—Ann Jernberg made two films to demonstrate the effectiveness of our work: *Here I Am* (Jernberg, Hurst, and Lyman, 1969) and *There He Goes* (Jernberg, Hurst, and Lyman, 1975). Using these films, we presented our new method throughout the Head Start system, gradually gaining acceptance and, finally, full recognition of our work.

In 1970, while we were searching for a name for this playful, therapeutic method—so unlike traditional play therapy—Charles Lyman, filmmaker of *Here I Am,* suggested the name *Theraplay*. The Theraplay Institute was established in 1971 and the first Theraplay class for mental health professionals was taught that year. In March 1972, Theraplay was written into a Health, Education, and Welfare (HEW) proposal for psychological services to Chicago Head Start programs. In 1976, in order to protect the integrity of the Theraplay method, we registered Theraplay as a service mark, the equivalent of a copyright or trademark.

Observing our success with children in Head Start, teachers, parents, and social workers began referring children to us for private treatment. Soon Theraplay was being conducted not only in Head Start classrooms but in a specially constructed Theraplay treatment room in Chicago as well. In the early 1980s we began training people at other centers in the United States and Canada. Theraplay is now being practiced in twenty-nine countries around the world. There are organized Theraplay associations in Finland and Germany.

After Ann Jernberg's death in 1993, it became urgent to put The Theraplay Institute on a more secure footing. In 1995 we incorporated it as a not-for-profit training, treatment, and consulting center. We have focused on training as the most effective way to spread the word about Theraplay. Our mission is to "build strong families and emotionally healthy children and adults through Theraplay training, treatment, advocacy, and research."

Although Theraplay continues to be used in Head Start programs, it has also spread into a wide variety of settings including early intervention programs, day-care centers and preschools, home-based treatment, agencies that provide foster and adoption services, centers that support training and care for teen mothers, residential treatment centers, long-term foster care settings, and day care for the elderly. The following is a sample of special populations and settings in the United States in which Theraplay has been or is being used: for deaf children with hearing parents; for Hurricane Katrina victims in public middle schools; for teens in schools, residential settings, and juvenile offenders programs; in summer camp for families with children with autism; for families who are in danger of having their parental rights terminated; in homeless and domestic violence shelters; and in home-based early intervention programs.

Theraplay's application abroad has been widespread and creative. It has been used with traumatized children in war-torn Bosnia; with children and families devastated by the tsunami in Sri Lanka; with children in orphanages in Russia and Latvia and in SOS villages in Finland; with AIDS orphans and street children in Botswana; with impoverished families in Argentina. It has been used successfully in a number of settings and with a wide range of populations in South Korea to enhance self-esteem and social-emotional functioning; for example, preschool children, children living in a residential home because of abuse in their biological families, runaway adolescents, developmentally delayed children, children with autism spectrum disorder, and children with insecure attachment.

The Core Concepts of Theraplay

In our effort to replicate the broad range of interactions that are involved in the healthy parent-infant interaction, we have extracted some basic principles that are the core concepts of Theraplay. They are the defining characteristics of a healthy parent-child

relationship. Relationships that share these qualities lead to healthy social-emotional development.

Theraplay is

- Interactive and relationship based
- A direct, here-and-now experience
- Guided by the adult
- Responsive, attuned, empathic, and reflective
- Geared to the preverbal, social, right-brain level of development
- Multisensory, including the use of touch
- Playful

In Chapter Two, we return to these ideas and consider the theory and research that supports each of these aspects of our work.

THE AUDIENCE FOR THIS BOOK

This book is addressed to those who provide direct services to children and families with attachment and relationship problems: psychologists and psychiatrists, social workers, counselors, family therapists, play therapists, pediatric nurses, child-care workers, teachers, occupational and physical therapists, speech and language therapists, adoption and post-adoption counselors and support workers, early childhood and developmental specialists. Those in the field of primary prevention and early intervention, and especially those in education for parenthood programs, will find it a useful approach for preventing later problems and reducing mental illness. Administrators of mental health or special education programs and agencies will also find it useful. Because Theraplay is not just a set of techniques but a unified way of relating to children that is positive, playful, and enriching, this book will prove helpful to parents, grandparents, teachers, and a wider reading public as well.

We intend the guidelines for Theraplay treatment to be easily understood, and we are certain that many of the principles can be usefully incorporated into the repertoire of any experienced therapist or teacher. We do not, however, expect anyone to become a skilled Theraplay therapist solely by reading this book. It is a requirement that all Theraplay therapists complete our structured sequence of training

and, in addition, complete a practicum program of supervised work. In spite of its apparent simplicity and intuitive naturalness, Theraplay is not an easy method to learn. There are many subtleties involved in responding appropriately to each child's and each parent's needs. Learning the method takes time and involves intensive training courses and supervision; these are available through The Theraplay Institute and through our two International Theraplay Associations in Finland and Germany. All open registration trainings are listed on our Web site, along with the requirements for certification: www.theraplay.org.

HOW THE BOOK IS ORGANIZED

The book is divided into three parts. Part One provides an overview of the Theraplay method and its basis in research. Chapter One outlines how treatment is organized; it describes how we use the four dimensions of Theraplay—*structure, engagement, nurture,* and *challenge*—to tailor treatment to each child's needs; it indicates how the core concepts of Theraplay relate to these dimensions; it identifies the sources of the attachment or relationship problems that bring children into Theraplay treatment; and it discusses situations in which Theraplay should not be used. Chapter Two reviews the theory and research that inform and support the core concepts of Theraplay treatment mentioned above. Chapter Three reviews research into the effectiveness of Theraplay.

Part Two describes strategies for Theraplay treatment and is designed to be used as a guide to practice. Chapter Four describes how to structure Theraplay treatment, how to plan the sequence within a Theraplay session, and how sessions are organized around each child's particular need for structure, engagement, nurture, and challenge. Chapter Five addresses issues that the Theraplay therapist faces in working with the child: how treatment evolves over time and how it must be tailored to the individual needs of the child and family; how to handle a child's resistance; and how to recognize and avoid the inappropriate use of countertransference experiences. It concludes with a list of practical guidelines for the therapist. Chapter Six describes how we prepare parents for their role in sessions, as well as how we help them become more responsive to their children's needs. It also describes how we teach them to carry on the Theraplay approach with their children at home.

Part Three describes how we adapt Theraplay treatment to the needs of children with a variety of behavioral, emotional, and relationship problems. Chapter Seven focuses on using Theraplay with children who have a variety of regulation disorders and sensory regulation issues. Chapter Eight describes how Theraplay can be used to help children on the autism spectrum. Chapter Nine considers how Theraplay can be adapted to meet the needs of children who have suffered complex trauma. Chapter Ten gives the basic principles of how Theraplay can be used to help children who are in foster or adoptive homes. Chapter Eleven describes how to adapt Theraplay in working with adolescents. Chapter Twelve moves beyond individual treatment to describe how Theraplay's positive, playful ways of relating can be applied to groups.

THERAPLAY

Third Edition

PART ONE

An Overview of the Theraplay Method

The first chapter of Part One presents an overview of the Theraplay method. The second chapter reviews the theoretical and research literature that informs and supports the core concepts of Theraplay. In Chapter Three, we review research into the effectiveness of Theraplay treatment.

CHAPTER ONE

Learning the Basics of the Theraplay Method

Theraplay is an engaging, playful, relationship-focused treatment method that is interactive, physical, personal, and fun. Its principles are based on attachment theory and its model is the healthy, attuned interaction between parents and their children: the kind of interaction that leads to secure attachment and lifelong mental health.[1] It is an intensive, relatively short-term approach that involves parents actively in sessions with their children in order to fine-tune the parent-child relationship. The goal is to enhance attachment, increase self-regulation, promote trust and joyful engagement, and empower parents to continue on their own the health-promoting interactions developed during the treatment sessions.

In this chapter we introduce you to the Theraplay method and give a picture of the process. In order to do so we discuss

- The kinds of problems that Theraplay is best suited to address
- The logistics and overall process, including a transcript of a first Theraplay session
- How Theraplay replicates the parent-infant relationship
- The core concepts of Theraplay

- How the Theraplay dimensions are used to plan treatment
- Why Theraplay might be needed
- When Theraplay would not be the treatment of choice

GETTING A PICTURE OF THE PROCESS

The parent-child relationship is the primary focus in Theraplay. Our model for treatment is based on attachment research that demonstrates that sensitive, responsive caregiving and playful interaction nourish a child's brain, form positive internal representations of self and others, and have a lifelong impact on behavior and feelings. The goal of treatment is to create (or fine-tune) a secure, attuned, joyful relationship between a child and his or her primary caregivers. When no parent is available, for example, in the case of a child in a residential treatment facility or in a school setting, the goal is to create a relationship-enhancing atmosphere and to establish a close relationship with one special staff person or with the Theraplay therapist. For children with Autism Spectrum Disorder or other developmental problems, the goal is to address the social interaction problems associated with these challenges. In all cases, we bring child and parents together in sessions to develop and practice the playful, attuned, responsive interaction that characterize a healthy, secure relationship.[2]

We prepare parents for their active role in treatment by establishing a safe and collaborative relationship with them as well as by helping them reflect on and come to terms with those aspects of their own experiences and attitudes that might get in the way of being able to respond sensitively to their child's needs. Through discussions, observation, and role play, we help them gain more empathy for and understanding of their child. At the same time, we work with the child to help her experience a different kind of relationship—one that is noncongruent with, and therefore challenges, the problematic one that she has come to expect. A distinctive aspect of the Theraplay method is that we bring parents and child together to practice a new and healthier way of interacting.

The goal of treatment is to establish or fine-tune a trusting emotional relationship between the child and her parents; this will involve a positive change in the child's internal working model of herself and what she can expect in interaction with her parents.

The parents' internal working model of themselves and their state of mind in relation to their child will also become more positive. The experience of having her caregivers attune to and modulate her arousal states will increase the child's capacity for self-regulation. There will be a reduction of the behavior problems that led to her referral for treatment.[3] More important, treatment will lead to the full range of positive outcomes associated with secure attachment: optimism and high self-esteem, the ability to empathize and get along well with others, and long-term mental health.

Although most children who come for treatment are beyond the infant stage, they still need the easily recognized elements of a healthy parent-infant relationship: attuned, empathic response to their needs; nurturing touch; focused eye contact; and playful give-and-take. Through these experiences, children learn who they are and what their world is like. They identify the important people in their world, usually their parents, and they discover how available and responsive these parents will be. Human beings have these essential needs throughout their life span: for companionship, for attunement, for co-regulation of affect, for feeling valued, and for experiencing joy together with another person.

In Theraplay there is an explicit emphasis on the family's health and strength. The therapist's optimistic message communicates to both child and parents that there is hope in their relationship. Within the treatment session, the child comes to see herself, reflected in the mirror of her parents' eyes, as lovable, capable, valued, and fun to be with.

Who Can Benefit

Theraplay is an effective treatment for children of all ages, from infancy through adolescence, but it is most frequently practiced with children from eighteen months to twelve years. Chapter Eleven describes how it can be adapted for use with adolescents. It has been adapted for individual and group work with the elderly as well.

Theraplay is effective with a wide range of social difficulties, emotional challenges, and developmental and behavioral problems. These include internalizing behaviors such as withdrawal, depression, fearfulness or shyness; externalizing behaviors such as acting out, anger, and noncompliance; and relationship and attachment problems. Theraplay has also been helpful in addressing the relationship problems associated with regulatory difficulties, with autism

spectrum disorders, with developmental delays, and with physical challenges.

Because of its focus on forming attachments and improving relationships, Theraplay has been used successfully for many years with foster and adoptive families. It is ideally suited to helping parents understand and respond to the needs of a child who has a history of trauma and disrupted relationships and to helping families and children form a new attachment. Theraplay has been equally useful with biological families who are at risk due to factors such as poverty, inexperience, substance abuse, community and domestic violence, mental and physical challenges, and lack of good parenting in the parents' own childhoods. Families with good parenting skills may also find Theraplay helpful for children whose behavior problems stem from stressors such as divorce, the birth of a new baby, the child's difficult temperament, a mismatch between the parent's and child's temperaments, or separations due to illness.

As an approach to parenting that is positive, empathic, and focused, Theraplay has been used in early intervention and prevention programs to strengthen the parent-child relationship in the presence of risk factors or the stresses of everyday life.

Theraplay is practiced in a variety of settings: in schools, homes, outpatient mental health clinics, hospitals, residential treatment centers, homeless shelters, and private practices.

Logistics

We now look briefly at the logistics and typical sequence of treatment before we describe a Theraplay session. In Chapter Four, we describe the process in more detail so that you will be able to implement it in your work.

PARTICIPANTS. Theraplay treatment includes parents or primary caregivers in the sessions. It can be successful using either one or two therapists. When two therapists are available, one works with the child and the other, the interpreting therapist, works with the parents.[4] When only one therapist is available, she conducts sessions with the child and includes parents in the activities as soon as she judges that the parents and child are ready. She meets separately with parents to answer their questions, to discuss what is happening in sessions with the child, and to prepare them for their role in sessions.

SETTING. The Theraplay room is simple, functional, and comfortable. Large floor pillows or a beanbag chair and soft toss pillows suggest that this is a place where you can relax and have fun. It is helpful to have an observation room with a two-way viewing mirror in which the parents and the interpreting therapist can observe and discuss what is happening in the child's session. If that is not possible, a simple video hookup or wireless connection can link the Theraplay room with another room that serves as an observation room. In many settings, however, such as schools, private practices, and homes, a viewing room and an interpreting therapist are not available. Throughout this book we will give examples of both models. Chapter Four explains how to coordinate the work of two therapists as well as how to manage both roles when you work alone.

NUMBER AND TIMING OF SESSIONS. The basic Theraplay treatment plan is for eighteen to twenty-four sessions. This includes an assessment period of three or four sessions, the treatment, and a follow-up period of four to six sessions spaced over a year. For more complex cases, the length of treatment will be from six months to a year. Theraplay sessions are thirty to forty-five minutes in length and are typically scheduled once a week.

The Sequence of Theraplay Treatment

The following section describes the three steps in the treatment process: assessment, treatment, and follow-up.

ASSESSMENT. The Theraplay assessment procedure includes the following elements:

- Standardized questionnaires about the child's behaviors and the parents' attitudes. These are usually completed by the caregivers before the intake interview.
- An initial intake interview with the child's caregivers, during which we begin to learn about the history and current functioning of the family. The child is not present for this interview.
- An assessment of the child's relationship with each parent using the Marschak Interaction Method (MIM) (Marschak, 1960,

1967; Marschak and Call, 1966; Booth, Christensen, and Lindaman, 2005), a structured observation technique designed to assess the quality and nature of the relationship between a child and each of his caregivers.

- A feedback session with the caregivers who were involved in the MIM sessions. In this meeting, we present our initial evaluation of the problem and show segments of the videotaped MIM sessions to illustrate particular points. If we recommend Theraplay treatment and the parents want to proceed, we make an agreement to embark on a certain number of sessions, depending on the severity of the presenting problem.

TREATMENT. As you will see in the following transcript, Theraplay sessions are designed to be engaging and fun. The therapist approaches each session with a plan based on an understanding of the needs of the particular child. In the moment-to-moment interaction with the child, the therapist adapts his plan and attunes his actions to the child's responses. Activities within each session alternate between active and quiet; sessions typically end with a quiet nurturing activity including feeding and singing to the child.

The initial session begins with a lively greeting and an active effort to get acquainted, during which the therapist "checks out" the child's important characteristics. He may note the color of her eyes, count the number of her freckles, see how high she can jump or how far she can throw.

Although each child responds in her own fashion to the experience of playing with her new therapist, many children follow a sequence from hesitant acceptance through a resistant phase to final enthusiastic engagement. We describe the six phases of treatment in Chapter Five.

Depending on the needs of the child, the parents may be present in the playroom from the beginning or may observe their child with his therapist from the observation room. They are guided in their observations by the interpreting therapist, whose job it is to help them understand what is going on and to prepare them for joining their child in the Theraplay room. When there is only one therapist, she meets with parents separately at a convenient time to discuss the session. In the remaining sessions, the parents come into the treatment room to interact with their child under the guidance of the Theraplay therapist. Once they have had some experience with

the activities in session, parents are given assignments to try out some of the activities at home between sessions. Chapter Six describes how we work with parents.

The final session is an upbeat party at which the child's strengths and achievements are celebrated. A strong emphasis is placed on how much the child and his parents are able to enjoy each other.

At the end of treatment, the parents fill out the standardized questionnaires again and the MIM is repeated in order to assess the outcome of treatment.

CHECKUP SESSIONS. Checkup sessions are scheduled at monthly intervals for the first three months and then at quarterly intervals for a year. These sessions follow the pattern of sessions in the later part of treatment with the parents joining in during the second half of each session. During the first half of the session parents have an opportunity to discuss any problems or issues that have arisen during the intervening weeks. When they come into the playroom they are able to demonstrate new activities that they have enjoyed with their child.

THERAPLAY IN PRACTICE

A Glimpse of Theraplay

This example of a Theraplay session shows how play can be used to create a closer parent-child connection through attunement to the child and guidance of the dyad in simple interactive activities. Following the transcript of the session, we describe how the interpreting therapist works with the parents.

Sara, seven years and three months old, was adopted at the age of three after suffering gross neglect in her birth home. When Sara came to live with her adoptive parents, she was worried about whether there would be enough food to eat. She avoided close contact and cuddling with her parents, but would sometimes seek indiscriminate contact with strangers. At the time of the Theraplay sessions, Sara displayed periods of compliance mixed with episodes of screaming, kicking, and biting others at home and school. She often argued with her parents and did the opposite of what adults requested. She

frequently wore a distant or negative facial expression which her parents interpreted as unhappy or bored. She was bothered by various sensory experiences such as loud noises or tags and seams in her clothing. Her parents wanted Sara to trust them and accept their love; they also wanted help in dealing with her defiant behavior.

During the initial intake interview, Sara's parents discussed their concerns and provided information about Sara's early history so that the therapists could learn more about the origin and meaning of the current problem. Following that interview, Sara and each of her parents were observed playing together in a structured MIM observation session. During the MIM Sara's need to know the rules and to take control of every situation was clearly demonstrated. Her affect ranged from shy or quiet to mildly bossy with some exaggerated smiling and giggling and some subtly negative expressions. She was uncomfortable accepting nurture from her parents. She expressed concern about her performance and actively criticized herself. The parents were loving and upbeat. They often asked questions, gave choices, and engaged in conversation with Sara in ways that seemed to reinforce her "little adult" role. Out of a sincere desire that Sara be happier, they tended to focus on positive affect and on how well she did on tasks rather than acknowledge Sara's difficulties and expressions of negative emotion.

Based on the interview and the observed interaction, the following treatment plans were developed:

- Provide Sara with multiple experiences of attunement to her positive and negative emotions
- Help Sara let her parents take over the task of providing structure and security for her
- Help Sara accept soothing, comforting nurture from her parents
- Focus on playful, cooperative experiences rather than performance
- Help the parents provide the above experiences and gain a deeper understanding of Sara's reactions and behaviors

Therapist and Child

Sara's mother participated in this first session with Sara and the Theraplay therapist while her father observed with the interpreting therapist from behind a two-way mirror. The decision to include a parent from the beginning was made both because of Sara's adoption history and because the family lived in another state and the parents, therefore, would be on their own after a short period of formal Theraplay treatment.

In this transcript of Sara's first Theraplay session, descriptions of the action are in parentheses; inferences about the meaning or intention of the action are in bracketed italics. A question mark indicates the tentative nature of the inference, which must be confirmed or denied by further observation.

Sara, her mother, and her therapist, Margaret, are standing in the treatment room doorway. The treatment room contains a floor mat and large pillows arranged as chairs for Sara and her mom. Margaret holds two beanie babies in her hands and kneels in front of Sara.

MARGARET: Would you like the tiger or the leopard?

SARA: (smiles shyly, looks up at her mother) The tiger.

MARGARET: I thought you might want that one. Okay, we'll put that on your head. (Sara smiles) I'm going to put one on Mommy's head too. Oh you both look good! Now hold hands with Mommy and me. Let's walk over to the pillows without dropping the beanies. (Margaret takes their hands and leads them to the pillows slowly and carefully) Okay Mom, you stand right there and hold out your hands. Sara, tip your head and drop your beanie into Mom's hands on the count of three . . . 1. . . 2 . . . 3.

MOTHER: I got it!

MARGARET: Now Sara, hold your hands out and Mom, drop yours. You got it! Here's where we'll sit. (helps them sit on the pillows next to each other)

MARGARET: Now I didn't have a chance to do this with you. (Sara sits forward eagerly, hands out) That's right. (Sara and Margaret take turns catching and dropping the beanie. Sara drops the beanie a little before the count of "3") *[Excited? Slightly oppositional?]*

MARGARET: *[Changes the task to change the pattern and reengage.]* Do you think you could do two?

SARA: Stack them?

MARGARET: Yes, exactly, you knew just what I meant. (stacks two beanies on Sara's head) Turn just your head so Mom can see her girl (Mom and Sara grin at each other). Okay, you have blue eyes, so the signal will be "blue." . . . green . . . black . . . brown . . . BLUE. (to mother) Your girl has great ears too!

MARGARET: (reaches into her bag of materials) I have some things in here.

SARA: Ooooh! (reacts with pleasant anticipation)

MARGARET: We're going to play six or seven games. Do you like bubbles? (Sara nods) Oh I'm so glad.

MARGARET: You and Mom get ready to pop them by clapping them. (demonstrates with her own hands)

SARA: Can I stand up? (jumps up)

MARGARET: We'll try it standing *and* sitting. *[It is more important to keep the engagement going than insist on sitting, although sitting would be calmer.]*

Sara laughs and jumps as she vigorously claps the bubbles with her hands; her mom claps the stray bubbles. A bubble lights on Sara's head and remains for a moment.

MARGARET: *[Sees an opportunity for contact between mother and child.]* Bend down Sara, there was one right here. (touches her head) Mom, touch her hair. Do you feel it, is it wet? (Mom strokes Sara's hair) I wonder if you could pop them with one of your hands and one of Mom's. (takes one hand of each and puts together; they try, it is difficult to coordinate) It's a little hard isn't it? *[Finds a reason to put Mother and child closer together.]* I think I know a better way. Sara, sit in your mom's lap and face me. Mom, put your hands over Sara's and wave them around, oh, that works better. (Sara leans against her mother's chest and giggles)

MOTHER: We can get lots of bubbles that way. (they lean forward together and pop all the bubbles; both have big smiles)

MARGARET: That was really neat, I like the way you two work together, quite a team, quite a team. (Sara continues to sit in her mother's lap, looks at Margaret with anticipation)

[Sara accepted closeness with her mother while involved in the game and remained there even after the activity had finished.]

MARGARET: Sara, we're going to make a stack of hands, put your hand right on top of mine, then I put my hand on yours, we go up, up, up. (Sara begins to place her hands sloppily) Yes, there's a funny way to do it. (Margaret demonstrates fast silly hand stacking) I want to see if we can keep going up so we can peek at each other underneath.

SARA: Okay. (they do it successfully and peek at each other under the hands)

MARGARET: Now, turn around and sit in my lap so you can do it with Mommy, would that feel all right? (Sara nods and faces Mother) Mom, see if you can go so high you see Sara underneath the hands.

MOTHER: Oh she's hidden . . . now I see you! *[They seem to be delighted to "find" each other.]*

After several rounds of stacking and peeking, Margaret decides it is time to introduce a nurturing activity. She takes a bottle of lotion out of her bag. Sara makes a high-pitched sound and scrunches her face. Margaret stops and looks at Sara.

MARGARET: Boy, that makes me think . . . lotion . . . you're going "yuck." You're not sure about lotion, is that right? *[Wants to check out all of Sara's reactions.]*

SARA: No, I like lotion. (with exaggerated politeness) *[Worried that she made a mistake to react to the lotion?]*

Margaret decides to introduce the lotion in a playful way before trying direct nurture.

MARGARET: Mom, put a bit of lotion on Sara's hands, but don't rub it in yet. Now do that hand stack again and it will be slippery! *[After a bit of play, Margaret decides that Sara could tolerate direct caregiving.]* Mom, you rub the lotion into one of Sara's hands first and then I'll do the other.

SARA: (looking at her hands being rubbed with lotion, wrinkles her face) They used to be crunchy.

MOTHER: Yes, they were very red and dry in winter. (gently stroking Sara's hands) But now you have the softest hands.

MARGARET: Let's look and see if any of those spots are left. (all three look at Sara's hands and arms and find red marks and freckles) Mom did you see this special freckle? Some people have them and some don't. Let me give you some more lotion Mom. We put lotion on freckles, 'cause it's fun and a nice thing to do. You can count them and put it on.

MOTHER: (Mom bends her head close to Sara's and looks carefully at her arms, counting and putting lotion on freckles. Sara extends her arms to Mom and counts too and their voices become a synchronized murmur) One, two, three, four, now the other arm . . .

SARA: Thirteen!

MARGARET: I noticed you have a scratch. We only put lotion where it will feel good, so we can go around the scratch. (When finished, Mother and Margaret each pull down one of Sara's sleeves)

MARGARET: I have another thing to do. Are you a good blower?

SARA: Yeah! Well . . . sometimes I'm not. *[Worried about her skills, adults' expectations?]*

MARGARET: Well, that happens to everyone. Here's what we'll do. (leans forward, hands cupped in front of face) Put your hands out and I'll blow this over to you. (blows cotton ball to Sara's hands)

SARA: (catches and blows back strongly, giggles)

MARGARET: No doubt about it, that was really strong. (Sara smiles and giggles; they blow a few more back and forth) Mom, I'm going to blow it to you and we'll go around the circle. (Sara eagerly arranges herself to face both Mother and Margaret)

MOTHER: (Several of Mom's blows are too hard and roll out of Sara's hands) I keep doing it too hard.

MARGARET: Mom, you didn't have practice time. You know, that's okay, it's just for fun. (they blow around the circle seven times and then switch direction for another six times) Once more around, then we have something else to do. (Sara nods, accepts shift of activity)

MARGARET: We'll make a handprint with you and Mom. Tomorrow when Dad comes in, he'll add his print to it and

that will be something for you to take home. Here's how we do it. This time we'll use lotion like paint. (applies lotion to Sara's outstretched palm and positions her hand over a piece of dark-colored construction paper) Now gently, Mom, push Sara's hand down so it makes a good print. (Sara begins to press down on her hand too. Margaret holds her hand) We can do this, Sara. *[Sara begins to take care of it herself but Margaret assures her the adults can take care of her.]* Now Mom, help her rub that in. Now we need a Mom hand. (Margaret paints Mother's hand as Sara watches) Mom has a nice big Mom hand, good for taking care of her girl. (Sara presses it down. Margaret shakes cornstarch on the prints and taps it off; the cornstarch clings to the lotion and makes a clear set of prints) There's your picture!

MOTHER: Wow, that's really neat!

MARGARET: One more thing before we finish.

The final part of the session includes feeding the child. Margaret has prepared a small bag with two kinds of cookies, originally used in the assessment, and a water bottle with a pop-up spout.

MARGARET: I have the cookies from before. (Sara looks quizzically at the bag) Oh, were you surprised that I mixed them? (Sara nods) *[Another instance of reading Sara's cues, checking out her reactions; in this case she was not necessarily rejecting the cookies but perhaps surprised that they looked different.]*

MARGARET: I know that Sara is a big girl and she could eat these herself, but when we're having special playtime, we like to take care of Sara and feed her. (Sara puts one hand up to her face) Yeah. (Margaret's tone matches this movement—a "can you believe that???" expression) Mom, pick one you think Sara will like, pop it in her mouth, and see if she makes a big crunch. (Sara chews vigorously and says she can't hear it) Okay, I'll feed one to Mom and see if you can hear hers. (Sara denies that it's very loud) *[It seems that Sara will accept being fed but won't agree to the entire experience.]* Sara, close your eyes and see if you can tell which cookie Mom is feeding you. *[Margaret wants to try another way to feed Sara that will interrupt the*

pattern of denial.] (Sara is pleased when she guesses correctly)

MOTHER: Should I feed her another one? *[Tentative, seems to be asking Margaret's permission.]*

MARGARET: You sure can, Mom; you don't even need to ask her, you'll know when she's ready. You know what would make a big crunch . . . two cookies. (Mother feeds Sara two and three cookies at a time; all agree that the crunches are louder. Then Sara grabs the water bottle and drinks) Now you're thirsty. (Margaret feeds a cookie to Mom and Sara at the same time) Now listen to that, get your ears and mouths close together. (all laugh. Sara takes water bottle)

MARGARET: Wait a minute. See if Mom can hold it for you. (Mother holds bottle and gives Sara a sip) You need a bigger sip? (Sara nods, accepts several, sighs at end; Margaret imitates the sigh) I heard that aaaah. Mom, give Sara another drink. (Sara raises her hand to the bottle but drops it and allows Mother to give her a drink; Sara then reaches for the bottle one more time) That's Mom's job! (Sara allows)

MARGARET: We have a song that we sing at the end of a play time. It's the "Twinkle" song but we make it about Sara like this. . . .

Twinkle, twinkle, little star,
What a special girl you are,
Nice brown hair and soft, soft cheeks,
Big blue eyes from which you peek.
Twinkle, twinkle, little star,
What a special girl you are.

(Sara looks at her mother several times as Margaret says the words) Why don't we do it together once and then we'll do it again next session. (Margaret and Mother sing. Sara looks at Margaret and presses her eyelid)

SARA: When I do this you have two heads. *[Avoiding the intimacy of being serenaded by diverting her attention and Margaret's?]*

MARGARET: When you push your eye it makes you see two? I could tell you were doing something. I'm glad you told me. You do that sometimes? (Sara nods) *[Accepts this behavior.]* Now, we put shoes on here in a funny way. *[Returning to a playful way to nurture since Sara has distanced herself from the direct nurture of the song.]* This is a special Mom job. Mom, she needs a kiss on that foot. Then I have to get the shoe on so fast that the kiss doesn't get away. (Mother kisses foot and the shoe bottom; Sara laughs delightedly) Oh boy, your Mom really loves you!

Margaret has Mother give Sara one more drink and then directs them to hold hands and stand up together. Margaret and Sara look at books in the waiting room for a few minutes while the interpreting therapist speaks to both parents. Sara spontaneously says of the session, "I like coming here."

Interpreting Therapist and Father

As the interpreting therapist and Father watched this session, they discussed Sara's reactions to the activities and her interaction with her mother and Margaret. At the beginning, the interpreting therapist noted, "Sara was excited and squealed and jumped around while popping the bubbles; she was calmer when her mom made physical contact with her." They also noticed that although Sara usually did not seek closeness or eye contact, she seemed to enjoy looking for her mom's face in the Stack of Hands game. Because one of the goals of the session was to have Sara experience many instances of attunement, the interpreting therapist drew the Father's attention to the many times when Margaret stopped to acknowledge or check out Sara's small reactions to the session events. Father smiled when he saw Sara allow her mother to count and lotion her freckles. He was surprised that Sara played the cotton ball game for as long as she did. The interpreting therapist pointed out, "I know she often says something is 'boring.' At those moments she may be worried about what's coming up next that she has to master. The level of the Theraplay activities is just so much younger than a game that she has to think about." Father noticed that Sara was

initially surprised that her mom would feed her and she "argued" a bit about hearing the crunches, but then she settled down to accept more cookies with pleasure. The interpreting therapist explained: "It often happens that feelings associated with early caretaking experiences are stirred up when children first find themselves accepting care from their adoptive parent. It is a new experience that she likes but is not yet sure of."

Interpreting Therapist and Both Parents

Because Sara's mother was in the treatment session and had not had the opportunity to discuss her observations or questions, the interpreting therapist met briefly with both parents immediately after the session.

INTERPRETING THERAPIST (IT): What did you notice about Sara and how she responded to the activities?

MOTHER: It felt really good for me to be able to feed her the water and have her depend on me to do it. The water especially I noticed because I never had the opportunity to feed her a bottle. It felt as if she was relying on me and she seemed to be accepting of it. I think it was good that she knew she could depend on me, that she wanted it. (Mom is a little teary)

IT: All of your instincts have been to care for Sara, but she really hasn't let you. When you both have a positive experience like this, it fills you up as well as Sara.

MOTHER: Yes, it's good. (nods, wipes eyes)

IT: At the end of sessions we often have some crackers or cookies and a juice box or water bottle. Eventually she might sit in your lap. The session provides this special time when you actually get to do this direct kind of nurturing. The fact that we're setting it up, we're giving her a structured opportunity somehow makes it so that Sara resists it less; she needs a bit of a structure. Then you can carry it forward in the future. You could set up a bedtime ritual for her with a few games, the song, and a backrub.

FATHER: Even a water bottle would be fine. We don't usually let her eat after brushing her teeth, but a bottle is something we could do because she does get a drink before she goes to bed.

MOTHER: She really liked that, I could tell.

FATHER: She seemed really at ease. She didn't look like she was bored; she looked like she was really enjoying it.

IT: She was receptive to the lotion and the hand stack. She was relaxed and focused. When you did the blowing of the cotton ball, she was very engaged in the play.

FATHER: I didn't think that was something that she would enjoy or want to do for more than a couple of times, but she did. You could tell she liked it. I thought that she'd need more challenging activities because basic things bore her; we've tried to challenge her by giving her more complex things to do, which in turn frustrates her more. These were really basic things.

MOTHER: It's good to know. I was surprised by the cotton ball game because she just kept wanting me to do it. It seems like such simple things that we can be doing; it's a lot to think about. I'm amazed. I just want to remember it all because I think this is really going to help her a lot.

Sara and her parents attended four more sessions and the parents met with the therapists after each one. We recommended that Sara continue to participate in Theraplay activities daily at home as well as to have additional treatment for processing her early experiences. Sara's parents sent the following message after returning home: "We learned so much and have already made so many changes in the way we parent Sara. Last night we had fun doing some of the Theraplay activities before bedtime and Sara loved it. We had her walk into her bedroom on her Dad's feet, we put lotion on her freckles, did the cotton ball blowing game, stacked hands, and sang her the special song. She woke up really happy this morning and very calm. I have already noticed a big difference!"

REPLICATING THE HEALTHY PARENT-INFANT RELATIONSHIP

Theraplay treatment involves replicating as much as possible the range of experiences that are an essential part of the healthy parent-infant relationship. If you picture what goes on in the interaction between

an infant and her parents, you have the model for Theraplay and how it works.

From the moment the baby is born, his parents hold him in their minds and are constantly alert to his moods and needs. They respond to his cries by feeding him, cuddling him, comforting him, and caring for him. They rock him, stroke him, and sing to him. When he is happy and alert, they respond to his inviting smiles and lively gestures with playful games and songs. They regulate and organize his experience, keeping him safe and helping him make sense of his world. As he grows older they encourage him to try new things and to explore his world.

The baby, in turn, is an active partner in the dance. He gazes intently at his parents and mirrors their moods and gestures. He signals his need for help when he's in distress. He invites them to play with him when he's needing company and he responds with joy to their antics. A mutual admiration society develops as they learn about each other and experience the reassurance and exhilaration of their satisfying relationship.

As you can see from the session, Margaret interacted with Sara in ways that are reminiscent of the interaction of parents with their young children. She was playful and engaging, she made physical contact with her, and she was attentive and attuned to Sara's every response. She focused on what was happening in the here and now rather than exploring issues related to her past. She was careful to slow down and modulate activities when Sara became too excited. She used challenging activities to keep Sara interested, and nurturing activities to comfort her and make her feel good. Rather than ask Sara to decide what to do, she took charge of the session to make it safe and fun. And, finally, she guided Sara's mother to begin to interact with Sara in this new way.

Using the Theraplay Dimensions to Plan Treatment

The great range of activities that make up the daily interaction between a mother and her baby can be seen to fall roughly into four dimensions: structure, engagement, nurture, and challenge. We make use of these dimensions as we plan treatment to meet the needs of the child and the parent in treatment.

- *Structure.* Parents are trustworthy and predictable, and provide safety, organization, and regulation.
- *Engagement.* Parents provide attuned, playful experiences that create a strong connection, an optimal level of arousal, and shared joy.
- *Nurture.* Parents respond empathically to the child's attachment and regulatory needs by being warm, tender, calming, and comforting. They provide a safe haven and create feelings of self-worth.
- *Challenge.* While providing a secure base, parents encourage the child to strive a bit, to take risks, to explore, to feel confident, and to enjoy mastery.

Based on their attentive observation and intuitive understanding of their child's needs, parents move from one activity to another with no conscious plan for what particular dimension of interaction their child needs next. The Theraplay therapist, however, must pay close attention to the child's actions and plan carefully to respond to the unique developmental needs of the child who comes for treatment. To help you understand why Theraplay emphasizes these dimensions, we now describe the role that each plays in promoting a healthy attachment relationship.

STRUCTURE. In the parent-infant relationship, the parent takes responsibility for the safety and comfort of the baby, initiates the interaction, organizes and regulates his experience, sets limits and provides guidance. It is essential to the child's feeling of security that she knows that someone is "better able to cope with the world" (Bowlby, 1988, p. 27).

As a consequence of the caregiver's structuring of the child's environment, the child not only enjoys physical and emotional security, but she is also able to understand and learn about her environment and she can develop the capacity to regulate herself. The adult conveys the message, "You are safe with me because I know how to take good care of you."

In treatment, the Theraplay therapist, like the "good enough" parent, structures the interaction in order to provide safety, organization, and regulation while remaining carefully attuned and responsive to the child's needs.[5] It is not reassuring to a frightened, unhappy, or

chaotic child to experience the adult as uncertain or to feel that she must decide what to do next. Such a child needs firm, confident, and playful leadership to draw her into interaction. Therefore the Theraplay therapist initiates the interaction, entices the child into the activity, and does not wait for the child to "choose" to relate.

In Theraplay sessions, the dimension of structure is addressed throughout by virtue of the adult taking charge of the planning and organizing of the session. It is also addressed through clearly stated safety rules, for example, "No hurts!" Structure is also conveyed through activities such as singing games that have a beginning, middle, and an end, and through activities that define body boundaries, for example, making handprints. Structure is not about control, but rather about conveying a comforting sense that someone bigger and more capable can make the world safe and predictable. Although all children benefit from the reassurance of structure, this dimension is most important for children who are overactive, unfocused, or easily overwhelmed; it is also central to helping children who have an anxious need to be in control. Structure is also an important focus in our work with parents who are themselves poorly regulated, those who set limits verbally but can't follow through, or those who have difficulty leading confidently.

Because of her anxiety about the past and the future, Sara, whose case we have just described, had a need to take control of every new situation; when she felt overwhelmed or fatigued from attempting to control, she often fell apart in a tantrum or an aggressive act. Knowing this, Margaret's goal was to relieve Sara of this burden by making the session as understandable and comfortable as possible. Margaret provided structure by confidently taking charge of the activities, making sure that Sara was safe, and organizing the session in ways that met Sara's needs. The activities also included physical movement that could be used to foster regulation and teamwork with her mother. Margaret helped Sara's mother to participate and to begin to take the lead in this type of simple, organized, and direct interaction.

ENGAGEMENT. The interaction between parents and their babies is filled with delightful play leading to emotional engagement. The baby signals her eagerness to be engaged by looking, smiling, cooing, and babbling. The mother responds and adds her own variety of sensitively timed responses that maintain her baby's alert connection

with her and moves the action forward. She is always aware of the baby's need to pause, look away, slow down, and reduce the level of excitement. Many traditional baby games, such as Peek-a-Boo, blowing on the tummy, and "I'm going to get you," serve to draw the baby into interaction with her caregiver and maintain an optimal level of arousal. These activities are delightful, stimulating, and engaging and create a positive self-image for the child. As a result, the child experiences herself as being seen and felt as a distinct and valued individual. She also learns to communicate, share intimacy, and enjoy interpersonal contact. The message is, "You are not alone in this world. You are wonderful and special to me. You are able to interact appropriately with others."

Many children who come for treatment convey a surface message that they want to be left alone. Such children need to be enticed out of their withdrawal or avoidance by an empathic invitation aimed at engaging them in a pleasurable relationship, a relationship in which they feel truly noticed and experience that they are not alone. Using activities modeled on the playful games of a mother with her infant, such as hand-clapping games, Hide-and-Seek, or Motor Boat, the therapist offers adventure, variety, positive stimulation, laughter, and a fresh view of life. These experiences help the child learn that surprises and new experiences can be enjoyable. Engaging activities are especially appropriate for children who are withdrawn, avoid contact, or are too constrained and rigidly structured. Learning to be more engaging with their child is essential for parents who are disengaged or preoccupied, who are out of sync with their child, who rely primarily on questions to engage their child, or who do not know how to enjoy being with their child.

Sara's parents were puzzled and worried about her erratic behavior; they felt she was unhappy and often disengaged from them. We observed that much of their interaction was verbal with a focus on encouraging positive emotions. In order to help Sara connect directly to another person and enjoy herself in play that did not require talking, Margaret planned a number of simple activities such as hand stacking and playing with bubbles. Sara was cooperative and able to engage for periods of time. When she experienced engagement as too intense, however, she interrupted it with a distraction or mild opposition. The therapist guided the mother to engage with Sara in this straightforward, simple way that was very different from the more grown-up approach she used in her attempt to get past

Sara's apparent boredom and rejection of activities. Margaret took every opportunity to respond to any reactions and expressions of positive or negative emotions. The therapist's way of checking out, acknowledging, and accepting Sara's reactions served as a model for future use by the mother.

NURTURE. In the parent-infant relationship, nurturing activities abound: feeding, rocking, cuddling, and comforting, to name a few. Such activities are reassuring, calming, and are essential to the formation of a secure relationship.[6] The parent anticipates the child's needs and conveys the message that she understands and is thinking about the child. As a result of experiencing the comforting presence of a nurturing adult whenever he needs it, the child gradually develops the capacity to internalize the soothing function of the caregiver and is able to learn how to take over these functions for himself. The message of nurturing care is: "You are lovable. I want you to feel good. I will respond to your needs for care, comfort, and affection."

To meet the unfulfilled emotional needs of the child in treatment, many nurturing activities are used, such as feeding, making lotion handprints, or swinging the child in a blanket. Such activities help the child relax and experience the calming effects of touch, movement, and warm, responsive care. They reassure him that his parents are available when he needs them. These activities are important in building the child's inner representation that he is lovable and accepted as he is. The soothing capacity of nurturing activities is important in helping a child become regulated. This dimension is especially useful for children who are overactive, aggressive, or pseudo-mature. Learning to respond to their child's needs for comfort and security is important for parents who have difficulty with touch and with displaying affection or who are dismissive or punitive.

Sara's early experiences with nurture had been negative and inconsistent. As a result, although she may have needed and even at some level desperately wanted comfort, she had for many years resisted her adoptive parents' efforts to cuddle and calm her. Taking their cue from her discomfort with closeness, her parents had backed off. Knowing this, Margaret planned playful activities involving touch and physical closeness as well as nurturing experiences such as caring for hurts, feeding, and singing; she hoped these would be intriguing enough for Sara to accept. When Sara showed some discomfort with

being touched and taken care of, Margaret turned the activities into games, such as, making a slippery hand stack or a lotion handprint and using a funny way to put shoes on. By the end of the session, Sara accepted the cookie and juice that her mother offered her.

CHALLENGE. In the parent-infant relationship, the parents often challenge the baby to take a mild, developmentally appropriate risk and help him master tension-arousing experiences. Later they support his exploration and encourage him to try new activities that promote feelings of competence. For example, a mother might "walk" her baby on her lap, or a father might hold his baby high, saying "So big!" When the caregiver supports her child's development and takes pleasure in the child's mastery, the child gains confidence in his capacity to learn, to accept challenges, and to have realistic expectations of himself. The message is clear: "You are capable of growing and of making a positive impact on the world."

In treatment, challenging activities are used to support and encourage the child's sense of competence. The activities are designed for success and are done in playful partnership with the adult. For example, the therapist might help a four-year-old balance on a pile of pillows and jump into his arms on the count of three. Such activities encourage the child to try new activities that lead to feelings of competence and confidence. Challenging activities are especially useful for withdrawn, shy, timid, or anxious children. Learning about appropriate challenge is important for parents who have inappropriate developmental expectations, are overly protective, or are too competitive.

Sara's determination to take charge and her unwillingness to allow her parents to nurture and care for her reflected a premature effort to grow up, which arose from an early, very real survival need. Sara's bossy, aloof, or bored expressions made her seem to her parents, at times, like a little adult; in response to her apparent boredom, they often increased the complexity of the activity in order to capture her interest. The increased challenge made her even more anxious, leading to tantrums and aggressive behavior. Her behavior seemed to stem from an underlying insecurity and sense of inadequacy and was the result of being emotionally overwhelmed. Margaret planned simple games with the focus on the pleasure of being together and playing rather than winning or achieving. Sara enjoyed the interactive game of blowing a cotton ball around the circle from hand to hand.

The simplicity of this game allowed Sara to relax, feel competent, share positive affect, and experience the back-and-forth of play.

Attachment research supports our multidimensional view of healthy development. Sroufe (2005, pp. 51–52) says, "Attachment security is only one of many environmental influences on the developing child. . . . Attachment generally refers to provision of a haven of safety, a secure base for exploration, and a source of reassurance when the child is stressed. But parents do more than this. They also provide stimulation for the child that may or may not be appropriately modulated. They provide guidance, limits, and interactive support for problem solving. In addition, they support the child's competence in the broader world—for example, by making possible and supporting social contacts outside the home." We would argue that the Theraplay dimensions reflect this wider definition of the parental role.[7]

Understanding the Core Concepts of Theraplay

In our effort to replicate the broad range of interactions that are involved in the healthy parent-infant relationship we have extracted some basic principles that we consider to be the core concepts of Theraplay. These core concepts are the basic qualities of the many interactions that take place between parents and their children that are acknowledged to be important to healthy social-emotional development. In the following brief outline we indicate how each relates to the dimensions we describe above. In Chapter Two, we return to these ideas and consider the theory and research that support these aspects of our work.

THERAPLAY IS INTERACTIVE AND RELATIONSHIP BASED. The focus of treatment is the parent-child relationship, which is supported by our innate capacities for social interaction. Parents are actively involved in treatment to enable them to take home the new ways of interacting with their child. The therapist and parents work together to engage the child in a healthier relationship. The dimension of engagement is especially important to the interactive quality of Theraplay.

THERAPLAY PROVIDES A DIRECT, HERE-AND-NOW EXPERIENCE. In order to provide a truly reparative experience, the focus is on what is actually happening between the child and his parents (or the therapist) in the

session. Rather than talking about events that happened in the past, the therapist and the parents respond in the present to the child's problematic responses in ways that repair the interaction. All of the dimensions—structure, engagement, nurture, and challenge—are involved in creating a direct here-and-now experience.

THERAPLAY IS GUIDED BY THE ADULT. Just as the good enough parent takes charge in order to make sure that her infant is safe and well cared for and that his emotional needs are met, the Theraplay therapist takes charge of the interaction during sessions and guides parents to do the same. If the child has difficulty accepting the adult's lead, the therapist remains in charge of the momentum of the session as she initiates new, positive interactions. The dimension of structure is especially important to the concept of adult guidance.

THERAPLAY IS RESPONSIVE, ATTUNED, EMPATHIC, AND REFLECTIVE. The healthy parent makes use of her capacity to attune to her baby's affect and to respond in an empathic manner that meets the child's needs and co-regulates her baby's excitement or distress. In order to do this the parent must be able to reflect on her own and her baby's experience. The Theraplay therapist lends her whole self to the interaction (and teaches parents to do the same) in order to provide the co-regulation that the child needs. The dimension of engagement is primary in interactions that are responsive and attuned.

THERAPLAY IS GEARED TO THE PREVERBAL, SOCIAL, RIGHT-BRAIN LEVEL OF DEVELOPMENT. Because attachment is formed during the early months when the right brain is dominant and co-regulation is essential, efforts to change negative patterns must be direct, interactive, and emotionally focused. We use the language of the right brain—nonverbal, face-to-face emotional communications involving touch, eye contact, rhythm, and attuned responses of pacing and intensity—to provide appropriate levels of stimulation to the areas of the brain that are involved in affect regulation. Activities are geared to the child's specific emotional needs and capacity to self-regulate rather than to the child's chronological age. Language is not a barrier to treatment because Theraplay relies so heavily on nonverbal communication. All the dimensions—structure, engagement, nurture, and challenge—are involved as we gear our interaction to the earlier levels of development.

THERAPLAY IS MULTISENSORY. Just as in the healthy baby experience, Theraplay involves all the senses. The therapist and the parents engage the child in the full-bodied, physical experience of the interaction. We encourage eye contact, echo sounds, provide sensory-motor stimulation and rhythmic movement, and we use touch to enhance the connection, to increase the child's awareness of self, and to provide physical soothing and regulation. The dimensions of nurture and engagement are associated with the multisensory aspects of Theraplay, particularly the use of touch.

THERAPLAY IS PLAYFUL. Treatment involves interactive, physical play. All Theraplay sessions are infused with the loving pleasure in the relationship that characterizes healthy parent-infant interaction. Play entices the child into a relationship and introduces an element of joy and excitement that is essential to the development of a zest for life and energy for engagement in all children. The dimensions of engagement and challenge are important during active play.

Creating Positive Inner Working Models

An important outcome of the ongoing interaction between parents and their child is that the child learns about himself and the world and what he can expect from others. Bowlby (1973, p. 203) describes the patterns thus laid down as "internal working models" that serve to guide the child's actions. As parents find increasing pleasure in being with their new baby, he in turn becomes more pleasurable to be with. The baby comes to see himself as lovable and capable of making an impact. In addition, his parents acquaint him with his body parts (as when his mother counts his fingers or plays This Little Piggy with his toes) and help him distinguish himself from the reality of the world at large (as when she plants the soles of his feet against her chest and encourages him to push). They teach him about physical realities such as gravity, time, and motion (as when his father tosses him up high in the air and catches him) or, later, about moral and social realities such as, "It hurts when you pinch me, and I won't let you do that."

As they interact with their baby, parents come to see themselves as loving and giving and at the same time as resourceful, strong, and competent. They find in their new parenthood the confirmation of many positive personal qualities, including a capacity for intimacy

and a firm sense of self, enhanced by their ability to be a strong role model to their children for confident assertiveness in the world.

For the baby, these pleasurable interactions produce a positive self-image as well as a positive image of his parents and the world. The baby comes to see his parents as warm, loving, caring, and trustworthy. He learns that they can be counted on when he needs them. He comes to view the world as a place he enjoys exploring and in which he can feel safe and well cared for. Experiencing this happy, responsive environment fortifies children with such a sturdy sense of self and resilience to stress that unless something occurs later on to interrupt their healthy development, they seldom need treatment.

UNDERSTANDING THE REASONS THAT THERAPLAY MIGHT BE NEEDED

Being cared for by attuned, responsive parents is essential to healthy emotional development. Missing these positive early experiences, for whatever reason, can lead to the problem behaviors and attachment or relationship difficulties that Theraplay is designed to treat. Even though, in contrast to other treatment modalities, Theraplay does not focus on helping the *child* understand her early unhappy experiences, the *therapist* must understand what led to the child's missing out on the healthy experience and therefore the underlying reasons for her current behavior. This understanding also points to how the relationship problem can be repaired.

By the time a child is brought for treatment, the early sources of attachment insecurity may no longer be present. The child may be easier to soothe, the mother's illness may be a thing of the past, or the child may have been removed from his chaotic, abusive home. Although an improvement in the environment can make a big difference for many children, those who are referred for treatment often show the long-term residual effects of their early unfortunate experiences. Patterns set early in life are often tenacious and, being the basis for the unconscious sense of self and of others, continue to cause difficulties. Children may fear giving up control, may keep others at a distance, may be emotionally volatile, or may lack empathy for others. They may be overwhelmed by feelings of shame, seeing themselves as bad, worthless, and unlovable. All of these problems can make it difficult for parents to meet their child's underlying needs.

We can avoid the temptation to blame parents if we understand the complex factors that affect the parent-child relationship and may have contributed to the current difficulties. Parents are all too willing to shoulder the blame, and must be helped to understand that the problems are too complex to attribute to any one factor. If we understand the child's experience as well as what might have prevented the parents from meeting their child's needs, and how these two factors interact, we can work together to help the child grow.

The Child's Reduced Ability to Respond

Because the response of each partner has such a powerful effect on the relationship, any condition that makes it harder for the parent and child to connect or that makes it difficult to soothe and comfort the child can result in behavior problems and relationship difficulties.

It is important that we know how the baby's temperament, special sensitivities, illnesses, or particular neurological problems (either in the past or on an ongoing basis) have made it hard for the child to take in and benefit from the empathic, accepting, comforting response that she needs.

CAUSED BY THE CHILD'S DIFFICULT TEMPERAMENT OR REGULATORY PROBLEMS. Babies are born with a wide range of temperaments (Thomas and Chess, 1977; Bradley, 2003) and thresholds to incoming stimuli, capacities for responding, and abilities to self-regulate (Brazelton, 1992, pp. 25–26), and any one of these factors can strongly affect the parents' attitudes and caretaking responses. Many children with regulatory and sensory integration problems (DeGangi, 2000) are so sensitive and irritable that even the most responsive, attuned parent finds it difficult to soothe and comfort the child. Children affected in utero by drugs or alcohol can also present serious regulatory challenges to their parents. In Chapter Seven we discuss how Theraplay can be adapted for children with regulatory problems.

CAUSED BY THE CHILD'S CONSTITUTIONALLY BASED NEUROLOGICAL PROBLEMS. Children with autism spectrum disorders, because of their constitutionally based neurological challenges, have more difficulty achieving the comfortable give-and-take characteristic of secure parent-child relationships. Shahmoon-Shanok (1997, p. 38) says, "[W]hen a child has severe difficulties in relating

and communicating, these difficulties affect not only the child's development; they also bear upon the relationship between the child and his or her parents." These children cope with what, to them, may be an overwhelmingly confusing world. The resulting uncertainty produces behaviors and responses that make the normal attachment process more difficult—but not impossible.[8] It is hard to engage with and soothe children who cannot respond to social cues or who constantly push you away. In Chapter Eight we discuss how Theraplay can be adapted to meet the needs of children diagnosed with autism spectrum disorders.

The Parent's Inability to Provide Responsive Care

Attachment or relationship problems can also develop if parents are inconsistently available or unresponsive to their child's needs. Children raised in an orphanage or removed from a neglectful home and cared for by a series of foster parents will also be strongly affected by the lack of good, consistent care.

It is important to understand the reasons why parents might be unable to respond to their child's needs: stressful family circumstances, overwhelming health problems, or the inability to provide adequate parenting because they were inadequately parented themselves. Prolonged separations, for any reasons, will profoundly affect the child's experience.

STRESSFUL FAMILY CIRCUMSTANCES. Many parents face overwhelming pressures: poverty, a rental lease that forbids children, in-laws who harass, a spouse who resents the baby, or a spouse who is abusive. There may be competing demands from the house, a job, or other children. If there is much external stress and strain, parent and baby may not find the time and freedom to enjoy each other's company.

Meeting the many demands of their lives can be so difficult that parents may find themselves propping the bottle, turning on the television set, and attending only to the child's physical needs. Warm, caring moments and shared playful enjoyment get lost as the parents tend only to the necessary and the routine, overwhelmed as they are by the serious problems of family survival.

HEALTH PROBLEMS. Various physical circumstances may prevent parents from establishing a good relationship with their baby.

Depression, illness, fatigue, pain, or the use of drugs may interfere with their ability to be attentive parents. Parents also may be unable to attend to a baby if a partner is seriously ill or if a close relative dies.

LACK OF GOOD PARENTING FOR THEMSELVES. Many young parents, still children themselves, or older parents who never got the attentive care they needed, find it very difficult to respond empathically to their child's needs. Many parenting difficulties have their origins in the parent's own early experiences of being inadequately mothered (Spitz, 1970; Main and Goldwin, 1984). From early on, some parents expect the baby to meet their needs rather than being able to respond empathically to the baby's needs.

SEPARATION FROM THE CHILD. Prolonged separations or the death of a parent can, of course, have a profound effect on a child. Children who have been removed from their biological parents and placed in foster care or in adoptive families often show the long-term effects of these disruptions on their ability to form a new relationship. Many suffer from the traumatic effects of neglect and abuse as well.

Perhaps the most damaging situation for a child, though, is that of being raised in an impersonal institution. In the worst institutions the child has no opportunity to form an emotional attachment to any caregiver. The plight of such children was vividly illustrated sixty years ago by Rene Spitz (1945, 1947) through his writings and films about infants raised in institutions. With the increase in the number of children adopted from foreign orphanages, we are once again observing the devastating effect of impersonal care (compounded in many cases by poor diet and inadequate medical attention) on the development of young children. Many of these children have significant impairments in ego structure, cognitive functioning, regulation of aggression, and ability to relate to people. Chapter Nine describes how we adapt Theraplay when working with children who have suffered complex trauma, including neglect, abuse, and other deprivations.

Interaction Between Child's Problems and Parent's Problems

When difficulties stem from both the child and the parents, the chances of relationship or attachment problems increase. A hypersensitive child whose parents are under stress will be more vulnerable

than a hypersensitive child whose parents are relaxed enough to adapt to his special needs. A drug-addicted baby raised by a calm, empathic foster mother has a much better chance of overcoming the regulatory problems resulting from the drugs than if he is raised by a mother who is still using drugs and therefore cannot provide the consistent, attentive care that her child needs.

Another example of such negative interaction is when a child's irritability or hypersensitivity interacts with a parent's problem (such as the mother's postpartum depression or the unavailability of adequate child-care facilities) and produces insecurity and behavior problems. The case of Adam in Chapter Four is an example in which the child's behavior problems have multiple causes.

Sometimes the problem is a mismatch in temperament between the child and a parent (Gerhardt, 2004). An active, noisy baby whose mother prefers a quiet, restful life is unlikely to receive the attuned responsiveness that fosters a good relationship. A quiet, lethargic infant will not appeal to a driving, energetic father. Even granted the best of all external circumstances, such mismatches can easily lead to conflict if one or the other partner is unable to adapt or is hindered in the adaptation process.

DECIDING WHETHER THERAPLAY SHOULD BE USED

Because we are so enthusiastic about the value of Theraplay for a wide range of parent-child relationship problems, we may seem to be offering it as a panacea for every kind of presenting problem. This is not the case; there are a number of situations in which Theraplay treatment would not be the first choice of treatment and other treatment and support should be provided instead. In some cases Theraplay might be used in conjunction with the other approach or after the child is in a safe setting. The basic principle to keep in mind when making a decision about using Theraplay is that you must be certain that the child can be kept safe. The following is a list of situations in which Theraplay should be used with caution or not at all.

Children with Dangerous Acting-Out Behavior

Although, in the long run, Theraplay might be helpful in working with a family whose child is acting out dangerously, it alone cannot provide

the safety that is needed. A child in so much pain and distress needs around-the-clock monitoring and safe containment, possibly within a residential treatment center or a specialized therapeutic home. Once safety is established, Theraplay can be part of the attachment work that the child needs in order to feel secure enough to resolve issues around trauma and loss. When the child is ready to process his experience, trauma-focused therapy would be an important part of the child's treatment. Theraplay, in combination with other methods, has been used successfully in residential care and group homes. In Chapter Eleven we present two case studies in which Theraplay was used with acting-out adolescent boys who were in residential treatment centers.

Children with Psychoses

A child suffering from a psychotic illness could benefit from the here-and-now focus of Theraplay treatment. The severity of his illness, however, first requires safe containment as described above. Furthermore, he would probably need to be stabilized with medication under the supervision of a child psychiatrist before any kind of therapeutic treatment could be helpful.

Children Who Have Experienced a Recent Trauma

Children who have experienced a recent trauma need immediate help to process and understand what has happened to them. However, they cannot do this without a basic sense of safety that allows them to feel calm enough to do the work. For children who do not have a secure relationship with their parents, Theraplay can be very helpful as a first step or in combination with a trauma-focused therapy. In Chapter Nine we discuss the role of Theraplay in working with traumatized children.

Children Who Have Been Sexually Abused

A child who has been sexually abused needs therapy in which there is explicit acknowledgment and processing of the abuse. She would also benefit from a modified form of Theraplay designed to establish a relationship with her caregivers that can support her as she processes her trauma. The modifications should take into account the child's

history and sensitivities: this would include giving the child choices, being sensitive to the child's anxiety and physiological arousal, and addressing the child's discomfort at all times. In Chapter Nine we discuss how Theraplay can be adapted when working with children who have been sexually abused.

Children in Foster and Adoptive Homes

Theraplay has been used effectively with children in foster and adoptive families, but it should not be assumed that it will be the only treatment such children need. Theraplay might be the logical first choice to help a newly adopted child establish a secure and trusting relationship with her adoptive parents. In Chapter Ten we describe how Theraplay can be used in working with children in foster and adoptive families. For children who require processing and integration of a traumatic past, with its related beliefs and shame, we recommend attachment-based treatments such as those developed by Hughes (2006), Gray (2002), and Keck and Kupecky (1995). Most adopted children at some time will need to explore issues related to the adoption: "Why was I given up?" "Where is my biological mother?" "Why did my father leave me?" "Who can I talk to about my sadness at losing her?"

Parents Who Have Serious Problems

When parents have their own unresolved issues, they cannot provide the care that their children need. You should not include parents in Theraplay treatment until you have determined that the parents are capable of providing the safe, responsive care that their child needs. Do not involve parents in Theraplay treatment if they are still abusing drugs, if they have not resolved the issues that led them to neglect or abuse their child, if they cannot control their anger, or if they cannot keep the child safe. The immediate focus should be on getting help for the parent. Until that happens such a parent would be too inconsistent and preoccupied to be successful in Theraplay treatment with their child. Once parents are stabilized and in a program that addresses their issues, you can consider including them in Theraplay sessions with their child. See Chapter Six for more detail about how to assess parents' ability to engage in Theraplay with their child, how to support and teach parents so that they benefit from the

Theraplay treatment themselves and are able to interact safely with their child.

Parents Who Are Mentally Ill

Parents who have mental illness, such as major depression or psychotic disorders, and are not stabilized on medication and involved in their own treatment should not participate in Theraplay. The vulnerable position in which the child is placed could be misused or misunderstood by the parent and therefore cause harm to the child. Parents need to have some level of insight into their own behaviors and parenting expectations. Parents with personality disorders should be carefully screened before making the decision to use Theraplay as they often have difficulty seeing their child's point of view and could cause harm to their child in the course of treatment.

In this chapter we have given a basic introduction and overview of the Theraplay method. We turn next to a consideration of the core concepts of Theraplay and a review of the theory and research that informs our attachment-based model of clinical practice. We will also review research into the effectiveness of Theraplay.

Notes

1. Bowlby (1988, p. 126) notes that the "pattern of interaction adopted by the mother of a secure infant provides an excellent model for the pattern of therapeutic intervention" that he advocates.
2. We use the term *parent* or *parents* throughout the book to refer to all caregivers including biological parents, adoptive parents, and foster parents. As the ideal is to have both parents involved in Theraplay treatment, we will generally use the plural even though we know that there will be times when only one parent is involved.
3. Sroufe et al. (2005, pp. 66–67) found that children with "secure attachment histories are more accepting of parents' limits and guidelines . . . because of confidence in the parent's responsiveness."
4. The title, "interpreting therapist," is a shorthand term to cover the extensive nature of the collaborative relationship that we establish with parents. In Chapter Six we describe these functions in detail. They include helping parents observe and reflect on their own and their child's experience as well as coaching them in sessions.

5. Winnicott (1965) uses the term "good enough mother" to describe the general style of parenting that he considers essential to healthy development. He is referring to the responsive, empathic relationship that we emphasize throughout the book. But he is also emphasizing that parents do not have to be perfect. They just have to be "good enough."
6. Goldsmith (2007, p. 211) says, "Nurturing interactions form the basis of secure relationships." They are "patterned on the 'ideal grandmother' . . . [who provides] unconditional love and acceptance and knows the child so well that she is capable of anticipating the child's needs . . . . [She] conveys her ability to effectively understand the child and, even more important, demonstrates that she has been thinking about the child even in the child's absence."
7. Sroufe et al. lists the following Tasks of Parenting (2005, p. 52). We indicate by initials the Theraplay Dimension(s) that fit each task: structure, engagement, nurture, and challenge.

   - Regulation of arousal—E/N
   - Appropriately modulated stimulation—E/S
   - Provision of secure base and safe haven—N/S
   - Appropriate guidance, limits, and structure—S
   - Maintenance of parent-child boundaries—S
   - Socialization of emotional expression and containment—E/S
   - Scaffolding for problem solving—C
   - Supporting mastery and achievement—C
   - Supporting the child's contacts with the broader social world—C/E
   - Accepting the child's growing independence—C

8. Oppenheim, Koren-Karie, Dolev, and Yirmiya (2008) review studies that challenge the idea that children with autism are unable to form healthy attachment relationships. Two points emerged: (1) Children with autism develop attachments to their caregivers; and (2) close to half develop secure attachments, as measured using the Ainsworth Strange Situation Protocol.

CHAPTER TWO

Understanding the Theory and Research That Inform the Core Concepts of Theraplay

Phyllis B. Booth
Sandra Lindaman

Theraplay was one of the first efforts to use attachment theory as a guide to treatment for parent-child relationship problems. We began providing therapy for children in the Chicago Head Start program in 1969, the same year that Bowlby's first book, *Attachment,* was published. As we developed our approach, we were strongly influenced by his work. Our assumption that we could change a child's view of herself (inner working model) by interacting face-to-face in a positive, responsive, and playful manner was based on his theory. In the forty years since we first began to play with children in the Head Start program, there has been a growing body of research into various aspects of attachment; this research helps us understand the power and effectiveness of Theraplay. As the understanding of the relationship between attachment and brain development has deepened, the findings have helped us refine what we do to include a greater emphasis on attunement, sensitivity, regulation, and reflection. We have, however, never lost sight of the basic principle of providing a playful, interactive, reparative experience that will change struggling relationships and negative inner working models into healthier and more positive ones.

Until recently, clinical applications utilizing Bowlby's theory have lagged far behind the large quantity of research based on attachment theory. There are currently a growing number of therapeutic models that apply this knowledge and research to prevention and treatment. This is the long-awaited fulfillment of Bowlby's own goals, which were to apply research into the development of attachment to prevention and clinical practice.[1]

As is true of all attachment therapies, we consider the relationship the primary focus of treatment. Many aspects of our work are also paralleled in other attachment-based therapies:

- We establish an attuned, supportive therapeutic alliance with parents, one that is modeled on the attachment relationship itself in order to provide a model for parents as they interact with their child.
- We help parents understand their own attachment experiences that might make it difficult to respond to their child.
- We help parents gain more understanding and empathy for their child.
- We work directly with the child to change the child's inner working model.

There are two elements, however, that we consider unique to Theraplay:

- We bring the parents and child together in order to guide the active give-and-take, the dance of attunement that will promote their child's healthy development. Through this we provide an active reparative experience for the parents and for the child.
- We also give parents an opportunity to have a direct experience of Theraplay for themselves. We do this as we practice activities in preparation for parents joining their child in sessions. In some cases we may have a full Theraplay session solely for the parents.

CHANGE IS POSSIBLE

When we set out to help the children in Head Start we made the assumption that change is possible. Our assumption was confirmed by our early work with Head Start children: we saw dramatic changes

in children's behavior that we attributed to a change in their inner working models. We take this assumption one step further by agreeing with Bowlby that it is possible, at any age, to create a healthy new experience for a child. Bowlby states (1988, p. 136), "Although the capacity for developmental change diminishes with age, change continues throughout the life cycle so that changes for better or for worse are always possible. It is this continuing potential for change that means that at no time of life is a person invulnerable to every possible adversity and also that at no time of life is a person impermeable to favourable influence. It is this persisting potential for change that gives opportunity for effective therapy."

The longitudinal research of Sroufe and others also supports this belief. Although there is considerable evidence that an early attachment category (secure or insecure) is both persistent and stable, there is also evidence that change, both positive and negative, can occur. Examples of positive change can be found when the child has a good adoption experience, or when family circumstances improve. As Sroufe (1988, p. 283) reports, for example, "When our . . . mothers [who were at risk because of living in poverty] form stable relationships with a partner, child adaptation improves." Conversely, it is well recognized that long absences or the loss of a parent through death or divorce can have a negative effect on a child's feelings of security.

Theraplay has the power of all parent-child psychotherapies: it addresses change both through the parents' experience and through the child's experience. This gives it the possibility of being exponentially more potent than therapies with a single focus (Stern, 1996). Mäkelä (2003, p. 7) describes it thus:

> Theraplay aims at causing simultaneous changes in the child's experience of him or herself, of adults and especially their parents and of the outside world. Simultaneously it offers the parents a new view and experience of their child. Seeing the well-being of one's own child enhances one's own feelings of being worthy and is thus a potent organizer of mental well-being for the parent also. And Theraplay gives a rare opportunity to tend to the emotional hurts of the parents through not only emotionally mutual mentalization and emotional attunement but through direct physical co-regulation to diminish anxiety and enhance feeling good.

In this chapter we review the theory and research that inform our attachment-based model of clinical practice. As we discussed in

Chapter One, Theraplay is modeled on the healthy parent-infant relationship. The following seven core concepts are aspects of that relationship that are acknowledged to be important to healthy social-emotional development.

Theraplay is

- Interactive and relationship based
- A direct, here-and-now experience
- Guided by the adult
- Responsive, attuned, empathic, and reflective
- Geared, as with an infant, to the preverbal, social-emotional, right-brain level of development
- Multisensory, including an extensive use of touch
- Playful

We turn now to review the theory and research that inform and support each of these core concepts and we provide examples of how the concepts are put into practice using the Theraplay dimensions and activities.

THERAPLAY IS INTERACTIVE AND RELATIONSHIP BASED

Theraplay is modeled on the interactive relationship between a mother and her baby. In the first edition of *Theraplay*, Ann Jernberg (1979, pp. 4–5), the founder of Theraplay, vividly describes the interactive relationship between a mother and her baby that we take as our model:

> Daily, the mother in the nursery with her baby nuzzles his neck, blows on his tummy, sings in his ear, . . . [plays] "peek-a-boo," and nibbles his toes. She picks him up, twirls him, spins him, rocks him, bounces him, flips him, and jiggles him. She holds him close and nurses him. She powders him, lotions him, combs him, washes him, pats him dry, and rubs him. She whispers, coos, giggles, hums, chatters and makes nonsense sounds. She peeks at him, pops out at him, . . . looks wide-eyed with surprise, and beams at him. In addition, she holds him close, [When he is upset, she comforts him and protects him. She] defines his life space, . . . his relationships,

> his use of time. And finally, she remains one step ahead of him, thus encouraging him both to move forward and to enjoy the challenge.
>
> Her baby, in turn, coos at [her], smiles at her, reaches for her, strokes her, worships her, imitates her, and enjoys being mirrored by her; he gurgles with her, he stares at her and gazes deeply into her eyes, and, finally, he names her. As he grows older, although he may sometimes protest, he responds to his mother's definitions, limits, and structures, and rises to [her] challenges.

Rebecca Shahmoon-Shanok (1997, p. 38), describing a beautifully attuned interaction between a two-year-old boy and his mother, comments on how a baby in a healthy relationship experiences "love and play, . . . attention and shared attention, . . . cognition and differentiated emotions, . . . communication and organization, . . . the use of symbol and narrative, and . . . an internal sense of safety and hope. [These happen] simultaneously, each element woven into all of the others in the context of contingent, reciprocal attachment. How ordinary and how *extra*ordinary it is that so much happens within relationship: autonomy grows out of attachment" [emphasis in original].

The richness of such relationships is our focus. Like all attachment-based treatments, Theraplay treats the relationship itself rather than focusing separately on the individual child or the parent. Many authors have supported this approach, including Busch and Lieberman (2007, p. 145), who suggest that because "the parent-child relationship is central to shaping personality development in the early years, . . . effective intervention for young children's social-emotional difficulties should focus on this attachment-caregiving system." In other words, as Stern (1995) has stated, the "patient" of infant-parent psychotherapy is the relationship itself.

Theraplay thus aligns itself with the basic premises of attachment theory (Bowlby, 1969, 1988) and with interpersonal theories of human development, especially Self Psychology (Kohut, 1971, 1977, 1984) and Object Relations Theory (particularly the work of Winnicott, 1958, 1965, 1971). Their arguments for the importance of the parent-infant relationship in the development of the child lend strong support to our work. Winnicott makes the point emphatically: "There is no such thing as a baby . . . [there is only] a nursing

couple. . . . Without a good-enough technique of infant care the new human being has no chance whatever" (1958, p. 99).

Bowlby (1969) goes further to postulate an innate drive toward relatedness that is the primary motivating force in human behavior. This drive allows for the creation of the strong bonds, or attachment relationships, that play a significant role in the child's development. The attachment bond is an emotionally charged, enduring relationship to a few clearly preferred individuals. The formation of an attachment bond is supported in both infants and adults by innate responses that ensure that the child and her caregivers remain close and interact in a caring way.[2] The healthy neonate has the potential to "enter into an elemental form of social interaction" and the "ordinary sensitive mother [has the potential] to participate successfully in it" (Bowlby, 1988, p. 7). The baby is born with a repertoire of attachment behaviors—crying, smiling, gazing, clinging—that signal his need to connect. Adults respond instinctively to the baby's signals by providing care. These innate, relationship-enhancing behaviors make it possible for the helpless infant to survive. The early interaction between parent and child is the essential environment in which the baby's hardwiring for connection sets the stage for the self and personality to develop.

Innate Responsiveness

In addition to the attachment behaviors that lead to safety and survival, human beings are equipped with innate capacities for responsiveness that lead to social interaction. These include (1) the ability to enter into rhythm, synchrony, and resonance and (2) the ability to imitate and understand the intentions of others.

RHYTHM, SYNCHRONY, AND RESONANCE. The workings of the human nervous system are based on rhythm, synchrony, and resonance.

Rhythm and Synchrony. Rhythm and synchrony refer to the infant's built-in capacity to synchronize her movements in response to the rhythm of her parents' speech and actions. In moments of synchrony, groups of neurons are activated simultaneously. Trevarthen (1989) has demonstrated that the fetus responds rhythmically to sounds from outside the womb. This capacity to synchronize continues after

birth. Susan Hart (2008, pp. 93–94) describes it as follows, "Right from birth, the infant is able to display movements that are precisely and systematically synchronized with adult speech. Newborn infants are prepared to communicate with their care-giver. . . . When infant and care-giver imitate and mirror each other's behaviour, a process is initiated that later develops into so-called protoconversations, interactions that are well-organized in timing and affective modulation. [Such interactions grow out of] a fundamental motivation for human contact. . . . [A mother's] facial movements, vocalizations, and gestures are co-ordinated or synchronized. Her movements are regulated to optimize her communication with her child."

Resonance. The baby is born with the capacity to enter into resonance with other people's emotional expressions, which allows him to attune with others. Resonance occurs when activated neurons cause other neurons to fire (either within a brain or between brains), thus increasing the overall level of activity. Siegel and Hartzell (2003, pp. 64–65) highlight the crucial importance of this capacity in establishing emotional health. "The music of our mind, our primary emotions, becomes intimately influenced by the mind of the other person as we connect with their primary emotional states. . . . Resonance occurs when we align our . . . primary emotions, through the sharing of nonverbal signals. . . . When relationships include resonance there can be a tremendously invigorating sense of joining." Bentzen and Hart extend this to point out the role of interactive resonance in expanding all the neural connections in the brain. "Interacting persons are drawn into each other's emotional world; they become emotionally attuned and thus affect each other. . . . Successful attunement with another person's nervous system enables the nervous system to develop flexibility and integrate neural patterns that may spread hierarchically throughout the brain" (Bentzen and Hart, 2005, as quoted in Hart, 2008, p. 78).

IMITATION. The ability to anticipate, imitate, and understand the intentions of others is another aspect of the innately social brain. This ability is based in the mirror neuron system, a part of the neurological substrate that directly links perception to action and makes resonance and attunement possible. The mirror neuron system shapes our internal, one-to-one, and larger social experiences,

including our ability to feel empathy. When we see someone perform an intentional act, our motor system is primed to imitate the same action; it is as if we rehearse the action in our brain. In this way, mirror neurons help us understand the intentions of others. Siegel explains it thus, "By perceiving the expressions of another person, the brain is able to create an internal state that is thought to 'resonate' with that of another person" (2006, p. 254). For example, a mother, seeing her distressed child, will respond by furrowing her brow, momentarily sharing her child's feeling of distress. Her mirror neurons connect with the child's experience, and allow her to respond empathically.

The recent research on how the brain supports and feeds on relationship and interaction explains both the effectiveness of Theraplay and its ability to create change. Theraplay reenacts a natural and necessary developmental process. Trevarthen and Aitken (2001, p. 4), summarizing the body of research about our innate capacity to enter into social interaction, describe the process as follows: The "natural sociability of infants, engaging the interest, purposes, and feelings of willing and affectionate parents, serves to intrinsically motivate companionship, or cooperative awareness, leading the infant toward development of 'confidence, confiding and acts of meaning,' and, eventually, to language."

Theraplay relies on these essential building blocks of social interaction in our interactive, relationship-based treatment. It is significant for our work, however, that children who are anxious and insecure do not readily enter into rhythm, resonance, and synchrony and therefore find it difficult to understand the intentions of others and join in the interactive dance (Hart, 2008, p. 92). It is a central and characteristic focus of Theraplay that we take special care to adapt to the anxious child's difficulty with engaging in a relationship. We provide the necessary acceptance and support to help such a child feel calmer and we set up face-to-face opportunities that encourage attuned interaction with her parents. As therapists, we make full use of our own capacity to resonate, synchronize, regulate, and read the intentions of the children and their parents who come for our help. Our task is to create the calm security that makes it possible for the family to develop and make use of the social building blocks which research now shows are essential for development.

THERAPLAY IN PRACTICE

Creating Social Interactions

In order to illustrate the interactive aspect of Theraplay, we return to the example of Sara that we described in Chapter One. Sara had missed out on the early experience of being in a resonant, synchronous relationship. Even in her very good adoptive home, Sara and her parents had had few opportunities to achieve affective synchrony because of Sara's erratic, explosive behaviors and rejection of her parents. From their first moment of meeting, Margaret, the therapist, communicated to Sara and her mother her interest and pleasure in being with them through her facial expressions, voice, and paced guidance of activities. She made gentle and reassuring contact with them by holding their hands and assisting them to sit comfortably. She led them in a rhythmic, turn-taking activity of stacking their hands up and down until they could make eye contact. She highlighted the discovery of their wonderful eyes with her own widened eyes and a tone of delight in her voice. When Sara indicated possible rejection of the lotion, Margaret tried to figure out Sara's response by mirroring it—wrinkling her own face and saying, "Yuck, lotion"—to see if that matched Sara's feeling. Although Sara denied disliking the lotion, Margaret hoped that her response would convey to Sara that she wanted to understand her reaction. Margaret encouraged the mother to look carefully at Sara's hands and arms in the way a new mother examines her baby. This led to a moment of true synchrony: The mother bent her head close to Sara's and looked carefully at her arms, counting and putting lotion on freckles. She murmured, "Sara, you have the softest hands." In response, Sara extended her arms and murmured in unison with her mother, "One, two, three, four, five, six . . ." Their heads and hands moved gently to the rhythm of the count.

THERAPLAY PROVIDES A DIRECT, HERE-AND-NOW EXPERIENCE

We approach the task of creating or repairing the parent-child relationship in the same direct, hands-on manner in which relationships are formed in the early months with an infant. By being together in the moment and by providing a new, reparative experience, we reorganize the internal states of the child into more positive, resilient forms. We want the child to experience herself as more lovable and capable, to see her parents as loving and trustworthy, and to experience the world as more organized, more interesting, and more joyful. We want parents to have a similarly transformative experience that leads to a changed view of their child as well as of their own competence and ability to respond to their child's needs. In order to do this we focus on what is actually happening between the child and his parents (or his therapist) in the session, creating reparative experiences in the here and now. We do not talk about past experiences or recent behavior and relationship issues, nor do we use indirect approaches such as child-centered play therapy, art therapy, or movement therapy to process experiences.

Primary Intersubjectivity

The importance of Theraplay's focus on the here and now is supported by Trevarthen and Aitken's concept (2001) of primary intersubjectivity. Primary intersubjectivity refers to the shared state of feelings and actions in a face-to-face human encounter. It emerges within the attachment relationship and includes the capacity for understanding what goes on in the mind of the other person. As we have seen, the infant is prepared to enter into relationships that are constantly being co-regulated. Using the Still Face paradigm, Tronick, Ricks, and Cohn (1982) have demonstrated that the infant is keenly responsive to and actively engaged in the mother's contingent and emotionally appropriate behavior. When the mother suddenly withdraws her attention, the infant attempts to reinstate the interactive pattern and, when unable to do so, becomes increasingly dysregulated.

This early stage of intense focus on each other is followed by secondary intersubjectivity, which develops when the parent and child begin to share their interest in objects and play materials. In Theraplay we focus on the level of primary intersubjectivity rather than introducing such play materials that would shift the

relationship to the secondary level of shared attention to objects. Primary intersubjectivity creates the setting in which the responsive parent can attune to her child's emotional state and create the resonance and synchronicity that can lead to change.

Now-Moments

Mäkelä, writing about what makes Theraplay effective (2003, p. 6), describes the importance of moments of high intensity that arise every now and then out of the ongoing, continuous "resonant hum of emotion" within a therapeutic relationship. These are the moments that create "sudden dynamic shifts in the internal states of both child and therapist." The Process of Change Study Group (Tronick et al., 1998) provides supportive evidence for "a theory of change in psychotherapy, in which intense now-moments, or moments of meeting, are the crucial points of new forms of internal organization. . . . [The intensity of these moments] expands the experience of both child and therapist. . . . There is a re-organization of the implicit ways of knowing of relationships—and the knowledge is shared by both." Because of the playful, engaging nature of Theraplay, it is full of such moments that lead to increased focus and pleasure.

THERAPLAY IN PRACTICE

Creating a Now-Moment[3]

Three-year-old Danica was sitting in a beanbag chair, her eyes wandering aimlessly around the room. Michael, her therapist, hoping to engage her in a playful game, picked up her hands and held them in front of his eyes; after a moment, he peeked out with a smiling face and a cheerful, "Peek-a-boo!" Danica was suddenly completely alert. She looked directly into Michael's eyes and giggled spontaneously at the surprising event; Michael laughed in turn. The two of them had just shared an intense moment of meeting. For the few seconds after the surprise, Danica and Michael were in a brand-new intensely focused state created by both of them. Each gave meaning to the event as pleasant and their giggling conveyed this shared meaning as it amplified the experience. The more

such moments occur, the more the child learns that it is both safe and pleasurable to be completely caught up in a moment of shared joy or attention with another person. Once this has happened, there is no going back—a deeper sense of connection has been established between the two of them.

Noncongruence

Many of the troubled children who come for Theraplay treatment have a negative view of what they can expect when interacting with another human being. Our positive, accepting approach presents the child with an experience that is noncongruent with his negative view. The discrepancy between what he has come to expect and what he experiences in a Theraplay session challenges his brain to develop a new, healthier experience of what it is like to be in a relationship. Hart (2008, p. 74) describes this process in neurological terms, "When the neural activation that was caused by an outside stimulus fails to match a previous experience exactly, without, however, completely missing the mark, it sparks a new process or a new experience. The difference between the new and the old experience creates learning or development."

THERAPLAY IN PRACTICE

Creating Change Using a Noncongruent Response

When John was struggling in a Theraplay session and pushed his therapist, Rachel, away with his legs, Rachel said, "My you've got strong legs! I bet when I count to three, you can't push me over with your legs!" Then Rachel looked John in the eye, placed her hands on his two feet and said, "One, two, three, push!" As John pushed, Rachel rocked backwards with a big "OOOOHHHH." When she rocked back up, she could see that John's face had changed from defensive fear to a moment of proud delight. What just happened? By reframing and organizing John's resistance into a moment of reciprocal play, she had given him an opportunity to experience himself as

strong, clever, and, most important, as still *connected* to her, rather than as bad, rejected, and isolated. Rachel had given John a new definition of what it means to be him.

Creating New Meanings Together

Theraplay's emphasis on the here-and-now experience appears to differ from the traditional focus of psychotherapy: thinking together about meanings and creating coherent personal narratives. Through shared experiences, however, Theraplay creates new meanings in an immediate and perhaps more lasting way. As Mäkelä (2003, p. 6) says, "[T]rue meanings are created when one experiences the sharing of one's bodily reality and one's emotional reality in expanded, dyadic states of preverbal consciousness. I know of no therapy more geared toward this end than Theraplay."

THERAPLAY IS GUIDED BY THE ADULT

Because we are working directly on the parent-child relationship, we do as healthy parents do; we provide an understandable, safe, and regulated experience, for the child and for her parents. We think of this aspect of our work as related to Winnicott's concept of a "holding environment": the provision of a reliable, responsive, nurturing environment within which the true self of the child can develop. Winnicott (1987, p. 97) describes the mother as communicating to her baby, "I am reliable—not because I am a machine, but because I know what you are needing; and I care, and I want to provide what you need."

A number of studies highlight the importance of parental guidance, structure, and rules in the development of competence, self-confidence, and resilience in their children.

Essential Parenting Tasks

The element of adult guidance and structure is often downplayed in child-centered therapies or in therapies where the focus is mainly on the child's attachment needs. Sroufe (2005, pp. 51–52) points out that a focus only on the child's attachment needs leaves out "some

important aspects of parenting, [that] even in the early years, lie outside the purview of attachment." Parents, he says, do more than provide "a haven of safety, a secure base for exploration, and a source of reassurance when the child is distressed." Within Sroufe's longer list of essential parenting tasks (see note 5 in Chapter One for the full list), the following relate to the important issue of parental guidance and structure:

- Regulation of arousal
- Appropriately modulated stimulation
- Appropriate guidance, limits, and structure
- Maintenance of parent-child boundaries
- Socialization of emotional expression and containment

These are the very aspects of parenting and of the therapeutic relationship that we emphasize when we organize the child's experience and help parents provide a more authoritative, organized, and regulated experience.

Authoritative Parenting

Research by Baumrind (1991) into the influence of parenting style on children's social and instrumental competence provides another support for our emphasis on parental authority and guidance, balanced with warmth and supportiveness, in developing healthy children. She differentiates four parenting styles based on whether parents are high or low on "parental demandingness" (relating to behavioral control, guidance, and discipline) and "responsiveness" (relating to parental warmth and supportiveness). Using these two categories, she identified four parenting styles: indulgent, authoritarian, authoritative, and uninvolved. The authoritative parenting style balances both demandingness and responsiveness. Authoritative parents "monitor and impart clear standards for their children's conduct. They are assertive, but not intrusive and restrictive. Their disciplinary methods are supportive, rather than punitive. They want their children to be assertive as well as socially responsible, . . . self-regulated as well as cooperative" (Baumrind, 1991, p. 62). Children whose parents use an authoritative parenting style are more socially competent,

do better academically, have fewer behavior problems, and achieve better psychosocial development.

Resiliency Factors

The International Resiliency Project (Grotberg, 1997), in a worldwide study of the factors that promote resiliency among children, found that the most frequently cited external resources and supports leading to resiliency included three elements which reflect the presence of an in-charge, caring adult:

- *Trusting relationships:* "People around me I trust and who love me, no matter what."
- *Structure and rules at home:* "People who set limits for me so I know when to stop before there is danger or trouble."
- *Role models:* "People who show me how to do things right by the way they do things."

Being "Bigger, Stronger, Wiser, and Kind"

And finally, our concept of adult guidance parallels an important concept in the attachment-based treatment program called the Circle of Security (Powell, Cooper, Hoffman, and Marvin, 2007). Their focus is on helping parents understand and respond to their child's attachment needs in order to provide both a safe haven when the child is distressed and a secure base from which the child can explore the environment. As a foundation for developing attuned responses to their child's needs, parents must be able to provide guidance and structure within which the child can safely navigate his world. In their useful graphic, Powell et al. represent the attachment relationship as a circle, with the child's need for exploration on the top half and his need for a safe haven on the bottom half. They represent the provision of structure and adult guidance by two strong hands and the motto: "*Always:* be BIGGER, STRONGER, WISER and KIND. *Whenever possible:* follow my child's need. *Whenever necessary:* take charge" (p. 174).

Many children who come for Theraplay treatment have grown up in situations where they have been unable to count on adults to

provide the essential guidance and support that would create a sense of safety, order, and regulation; they have come to rely primarily on themselves. In Theraplay we provide the adult guidance that the above studies highlight, and we teach parents to provide it for their children.

THERAPLAY IN PRACTICE

Providing Adult-Guided Experience to Child and Parent

As we noted with Sara earlier, the therapist took the responsibility to plan and lead Sara and her mother through a number of pleasant, interactive activities in their thirty-minute session. When Sara was young she was often left to fend for herself; she had, as a result, developed a pattern of rejecting adult authority. To provide a sense of safety and order, Margaret was explicit about how many games they would play. She made sure to demonstrate and explain the activities clearly. She began with an engaging and familiar activity: blowing bubbles. Then she added a less familiar, more challenging activity: making a stack of hands. She made decisions about when to move to the next task, thought about how she could draw parent and child to each other, and encouraged the mother to begin to take ownership of what was happening. After a demonstration, she had the mother take over a nurturing activity of applying lotion so Sara could also enjoy doing this with her mother. Because of her careful attention to planning and guiding the session to meet Sara's needs, Margaret was able in this very first session to provide enough safety and comfort for Sara and her mother to be able to achieve the moment of synchrony that we saw when they counted Sara's freckles.

THERAPLAY IS RESPONSIVE, ATTUNED, EMPATHIC, AND REFLECTIVE

The adult guidance and structure that we have been describing is always based on our assessment both of the child's underlying needs and of the needs that arise in the interactive moment. In order

to respond appropriately, we must be able to attune to the child's emotional state and be able to empathize with and reflect on his experience.

Our emphasis on responsiveness, attunement, empathy, and reflection is supported by a body of attachment research indicating that these are essential qualities of the kind of parenting that leads to secure attachment. In this section we review this research. We begin with a description of the research findings that indicate that responsive parenting leads to secure attachment. We discuss the relationship between parenting styles, children's attachment categories, and the development of inner working models. We then consider the internal qualities that allow a parent to respond in a sensitive manner: her ability to attune to the vitality of the child's affects, which leads to empathy, and her capacity to reflect on her own and the child's experience.

Responsive Parenting

Bowlby (1969, p. 306) made the assumption, which has been supported by further research, that a child who received "mothering" would develop a secure attachment to the mothering figure: "mothering" included "engaging in lively social interaction with [the child] and responding readily to his signals and approaches." In order to test Bowlby's assumption, Ainsworth (1967, 1978) observed mothers and their babies in their home environments, first in Uganda and later in the United States. She then correlated these home observations with laboratory observations of the toddler's response to the stress of being separated from his mother. Her initial studies set in motion a flood of research into the relationship between styles of parenting and their consequent secure and insecure outcomes for the child, including a number of longitudinal studies of attachment that have traced into adulthood the behavioral outcomes of early patterns of attachment (Sroufe et al., 2005; Grossmann et al., 2005).

Three basic attachment categories have been observed in this research, reflecting the child's organized strategies for responding to stress: Secure, Insecure Avoidant, and Insecure Ambivalent. A fourth group of children, classified as Disorganized, have no organized strategy because their experience has been so unpredictable. The children's responses have, in turn, been shown to be related to the particular style of parenting they have received.

Parents whose children are *securely* attached are warm, sensitively attuned, and emotionally available. The parent responds quickly and contingently to her baby's cries and encourages mutually enjoyable interaction. She is accepting of her own and the child's positive and negative feelings and is able to support or facilitate regulation. An early secure attachment relationship has been shown to lead to long-term mental health and to be a protective factor against various later adversities and stress.[4]

Parents whose children are *insecurely* attached are, by contrast, less responsive, less warm, and less available; the parents themselves may avoid, or be ambivalent about, close relationships. Two very different ways of coping have been identified among children who are insecurely attached: *avoidant* and *ambivalent*. The *insecure avoidant* child suppresses his behavioral response of distress at his mother's departure even though measures of heart rate and of cortisol levels make it clear that he is experiencing physiological stress. The *insecure ambivalent* child expresses his distress by alternating between anxious clinging and angry withdrawal.

Parents whose children show *disorganized* attachment are often overwhelmed by unresolved loss, or abuse in their own life. They are unable to provide a sense of safety and may even respond to their child in a threatening way. When the source of fear comes from the very person who should provide a haven of safety, the child becomes confused. In the reunion with the mother the child may, for example, move eagerly toward her and then turn away, or sit on the floor looking into space and making odd sounds (Main and Hesse, 1990).

When unresponsive or unpredictable parenting leads to insecure or disorganized attachment, a child is at risk for later maladaptive outcomes. Research has shown that these outcomes include social incompetence with peers and teachers, poor impulse control, anxiety, depression, conduct disorders, dissociative disorders, and other psychiatric problems.

Inner Working Models

Out of repeated experiences of interaction with a parent, the child develops patterns of expectations that Bowlby (1973) calls inner working models. This concept is variously described in the literature as "inner representations" or "road maps," or "implicit relational knowing." The attachment categories that we have described above

are the behavioral outcomes of the inner working models that the child has developed. Parents' responses to their child—how they play with her, comfort her, listen to her, discipline her—all work to form patterns of expectations and beliefs about herself and what she can expect from others that continue to influence her behavior and lead her to expect similar experiences as she interacts in the world. When another person responds in the familiar way, it reinforces the pattern of expectation that has been laid down through earlier experiences. Bowlby describes it thus:

> [E]ach individual builds working models of the world and of himself in it, with the aid of which he perceives events, forecasts the future, and constructs his plans. In the working model of the world that a person builds, a key feature is his notion of who his attachment figures are, where they may be found, and how they may be expected to respond. Similarly, in the working model of the self that anyone builds a key feature is his notion of how acceptable or unacceptable he himself is in the eyes of his attachment figures" [1973, p. 203].

When things go well in the parent-infant relationship, the child develops an inner representation of *himself* as lovable, special, competent, and able to make an impact on the world; of *others* as loving, caring, responsive, trustworthy, and reliably available; and of the *world* as a safe, exciting place to explore. Within a secure attachment, he begins a process of learning about himself and the world that is positive and hopeful and that will have a powerful influence throughout his life.

When given unresponsive, unpredictable, neglectful, or abusive care, the child develops an inner representation of *herself* as unlovable and incompetent; of *others* as uncaring and untrustworthy; and of the *world* as unsafe and full of threat. Within an insecure or disorganized attachment, therefore, the process of learning about oneself and the world becomes negative, hopeless, and full of shame. Many behavior problems of these children can be traced back to early insecure or disorganized attachment experiences and to their consequent dysregulation and negative views of themselves and the world.

The research-based understanding of the relationship between children's early experiences and their later approach to the world supports Theraplay's focus on improving the patterns of parent-child relationships. Our goal, as stated in Chapter One, is to change the

child's inner working model through interactions that are responsive, attuned, empathic, and reflective.

Attunement, Empathy, and Reflective Function

Given the body of evidence for the importance of responsive parenting in the development of attachment, we must look closely at the internal qualities that allow a parent to respond sensitively to her child's cues. These include both the ability to attune to the child's emotional responses and the capacity to reflect on or be mindful of her own and her baby's experience.

ATTUNEMENT. The first step in a parent's being able to understand her baby's experience is to resonate with and attune to her child's actions and feelings. Mothers who are preoccupied with their own problems are unable to do this. Stern (1985) describes this as attunement to "vitality affects." Important to his theory is the idea that emotions can be seen as having two major forms: vitality affects and categorical affects. Vitality affects are the contours of activation, the waxing and waning, the crescendos and decrescendos of feeling. Categorical affects, on the other hand, are specific emotional responses, such as joy, sadness, anger, or shame. The ongoing experience of being together allows the sensitive mother to attune to the level and tone of the child's emotion. According to Stern (1985, p. 142), attunement is expressed in behaviors that reflect "the quality of feeling of a shared affect state without imitating the exact behavioral expression of the inner state." The mother's ability to attune to the child's emotional level plays a crucial role in helping her identify his feelings and in co-regulating the shared experience. Infants learn about their feelings by observing themselves in the mirror of their mother's face. Winnicott (1971, p. 112), describing a mother who genuinely reflects her baby's emotional state, says, "[T]he mother is looking at the baby and *what she looks like is related to what she sees there*" [emphasis in original]. Babies do not see themselves in the face of a mother who is unable to attune and simply reflects her own mood. As a result of repeated experiences of attunement, the child becomes aware of his own feelings.

In mirroring and attuning to the child's feelings, the healthy parent avoids being swept away by the tide of the child's feelings. She also makes clear to the child that she is mirroring *his* feelings and not

expressing her own. In order to do this, her mirroring response must be marked in some way: by exaggeration, as Fonagy, Gergely, Jurist, and Target (2002) suggest, or by being expressed in some form other than pure imitation, such as using her expressive voice to match the child's actions, as Stern suggests (Stern, 1985). If she attunes, for example, to the child's anger, she must clearly indicate that it is the child's anger and not her own anger that she is expressing. If she can do this successfully, she can modulate and organize the child's affect and the child will become calmer.

Attunement to affect is important not only in the parent-child relationship, but also in a therapeutic relationship. Siegel (2006, p. 255) points out that the therapist's capacity to attune and understand can play an important role in leading toward health for all clients. "Being empathic with patients may be more than just something that helps them 'feel better'; it may create a new state of neural activation with a coherence in the moment that improves the capacity for self-regulation."

In Adam's treatment, which we describe in Chapter Four, we see an example of mirroring that is clearly marked as belonging to the child and not to the therapist. Adam had become angry, and Madelyn mirrored the intensity of his feeling with a strong statement, "You're mad. You're really mad." At the same time she clearly signaled that she was not angry at Adam by immediately changing her face and by maintaining a calm and gentle manner.

THERAPLAY IN PRACTICE

Attuning to the Child's General Level of Arousal[5]

When Mike chose to do his Checkup with Angela in a quiet, relaxed manner, it was because he was attuned to her basic state of physiological arousal and had judged that Angela was able to sit still and focus long enough for him to capture her attention. When she became interested in the freckle he found and stared at it intently, Mike responded with a quiet, rich, energy-filled voice that mirrored the intensity of her look: "Yeah, uh-huh, neat freckle." In another case, when Bernard came bounding into his session in a state of high energy,

> Margaret knew he would be unable to tolerate so much quiet, focused attention. Attuning to the vitality of his affect, Margaret immediately shifted her plan and began the session in a more active way in order to make a connection with him. She checked how high he could jump and then she played a game of Motor Boat in order to organize and gradually calm him down.

EMPATHY. The mirroring and attunement that we have been describing not only helps the child to become aware of his own feelings, but it also helps him understand that others have feelings and intentions as well. Stern (1985) argues that the affective attunement between a mother and her baby makes it possible for the baby to understand not only his own feelings but also the feelings of others. Many experiences of affect attunement make it possible for the child to develop empathy for others. In the same process, the mother develops empathy for her child and learns how to "read" her child's mind.

REFLECTIVE FUNCTION: AWARENESS OF SELF AND OTHERS. Repeated experiences of mirroring, affect attunement, and empathy lead to the important ability to reflect on the feelings of others. Peter Fonagy and his colleagues (2002) take the concepts of attunement and empathy one step further and describe an additional internal quality that is required for the mother to respond sensitively to her child's needs: the capacity for what they call "reflective functioning." Siegel uses the term "mindsight." Not only does a mother need to be able to attune to the child's affect but she must also be able to reflect on her own and her child's internal states. Research indicates (Slade, 2002, p. 12), that "a mother's capacity to reflect upon and understand her child's internal experience is what accounts for the relation between attachment status and her child's sense of security and safety."

Reflective functioning involves being able to step back and monitor one's own experience as well as being able to regulate and fully experience those emotions. Slade (2002, p. 11) suggests that the capacity to reflect makes it possible to understand that one's "own or another's behaviors are linked in meaningful, predictable ways to underlying mental states, to feelings, wishes, thoughts, and desires. . . .

[In relation to her child, the mother must be able] to hold in her own mind the notion of her child as having feelings, desires and intentions," and to understand that the child's behavior is a reflection of those underlying intentions and emotions. The mother may do this in her own mind: "He *knows* I'm going to feed him," or "She's getting tired now so I'll put her to bed." Even more important in its effect on the child, she is likely also to put her understanding into words. "You're feeling a little *sad*." "That made you really *mad*." "Oh, you're not so sure about that." The next step is to acknowledge the connection between these feelings (internal states) and both the child's behavior and the mother's role in causing that behavior. "It made you so mad when I didn't let you go on playing with your toy." "Oh, no wonder you are upset. You thought I was going to take you with me to the store and when I didn't, you felt really disappointed." Highly reflective mothers are able to see a link between a whole chain of feelings and behaviors, including their own feelings and responses.

Reflective function is linked to affect regulation, both for the mother and for the child. Slade (2002, p. 11) says, "A mother's recognition of a link between her infant's mental states and behavior will make it possible for her to develop a mental model of his experience, and thus aid in . . . his developing capacities for self-regulation. Likewise, her capacity to appreciate the dynamics of her own affective experience is regulating as well."

When a mother is able to understand her child's feelings and intentions and put them into words, this allows the child to discover his own internal experiences via his mother's experience of them. It leads also to the child's being able to understand that someone else's experience and point of view might be different from his own. Being understood and responded to in this way leads to a sense of acceptance and security.

Perhaps not surprisingly, therefore, there has been found to be a strong link between a mother's reflective capacity and the attachment security of her child. The mother's ability to reflect on her own attachment experiences, to develop a coherent narrative even when she did not have an ideal early experience is related to secure attachment for her child. Slade (2002) reports that even a deprived, traumatized mother, if she has good reflective capacity, can protect her child from the effects of trauma and can mediate the effects of her own trauma on the care she gives her child. This reduction in the effects of trauma explains the special emphasis that Fonagy and his colleagues

(2002, pp. 16–17) place on the survival value of the capacity to understand affect. They propose "a reorientation of attachment theory, from an emphasis on templates for relationships, fixed in early infancy, to a model that views attachment as the context provided by evolution for the development of interpersonal understanding." This understanding leads to a robust and positive approach to life's challenges. Thus, there is a selective advantage in being able to understand internal states.

Slade (2002) describes the effectiveness of treatment programs that help parents understand their own feelings and the way in which they relate to their own behavior. The focus in these treatments is not on interpreting why parents feel as they do, but rather on deepening parents' appreciation of their own and their child's experiences and feelings. When positive change is effected in parent-infant psychotherapy, Slade sees it as a direct outgrowth of the therapist's implicit focus on the parent's reflective capacities.

Theraplay, too, focuses directly on helping parents develop and expand their reflective capacity. In Chapter Six we describe how we do this during the feedback session following the MIM as well as how we do it when parents are observing their child during a session. It can be seen, then, that research supports Theraplay's attuned, empathic approach, both in our work with the child and with his parents.

THERAPLAY IS GEARED TO THE PREVERBAL, SOCIAL-EMOTIONAL, RIGHT-BRAIN LEVEL OF DEVELOPMENT

New technology has made it possible to look beneath the observable interactions that take place between a mother and her baby in order to understand how early attachment experiences shape the baby's brain. The interactive development of the right-brain limbic system is intimately bound up with the co-regulation of affect, which is essential to the development of the capacity for self-regulation and to ongoing mental health. As we understand how the brain develops and how it is shaped by experience, we can match our clinical practice with the biological realities of development. Our goal is to provide experiences that can reorganize the brains of the children with whom we work. By focusing on the early levels of social-emotional development, using the communicative channels—the "language"—of the right brain and replicating the attuned, responsive, playful interactions of

a parent with her infant, we can create changes in the brain that lead to affect regulation and long-term mental health.

In this approach we are supported by the work of Alan Schore. Based on their extensive synthesis of developmental and neurobiological research over the last fifteen years, Schore and Schore (2008, p. 9) suggest that Bowlby's core ideas have been expanded into a more complex and clinically relevant model: "[A]ny theory of development and its corresponding theory of therapy must include these psychobiological findings regarding precisely how early emotional transactions with the . . . [mother] impact the development of psychic structure, that is, how affective attachment communications facilitate the maturation of brain systems involved in affect and self regulation. The rich intricacy of an integrative interdisciplinary theory now encompasses all the essential elements that allow us to comprehend and treat disorders of self and affect regulation more effectively."

In this section we discuss the following issues and how Theraplay relates to each:

- The experience-dependent development of the brain
- The nature of the social-emotional brain
- The central role of affect regulation
- Brain development as a guide for treatment

The Experience-Dependent Brain

An infant is born with his own unique genetic makeup and associated temperament and physiology. However, the way in which the genetic endowment is expressed depends entirely on how it is shaped in the interactive experience between the baby and his responsive parents. The infant must experience attuned, responsive care and affection in order for the social-emotional right-brain structures to develop normally. The brain structures involved include the limbic system and its associated orbitofrontal cortex, which is involved in the capacity to self-regulate. Evidence for the importance of attuned, responsive care can be seen in children who are raised in orphanages. Because they have missed out on these essential regulating experiences, they have areas in the emotional control parts of their brains that are not fully developed. Emphasizing the social nature of this shaping

process, Gerhardt (2004, p. 38) says, "[T]he kind of brain that each baby develops is the brain that comes out of his or her particular experience with people. . . . Our brains are socially programmed by the older members of our community, so that we adapt to the particular family and social group we must live among. . . . Without the appropriate one-to-one social experience with a caring adult, the baby's orbitofrontal cortex is unlikely to develop well."

A period of rapid neuronal growth, particularly in the social-emotional right-brain structures, takes place during the infant's first two years, at the same time that attachment patterns are being formed. This early proliferation of neurons must be shaped and "pruned" by interactive experiences with caregivers. The vital relationship experiences we describe in this chapter—the synchrony, resonance, and emotionally attuned responsiveness; the eye contact, touch, movement, and play—organize the developing brain and determine how the genetic makeup will be expressed throughout the lifetime. By providing well-modulated stimulation, the mother facilitates growth of neuronal connections between the orbitofrontal cortex and the limbic structures in the brain that mediate the capacity to self-regulate. Patterns of interactions and expectations—inner working models—are formed and the foundations are laid for later self-regulation. Margot Sunderland (2006, p. 22) describes it thus: "With emotionally responsive parenting, vital connections will form in [the child's] brain, enabling him to cope well with stress in later life; form fulfilling relationships; manage anger well; be kind and compassionate; have the will and motivation to follow his ambitions and his dreams; experience the deepest calm; and love intimately and in peace."

The Nature of the Social-Emotional Brain

The brain develops from the bottom up. The brain stem, the most primitive, central area, is functioning at birth. As we have said, the social-emotional brain has its major development in the first two years after birth. The highest parts of the brain, which are the cortical areas, including the left brain, are the last to develop. In order to develop properly, the brain requires appropriately timed and patterned responses at each stage of its development. Therapy with a child who has missed out on attuned responses must address the earlier needs before moving on to higher-level functions. Some of

them can be addressed only by providing experiences that would have been crucial for the development of the social brain in its primary developmental phase. A major focus of Theraplay treatment is on providing these experiences.

The basic structures of the brain stem and sensorimotor cortex are active at birth and maintain the essential functions of life—breathing, internal regulation of body systems, and the primitive fight, flight, or freeze response. Without the help of an attuned, responsive parent to help regulate the physiology of the young infant, however, she is in danger of overreaction and being subject to repeated states of traumatic dysregulation. The main task of parenting during this early period is to provide the external response to the baby's needs that keeps her in a regulated state.

The limbic system and its associated orbitofrontal cortex, what we are calling the social-emotional right brain, develops next. These structures are dominant during the first two years of life. Therefore, they receive much of the impact of the early parenting experiences that create patterns of attachment and are strongly implicated in the development of regulation. Gerhardt (2004, pp. 37–38) says that "The orbitofrontal cortex, which is so much about being human, develops almost entirely post-natally. . . . Without the appropriate one-to-one social experience with a caring adult, the baby's orbitofrontal cortex is unlikely to develop well."

The right-brain limbic system, including the orbitofrontal cortex, serves the dual purpose of attuning to the social environment and regulating the internal state of the body. It processes and regulates emotional information and manages emotional behaviors and responses to other people and their emotional cues. It mediates social life and is the neural basis for social interaction and empathy. As Gerhardt (2004, p. 36) says, "The capacity to empathize, to vicariously experience what [others] experience to some degree and to have an ability to infer their state of mind, requires a developed orbitofrontal cortex. It is particularly linked to the right side of the brain, which is specialized for grasping the general feel of things, the whole picture, and which is particularly involved in visual, spatial and emotional responses."

The right brain processes visual cues, sensory data, and nonverbal communications in a holistic way. It mediates pleasure and pain and the more primitive emotions. It is involved in the infant's ability to self-soothe and regulate bodily processes. It is the only part of

the brain that has a map of the whole body. The right brain also stores inner working models of relationships. It is the center for social cognition, understanding of others, and mindsight. The early experiences that shape the right brain make use of the "language" of the right brain, which includes nonverbal, face-to-face emotional communications involving rhythm, eye contact, attuned responses of pacing and intensity; these are the experiential food for the right hemisphere during early development.

In contrast, the later-developing left brain is specialized for non-limbic connections. It is involved in the infant's exploratory actions and is primarily linguistic, linear, and logical. The left hemisphere is slower in its processing and inept at reading nonverbal, social, or emotional cues. The left hemisphere has an "interpreter function," using pieces of information to assess distinctions and causal relationships. It is the left brain that is involved in the cognitive aspects of many traditional therapies.

In Theraplay we use the nonverbal language of the right brain rather than the verbal language of the left brain because we want to change brain patterns and expectations in the same way that they are formed initially. Describing this process, Mäkelä (2003, p. 6) says, Theraplay's "extensive use of touch, eye contact and 'parentese,' the calming and stimulating way of speaking throughout one's activities . . . creates a resonant hum of emotions through (ideally) noticing the minutest emotional cues of the child and responding to them. The response is often just an attuned statement of having noticed, but being noticed makes all the difference."

THERAPLAY IN PRACTICE

Using the Language of the Right Brain

The following example is from Mäkelä (2003, p. 5):

> A Theraplay-therapist is holding a panicky, [dysregulated, three-year-old] child in her lap, checking out what a wonderful girl she is. The girl cries until, all of a sudden, the therapist beeps her nose. The child is startled and smiles. The next time, with another sound coming from the therapist's nose,

the child giggles. Then, for three sessions she whines, cries, and turns away from all the therapist's advances. One day, to the child's amazement, a soap bubble pops before her finger even touches it. The therapist's voice shows similar amazement: what happened? The child, who has forgotten to whine, pops the next bubble, and the therapist rejoices. The next session, the child is suddenly still, absorbed by the eyes of the therapist, who attunes to every gesture and vocalization of the child, matching them to the nurture she is giving to the child's feet; playing peek-a-boo with them, rhyming the child's "mama" into a familiar song. Never before in her 3 years has the child been in prolonged eye contact. Now her eyes spell-bind the therapist, and her mother and me, looking from behind the mirror. Her whole countenance has changed from a frizzled rag doll look to an intense, oriented, girl of three. Two sessions later as she is cuddled in her mother's arms she reaches up to find the curly blond locks of her mother's hair and starts to play with them, looking intently into her mother's eyes. Her mother says her daughter was born to her at that moment. Needless to say, the intense separation difficulties and panicky behaviour that brought her into treatment had disappeared; there was soon no further need for treatment.

The Central Role of Affect Regulation

Brain research places the role of affect regulation at the center of human development and highlights the parent's crucial role in creating the child's capacity to self-regulate. Without the help of a co-regulating caregiver, the brain is awash in highly charged emotions. The following example illustrates how a healthy mother responds to and regulates her baby's distress.[6] Think of the response of a mother whose baby is upset and crying. What does she do? She intuitively matches the child's level of distress, and then gradually calms him. She picks him up and holds him close, rocking him up and down in strong, rhythmic motions that synchronize with the level of energy

of her infant's distress. Gradually she slows her pace and softens her voice. She may hum or sing "Hush, hush, hush, little baby" as she gradually offers her own capacity to self-regulate to the process of helping to soothe his distress. The baby can feel the vibration of his mother's chest as she hums and he can *feel her intention* to help him through this experience. Many repetitions of this type of behavior on the part of the parent provide the infant's immature nervous system the experiences it needs to learn to calm, organize, and soothe himself. If the mother were to hold the baby loosely, not bounce him, and not verbalize at all, the baby would not feel her presence and would not be soothed. If this happens chronically, he will not learn how to soothe himself or manage intense feelings, and he will also learn that no one can help him when he's distressed.

In healthy development the mother attunes to shifts in the infant's internal states of arousal as she gazes at her infant. She regulates her own state of arousal and then, using her capacity to attune to and resonate with her baby's affect, she in turn regulates her baby's state up or down as she senses his needs, thus leading to a dyadic regulation of emotion. Based on her attunement to the baby's state, she confidently initiates just the type of interaction that meets his need. Within the secure attachment relationship, the mother co-regulates the infant's developing central and autonomic nervous systems. As the child grows and develops, he internalizes these experiences and becomes increasingly able to regulate responses to emotional and sensory stimuli on his own. All of this is encoded in the brain as neural pathways.

In describing this process, Mäkelä (2003, pp. 5–6) points out that there are two ways that parents help their children learn more flexible internal state regulation: on the physical and on the emotional levels.

> The most primitive is the physical co-regulation of both negative and positive vitality-states. This is what good-enough parents do almost continually during the first months of life: holding, touching, stroking, vocalizing softly (or enthusiastically as the situation calls for) in "parentese." All these activities directly strengthen the calming limbic circuits in the child's brain. They are also direct ways to co-regulation at any age as this sensory input directly accesses the calming circuits.
>
> After the development of core-self and core-other consciousness at about eight months (Stern, 1985), the second way of helping the child

> create flexibility in reacting develops: emotional co-regulation. This happens through the attunement of vitality affect. The parent picks up the intensity or rhythm of the child's gesture and mirrors it back with a calming or positive modification through expression, voice and touch. In good-enough parent-child dyads, the attunement of the child's emotional communications happens nearly continuously while the child is awake and within communicative reach of the parent. This can be seen as a resonant flow of being together; a resonant hum of emotion.

According to Schore (1994, p. 33) such early parenting experiences lead to the creation of the capacity to respond to both positive and negative experiences without losing a sense of one's self. He says, "The core of the self lies in patterns of affect regulation that integrate a sense of self across state transitions, thereby allowing for a continuity of inner experience. Dyadic failures of affect regulation result in the developmental psychopathology that underlies various forms of later forming psychiatric disorders."

In Theraplay treatment, we look for ways to calm and soothe the overexcited child, to enliven the lethargic child, and in either case to develop a greater capacity for self-soothing. With the child who is easily overstimulated, we use a preponderance of calming, nurturing activities, such as quietly blowing a cotton ball back and forth, rather than having the child push the therapist over and end up in an exciting flip. When a child reaches too high a level of excitement, we slow the activity down to keep him from escalating out of control. With such a child, our goal is to increase his capacity to tolerate excitement without losing control.

THERAPLAY IN PRACTICE

Organizing and Down-Regulating a Chaotic Child[7]

When Brad ran around the treatment room chaotically, his therapist, Susan, took his hand and organized his running into a game of Ring-Around-a-Rosy. As they said, "All fall down," Susan quickly placed Brad in her lap facing away from her in order to reduce the stimulation. As he settled down she began

helping him make fingerprints in Play Doh. When he was quite calm, she fed him a chewy granola bar. On a regulatory level, Susan had joined Brad at his highly aroused state and organized his experience into a meaningful shared activity. She provided both the structure and the engagement to focus and organize his attention. Then she provided a nurturing experience—holding Brad on her lap, pressing his fingers into the Play Doh, and giving him something to eat—to soothe and calm him.

In contrast to the child in the example above whose dysregulation takes the form of high activity, the child in the following example has shut down, perhaps in response to stimulation that she cannot organize. She appears underresponsive to bids for connection and frequently disengages. With such a child, we use activities that engage and stimulate her at a level that does not overwhelm her so that she can be gently enticed into interaction.

THERAPLAY IN PRACTICE

Up-Regulating a Passive Child

Becky, a three-year-old child recently diagnosed with autism, participates with her father in an MIM. Becky has only fleeting interpersonal contact, does not speak, and has some repetitive movements. On the task, "Play Patty-Cake with the child," her father, Ned, takes her hands in his and rhythmically moves them to the words of the song. Becky looks at him during the first verse, but then her gaze drifts up to the ceiling lights. Ned looks up too and asks, "What are you looking at, honey?" When he releases Becky's hands, she wanders away from him. He looks disappointed and says, "Not interested in Patty-Cake, huh?" Later in an interview, he describes Becky as a "phantom" in their home, someone who constantly is slipping away from interaction with her parents. Over six months of

weekly treatment, her therapist, Sharon, finds playful, physical, interactive ways to engage Becky and then prolong that engagement through turn taking. Sharon catches a bubble on a wand and holds it in front of Becky for her to pop with her finger. She presses the tip of Becky's nose and makes a "beep" sound and encourages Becky to reach out to touch her therapist's nose to hear her beep. Sitting across from Becky on the floor, she puts Becky's feet on her chest and encourages Becky to push her over on the count of three and then pull Sharon up with her hands to see her smiling face. At first Becky does these activities passively and without expression. Within a few sessions, Becky is smiling in response to her therapist's smiles and animated facial expressions. Becky begins to fill in words in the phrase, "Ready . . . set . . . go" and press Sharon's nose longer for a drawn out "BEEEEEP." After twenty sessions, Becky sang along to "The Wheels on the Bus" and independently recalled words of the song. Her mother later reflected that Becky "not only had to be taught how to interact, she had to discover that it was a highly enjoyable thing to do."

Responding sensitively to a child's needs requires careful attunement to the child's rhythms of engagement and withdrawal. The mother must sense her child's readiness for interaction and respond with synchrony and affective resonance in ways that, as we have seen, lead to moments of shared joy. She must also allow him periods of quiet disengagement while she remains alert to his signals that he is ready to reengage. There cannot, however, always be such perfect attunement. Schore and Schore (2008) remind us that there will, inevitably, be moments when the mother misattunes to her child's needs. At these moments it is essential that she reconnect with the child. "In moments of interactive repair, the 'good enough' caregiver who has misattuned, can regulate the infant's negative state by accurately re-attuning in a timely manner. The regulatory processes of affect synchrony that create states of positive arousal and interactive repair that modulate states of negative arousal are fundamental building blocks of attachment and its associated emotions, and resilience in the face of stress and novelty is an ultimate indicator of attachment security" (p. 11).

Using Brain Development as a Guide for Treatment

As we have said, the most significant impact of the new findings about the brain is the emphasis on dyadic regulation. Any therapy that attempts to create change must include significant attention to co-regulation of the interactive experience. Schore and Schore (2008, pp. 17–18) state that a therapeutic approach must be "rooted in an awareness of the centrality of early dyadic regulation, a thorough knowledge of right hemispheric emotional development, and a deep understanding of the dynamics of implicit procedural memory. An understanding of the right-brain mechanisms that underlie bodily-based, non-verbal communication is essential."

As a result of his extensive study of the effects of trauma on the brain, Perry (2006, p. 39) says that an understanding of how neural systems develop suggests specific therapeutic interventions. Matching the correct therapeutic activities to the specific developmental state and physiological needs of a maltreated or traumatized child is a key to success. "Therapeutic activities will be most effective if they are provided in the sequence that reflects normal development—from the brainstem up." In order to keep the child's state of arousal at a manageable level, a sense of safety is essential. "Music and movement activities that provide patterned, repetitive, rhythmic stimulation of the brainstem [can help] modulate brainstem dysregulation." Though Perry is talking specifically about children who have been traumatized, his recommendations are useful for all children who have had experiences that disrupt their ability to self-regulate and respond with resilience.

Attunement and regulation are a major focus in Theraplay. As we work with the child and with his parents, we provide experiences of co-regulation in the same way that parents do with infants: lending our whole self to the task of resonating, synchronizing, attuning, and regulating. We intervene at the appropriate physiological level to connect with the dysregulated child and capture the "attention" of his right brain.

Keeping in mind the neurosequential development of the brain from the bottom up, as Perry suggests, we direct our work with each child to the appropriate level to meet emotional and regulatory needs. If the child is in a state of panic, we focus on soothing the most primitive part of the brain—where the fight, flight, or freeze response holds sway—by helping parents to provide gentle rhythmic rocking

and other soothing experiences that affect the child at the most basic level of brain function and development. If the child is somewhat calmer, we can use a wider spectrum of emotional communication. In our work with children of all ages, we use Theraplay's full range of playful, engaging interactions that seem designed for younger children in order to communicate with the early developing areas of the brain. When adapted sensitively to the child's developmental age, they can support later corrective development and regulation. As Mäkelä says, (2003, p. 6) "this is . . . the basic stuff of Theraplay. . . . Theraplay is not effective because of a series of playful activities. The activities are the going-on-being of Theraplay while the resonating of every possible emotional expression of the child is the crucial element in communication."

Once the child is sufficiently calmed and well regulated and has established a secure attachment, other approaches to treatment can be added, approaches that address the logical, linguistic left brain in order to help the child understand and process her experiences, beliefs, and early trauma. In Chapter Nine, we discuss how to adapt Theraplay for children who have experienced complex trauma and include a section on how to combine Theraplay with other modes of treatment.

THERAPLAY IS MULTISENSORY

Just as in the healthy baby experience, Theraplay involves all the senses. The therapist and the parents engage the child in interactions that involve the whole body and make use of the many physical aspects of the language of the right brain; encouraging eye contact, echoing sounds, and providing sensory-motor stimulation and rhythmic movement. They also use touch to enhance the connection, to soothe and regulate and to increase the child's awareness of self. Taste and smell are also involved in many nurturing activities.

Stimulating the Body Senses

When we jump up and down with a child, lift him high in the air, or firmly rub his arms and legs with lotion, we are stimulating the body senses in the same way that parents do. The importance of such stimulation in both physical and emotional development is confirmed by Williamson and Anzalone (1997, pp. 31–32) in their study of

sensory integration problems in children with severe difficulties in relating and communicating. They found that the engagement of a child's "tactile, vestibular, and proprioceptive systems are intimately involved in the infant's developing sense of self and ability to interact motorically and emotionally with people and objects."[8] It is the specific involvement of touch (tactile system), the sense of where you are in space (vestibular system), and the use of muscles, tendons, and joints to create an awareness of the position of your body in space (proprioceptive system) that spurs this growth. They found that sensory stimulation for "children who have problems in these systems enables the child to attain desired sensory thresholds, achieve an optimal level of arousal and attention, and support a more positive affect during social and environmental interactions" (p. 36).

Some children's tactile defensiveness makes it very difficult for them to accept the soothing, nurturing touch that is so essential in learning that their parents can be a source of comfort to them. Again, we help such children increase their comfort with touch by gradually introducing them to various levels of touch (firm touch is usually more acceptable than light touch) and various kinds of textures (cotton ball, feather, powder, lotion).

Other children find it very difficult to manage their bodies in space, or to handle vestibular stimulation. Their difficulty leads them to avoid active off-balance movement and to resist letting anyone move them about. For such children it is important to introduce them gently to a variety of postures in a relaxed, reassuring manner in order to help them overcome their fears and learn that it is safe to move about freely.

Still other children have such a need for proprioceptive stimulation that they are constantly jumping up and down, flapping their hands, and becoming overexcited. The active physical play in Theraplay organizes their frantic, random movements and yet gives them plenty of much-needed sensory stimulation. Combining a focus on the relationship with treatment of specific sensory integration problems is helpful to many children. In Chapter Seven we discuss how an understanding of sensory sensitivities can be helpful in the treatment of children with disorders of sensory regulation. For all children, however, stimulation of the bodily senses feeds both their sense of self and their ability to form relationships.

The Importance of Positive Touch

It is worth considering the importance of the sense of touch in more detail, both because of its role in development and because of the depth of relevant research. Touch is indeed fundamental to the human experience. As Brazelton (1990, p. 561) says, "Touch functions on many levels of adaptation, first to make survival possible and then to make life meaningful." Because Theraplay uses the parent-child interaction as our model, touch has always been important in our work. Myrow, describing the value of touch in Theraplay, says (1997, p. 1), "With the experience of touch from a loving caretaker, the child develops a sense of self; the capacity to relate to other people; essential skills in modulating affect; a sense of being able to master the environment; and a belief in his own worth." When we encourage parents to include more touch in all their interactions, we are helping them foster a secure attachment by becoming the source of comfort and calm for their child.

THERAPLAY IN PRACTICE

Using Touch to Deepen the Connection

Touch was an important part of the Theraplay interaction between eight-year-old Jenny and her adoptive mother. Jenny was adopted at age two after significant loss and trauma. In a follow-up session five years after the ending of regular Theraplay sessions, Mom and Jenny sit across from each other on the couch. As she had done in many of her earlier Theraplay sessions, Mom puts a line of small dots of lotion from Jenny's ankle to her knee, counting as she goes, " One, two, three, . . . sixteen, seventeen, eighteen! Look how long your leg is. I can't believe it! Do you know how long you were when I first met you? Five dots! Five dots long. Your foot fit right into the palm of my hand." Mom massages the lotion in with firm strokes as Jenny smiles in delight and nestles close to her.

Concern about the possibility of negative or harmful touch has led many administrators and professionals—school principals, teachers, therapists, caregivers—to avoid the use of touch as much as possible. In some settings touch is forbidden between adults and children. While we emphasize that it is essential to avoid all inappropriate or harmful touch, we do not agree that avoiding touch altogether is a good solution. Touch is essential to healthy development; denying touch to children in schools and other settings could have harmful consequences. The way to avoid accusations of bad touch is to make sure that all touch is appropriate and meets the needs of the child. In Theraplay, all treatment is videotaped so that any question about the appropriateness of touch in any given situation can be verified. If children are deprived of the kind of touch that leads to self-esteem and connection to important people in their lives, they may seek touch in inappropriate ways. The solution is to provide good touch, rather than no touch.

EFFECT OF TOUCH ON SOCIAL DEVELOPMENT. The importance of touch in social development and attachment is well established. In an effort to explore the factors that lead to infant bonding, Harlow (1958) raised infant monkeys in isolation. Given the choice between a wire surrogate mother that had a nipple with milk available and a terry cloth surrogate with no milk, the monkeys clung to the terry cloth for comfort even at the expense of almost starving themselves. Harlow (p. 676) states that "contact comfort is a variable of overwhelming importance in the development of affectional responses." Even the comfort of a soft-textured surrogate, however, could not substitute for the care of a real mother. The monkeys reared in isolation behaved in autistic-like ways. They indulged in stereotyped behaviors and often turned to their own bodies for comfort. They were incompetent in peer relationships and later were inadequate parents, if they could mate at all.

Considering the infant's innate need for physical contact, Montagu (1971, p. 136) concluded that "the behavior and motivations of all mammalian infants are directed toward maintaining [physical] contact with the mother. Contact seeking is the foundation upon which all subsequent behavior develops." Starting from Bowlby's premise that physical contact with an attachment figure is the most important signal to an infant that he is safe, Main (1990, p. 484)

argues that the accessibility of that primary attachment figure in times of stress, or as support for exploration, is an "organizing principle in the infant's behavior." (See the next section for more discussion of touch and stress reduction.) If the attachment figure is not within reach or physically accessible, or especially if she rejects the infant's touch, anger and conflict may develop in the infant.

EFFECT OF TOUCH ON PHYSIOLOGICAL AND INTELLECTUAL DEVELOPMENT. In addition to promoting psychological and emotional well-being, touch also regulates physiological development. Clinical data suggest that early tactile experience influences an infant's immunological response, growth rate, weight gain, and ability to withstand stress. For example, Field's research (1995, p. 107) shows that preterm infants given daily full body massages show a greater weight gain, increased activity, and higher levels of performance on the Brazelton Neonatal Behavioral Assessment Scale.

Touch has also been found to be a significant factor in guiding perceptual and cognitive development. Barnard and Brazelton report, for example, that touch can increase an infant's sensorimotor performance, learning, responsivity, and visual recognition capacity (Barnard and Brazelton, 1990).

Although there has not been extensive work on touch in relation to adolescents and adults, preliminary research suggests that touch remains important for the maintenance of both physical and emotional health at all ages (Field et al., 1998; Fanslow, 1990). For example, Diego, Field et al. (2002) found that aggressive adolescents benefited from massage therapy, and Hart, Field, and Hernandez-Rief (2001) found that anorexia symptoms are reduced by massage therapy.

EFFECT OF TOUCH ON MANAGEMENT OF STRESS. As we have seen, studies indicate that touch is important in regulating infant stress. Tronick (1995, pp. 64–65) also found that babies who were touched by their mothers during an experimentally induced, brief stressful episode showed reduced levels of stress as compared with babies who were not touched. He concluded that "touch is a component of the mutual regulatory process of the caretaker-infant dyad and that it serves as an external regulator of the affective and behavioral organization of the infant." Tronick also theorizes that different forms of touch convey different messages. Gentle holding and stroking, for example,

communicate safety, soothing, and comfort. Poking and pinching, on the other hand, convey threat. In this sense, touch may be seen as critical to the communication system between mothers and infants.

Mäkelä (2005) cites research which indicates that ample stroking, touching, and cuddling can overcome a genetic susceptibility to anxiety and low stress tolerance in both rat pups and monkeys. "A strong genetic predisposition [in rat pups] to anxiety is associated with weak nurturing. However, if the susceptible rat has received profuse licking during infancy, she behaves toward her own pups as though she did not have this genetic predisposition toward anxiety and weak nurturing." Similar research using rhesus monkeys found that anxious, irritable monkeys whose mothers seldom hug and cuddle them develop lower problem-solving skills and remain at the bottom levels of the social hierarchy. If, however, monkeys with the same genetic predisposition to anxiety and irritability are placed with mothers who cuddle and touch them frequently, the adopted monkeys increase their inquisitiveness and ability to explore.

EFFECT OF TOUCH ON BODY IMAGE. The development of body image is also affected by the quality of touch a young child receives. Weiss (1990, p. 428) reviewed the literature on the connection between tactile experience and the development of body perception. He cites research suggesting that if a human infant is not touched and handled sufficiently at an early age, he may develop a distorted body image. "Studies have indicated that an individual who receives body contact from others over most body areas, in contrast to only a few areas, generally feels more attractive, closer to other persons, possesses an accurate perception of the form and shape of his body, and has a more positive liking for himself as a person" (p. 432).

As these wide-ranging investigations show, the evidence for the importance of touch in the interaction of parents with their children is overwhelming. Touch is part of the primary vocabulary of the right brain. Clearly, as a treatment intended to help a child form an attachment, improve self-image, and regulate or modulate anxiety, Theraplay is confirmed in its inclusion of positive touch as an important part of its treatment model.

THERAPLAY IS PLAYFUL

Theraplay involves emotionally attuned, interactive, physical play. Play entices the child into a relationship and introduces an element of joy and excitement that is essential to the development of a zest for life and energy for engagement in all children. In Theraplay, positive affective states of excitement and joy are tuned into and amplified in physical play that helps the child learn to share and expand joyful experiences and also to modulate them so that they do not become overwhelming.

Optimal Arousal, Shared Joy

Stern (1974, p. 416) stresses the importance of play in providing joyful, positive experiences. He writes, "The more games with which a mother can interest and delight an infant, the more practice he will have in experiencing affectively positive arousal . . . in a greater number of human situations." A familiar form of play between a father and his baby helps to illustrate this: the father holds the baby high in his arms. With a big smile on his face he throws her into the air and catches her in a warm embrace. He does this just the right number of times, in just the right rhythm, and at just the right height so that she increasingly enjoys the experience but does not become overwhelmed. Sensing when to stop, he cuddles her in his strong arms, rocks her in a soothing manner and talks gently to her. "You are my big girl. We had fun together."

In her review of research into what informs good parenting, Sunderland (2006) emphasizes the value of gentle physical play between adult and child as well as rough-and-tumble play—the kind of play "which can transport children into states of joy and often results in a child's bursting into squeals of laughter or delight" (p. 104). "Joy is the result of human connection. With high levels of bodily arousal, optimal levels of epinephrine rushing through the body, and optimal levels of dopamine and opioids cascading over the brain, we feel intensely alive, wide awake, and with tons of energy to do what we want to do" (p. 91). She calls this "joy juice," asserting that we gain access to this essential compound through emotional connection with others.

Theraplay's playful approach replicates the warm, intimate contact between mother and baby that produces these elevated brain opioids,

the endorphins that increase pleasure in the brains of both the mother and the baby.

Synchrony and Healthy Relationships

Episodes of play create a state of affective synchrony, in which both players are in affective resonance with each other. This state of resonance created through facial expressions, play, and physical contact enhances the development of synapses in the child's brain (Hart, 2008). They also lead to heightened awareness and exhilaration that enhance self-esteem and create strong connections.

Winnicott describes the importance of play in creating an intermediate area of experience between subjectivity and objectivity, that is, play that bridges the reality-based play of the mother with her infant and the fantasy-based play that comes later. He writes, "*It is play that is the universal*, and that belongs to health: playing facilitates growth and therefore health; playing leads into group relationships" (1971, p. 41) [emphasis in original].

As we have said, the workings of our nervous systems are based on rhythm, resonance, and synchronicity. The kind of organized, interactive play that Theraplay encourages provides just the sort of rhythmic, well-regulated, joyful synchronicity that has been found to be crucial in a child's development. The creative rhythms of another human being are the stuff of rich growth. Children who are instead constantly involved in video games are learning only the rapid rhythms of the electronic game; too often these rhythms are coordinated solely around life-and-death struggles and violence.

Stress Reduction and Regulation

Play reduces stress and helps in the regulation of a child's emotions. Blowing raspberries on a child's tummy, tossing her in the air, spinning her around, and other spontaneous, unpredictable activities have natural antistress effects and are important for long-term emotional health. Such play, Sunderland (2006, p. 104) says, can "enhance the emotion-regulating functions in the frontal lobes, helping children to manage their feelings better." During play the body's arousal system (autonomic nervous system) is activated with high levels of adrenaline. Repeated activation of these brain chemicals in childhood enables the child to be spontaneous and to feel awe and

wonder about the world. Not only does this attitude of openness to new experiences create a healthy approach to life, the particular brain chemistry also promotes resilience in the face of stress. It is perhaps obvious, but worth noting, that joy itself tends to counteract negative emotions, thus promoting a more positive and calm attitude.

Brain Organization

Play also has a profound effect in creating new neural connections in the brain. The elevated endorphins created by the kind of intimate, playful contact between mother and child that we have discussed help in forming new synapses and in optimizing brain organization. Sunderland (2006, p. 104) reports that play activates a "fertilizer" in the higher brain called brain-derived neurotrophic factor (BDNF), which "helps to program the regions in the frontal lobes that are involved in emotional behavior. Research shows that there is increased gene expression of BDNF in the frontal lobes after play." Such play enhances "the development of [the] higher human brain, with all its amazing functions, including better management of emotions and stress." In Theraplay we provide many opportunities for parents and their children to play together. In doing so, we enhance these higher brain functions and support the management of emotions and stress. The following case describes in the child's own words her experience of the wonderful effects of play.

THERAPLAY IN PRACTICE

"Playing Makes My Mind Feel Calmer"

Maria was adopted from Guatemala at the age of nine months. Her infancy was filled with severe deprivation and probable abuse. When her adoptive parents first met her, she seemed miserable; at times she was aggressive toward them. As a toddler and preschooler she was extremely sensitive and reactive to her to surroundings. As time passed, Maria developed into a smart, curious, verbal, and controlling child who had frequent severe episodes of dysregulation. Her initial Theraplay sessions, which began when she was five years old,

consisted primarily of very simple, playful, reciprocal activities between the therapist and Maria and between Maria and her mother, for example, blowing cotton balls back and forth on a scarf, decorating each other with five feathers in matching places, and measuring Maria with crepe paper strips. A favorite game was La La Magnets. The parent and child hold hands and swing them side to side chanting "la la la." When the therapist says "elbows," they touch elbows, then la la la fingertips, la la la foreheads, and so on. The mother said she used this game at home to get cooperation when bathing Maria. Maria's behavior gradually settled and she became less explosive. After the first three sessions, Maria volunteered that the play sessions made her want to cry less. After several months of Theraplay, Maria learned that her thirteen-year-old cousin, Sarah, was having severe behavior problems. Maria spontaneously said, "Maybe Sarah should have Theraplay. I don't know how it works, but playing makes my mind feel calmer." Maria's mother reports that Maria is now much happier and more relaxed. "Theraplay has helped her be able to play with other children."

The Harmful Effects of Lack of Play

In his book on how play shapes the brain, Stuart Brown (2009) reports on research that indicates that young rats who were denied opportunities for rough-and-tumble play develop numerous social problems when they become adults. They fail to recognize social cues and the nuances of rat hierarchy; they aren't able to mate. By the same token, people who play as children "learn to handle life in a much more resilient and vital way."

Children who don't have enough time for socially interactive play will compensate by playing more roughly and at the wrong times. Such children are often labeled as having attention-deficit hyperactivity disorder (ADHD). Panksepp (2007, p. 14) posits that more free play could reduce the rising incidence of ADHD, which he ties to fewer and fewer opportunities for children to engage in naturally, self-generated social play. Panksepp suggests that "[s]ustained satisfaction of the primal PLAY urge may reduce the incidence of impulse control

disorders by promoting pro-social regulatory functions of the frontal lobes. . . . Real play opens up the possibility of using all of our natural emotional tools for the epigenetic construction of social brains."

Recently published research at the Albert Einstein College of Medicine headed by Romina Barros confirms Panksepp's suggestion that children would do better if they had more time to play (Parker-Pope, 2009). Children who had more than fifteen minutes of recess each day showed better behavior in class than children who had little or none. Concentration and learning seemed to improve as well.

Play, then, is central to children's healthy development. Theraplay's playful approach is able to stimulate, entice, and delight children who have turned away out of fear or hopelessness or whose inherent underreactivity has made it difficult for them to respond. Such playfulness helps them risk allowing themselves to connect with and to share joy with others. Play can help to repair the early relationship and developmental patterns that have led to their difficulties.

In summary, Theraplay's core concepts, which are the foundation of its treatment approach, are clearly supported by research related to attachment theory and brain development. Over the last forty years, Theraplay has provided effective, research-informed treatment that continues to be refined as our knowledge of relationships and brain development increases. In the next chapter we review the research that has been done to assess the effectiveness of Theraplay.

Notes

1. See Oppenheim and Goldsmith, 2007, for examples of such work.
2. Bowlby defines attachment behavior as "any form of behaviour that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world. It is most obvious whenever the person is frightened, fatigued, or sick, and is assuaged by comforting and caregiving. At other times the behaviour is less in evidence. Nevertheless, for a person to know that an attachment figure is available and responsive gives him a strong and pervasive feeling of security, and so encourages him to value and continue the relationship. Whilst attachment behavior is at its most obvious in early childhood, it can be observed throughout the life cycle, especially in emergencies" (Bowlby, 1988, pp. 26–27).

3. This Theraplay in Practice example is based on Dafna Lender, "What's Behind These Theraplay Activities: A Window into Attachment." *The Newsletter of the Theraplay Institute,* Summer, 2006.
4. The following is a list of the good outcomes for children who are securely attached. In order to emphasize the value of secure attachment, the Circle of Security leaders present it to parents and ask them to identify which of these outcomes they want for their children. (Source: Kent Hoffman PowerPoint Presentation. "Understanding Attachment: The Circle of Security Approach," Chicago, IL, July 18–19, 2008.)

   Fifty years of attachment research have shown that children who are securely attached:

   - Enjoy more happiness with their parents
   - Feel less anger at their parents
   - Get along better with friends
   - Have stronger friendships
   - Are able to solve problems with friends
   - Have better relationships with brothers and sisters
   - Have higher self-esteem
   - Know that most problems will have an answer
   - Trust that good things will come their way
   - Trust the people they love
   - Know how to be kind to those around them

5. This example is based on Dafna Lender, 2006.
6. This example is based on Dafna Lender, 2006.
7. This example is based on Dafna Lender, 2006.
8. The tactile system functions both for protection and discrimination. The vestibular system tells you where you are in space and is important in maintaining an appropriate level of arousal. The proprioceptive system consists of receptors in the muscles, tendons, and joints that provide the perception of movement and position of the body in space (Porges, 1993).

CHAPTER THREE

Research Findings That Support the Effectiveness of Theraplay

Rand Coleman

Theraplay has progressed in the past forty years from being a treatment supported mainly by clinical report and case study to a treatment supported by experimental evidence. It has progressed from being used for only a few psychiatric disorders to having demonstrated efficacy with many emotional and psychological problems, including situations of dual diagnosis.

The early theory and format for what later became Theraplay was developed by DesLauriers and Carlson as a treatment for autism. In the 1960s they made an effort to assess their work using a multiple case study approach; the results of this study were eventually published in *Your Child Is Asleep: Early Infantile Autism, Etiology, Treatment, Parental Influences* (1969). Five children with severe autism were studied intensively over a period of a year while receiving this new method of treatment. The children showed statistically significant gains on intellectual and adaptive skill batteries, improving much more than would be predicted by development alone (for example, within a year one child's Vineland score increased from 54, moderately impaired, to 73, borderline, and his Cattel IQ increased from 57 to 70). Personality and socialization qualities were measured

with the Fels Scales (which included such subscales as Affectionateness, Conformity, Friendliness, and Gregariousness), and these scales showed consistent improvements for all the children. Improvements were documented by separate raters: parents, therapists, and clinic observers.

Ann Jernberg, using a modified form of DesLauriers' technique that she called Theraplay, produced two films, each with three-year follow-ups, which demonstrated Theraplay's clinical utility in working with children in Head Start programs (Jernberg, Hurst, and Lyman, 1969, 1975). She published a variety of qualitative case descriptions, reporting clinical improvement when using Theraplay with clients suffering from a range of problems including oppositional behavior, relationship problems, and social withdrawal (Jernberg, 1976, 1979, 1984, 1989). Although the cases were highly instructive, from a research standpoint they suffered the weakness of being mostly qualitative and anecdotal in their descriptions.

Kupperman, Bligh, and Goodban (1980) used a case study approach when examining the innovative integration of Theraplay with speech therapy techniques. Target phonemes were embedded into the Theraplay activities of six children with articulation disorders. After only twelve sessions for five subjects and ten sessions for one subject, all the children showed improvement in articulation, compared with baseline. Lack of controls limited the conclusions, but the authors noted that the very short length of treatment (six weeks) argued against maturation as the agent of change.

Since 1994, Theraplay has been subjected to research with an expanding variety of clinical populations. These are summarized below by general domain.

ATTACHMENT DISORDER

Theraplay's use of attachment-based play and its promotion of emotional connection between family members make it a natural choice of therapy for children with attachment and relationship problems. Indeed, Theraplay is commonly used by some clinics specializing in treatment of attachment problems (Walters, personal communication, 2008). The SOS Children's Villages in Finland—microcommunities designed specifically for the care of children who cannot live with their biological parents—serve a large population

of children with special emotional needs who are in long-term foster care. Theraplay has been used as one method of treatment for both internalizing and externalizing emotional disorders (Mäkelä and Vierikko, 2004). The authors reported that the conditions of abuse, neglect, and loss necessitating long-term care in the SOS Villages predisposed the children to attachment problems in addition to other behavioral deficits. An initial screening using the Child Behavior Checklist (CBCL) (Achenbach, 1991a), with all children in SOS Villages across Finland found that over 50 percent of the children had clinically significant scores, defined conservatively at or beyond the 95th percentile, on one or more scales of the CBCL.

Due to the lengthy travel distances from remote SOS Villages to clinics providing treatment, Theraplay was provided in two four-day intensive sessions about six weeks apart. Twenty children ranging in age from four to thirteen years participated with their foster parents in the Theraplay treatment. Children who continued to have emotional deficits after living in care for over one year and who were not participating in other forms of treatment were selected for the project. The treatment format included pretesting, posttesting, and a six-month follow-up, relying on repeated measurement with the CBCL to assess change over time. Results across all children and all scales showed marked decrease in symptoms. Immediate changes were noted after completion of therapy when compared to baseline (significant at $p = .002$), and further change was documented after an additional six months had passed ($p < .001$).

Internalizing behaviors on the CBCL are defined and measured by the subscales for Withdrawal, Somatic Complaints, and Anxiety-Depression, while Externalizing characteristics are measured by subscales for Rule-Breaking Behavior and Aggressive Behavior. Other subscales include Social Problems, Thought Problems, and Attention Problems. As shown in Figure 3.1, both Externalizing and Internalizing features decreased immediately after therapy and remained lowered at the six month follow-up.

An analysis of boys and girls separately across individual subscales showed that both boys and girls benefited and reductions in clinical measures were obtained across all scales used for measuring Externalizing and Internalizing characteristics. In some cases, the reduction in symptoms was more dramatic after the six-month follow-up than it was immediately following conclusion of therapy

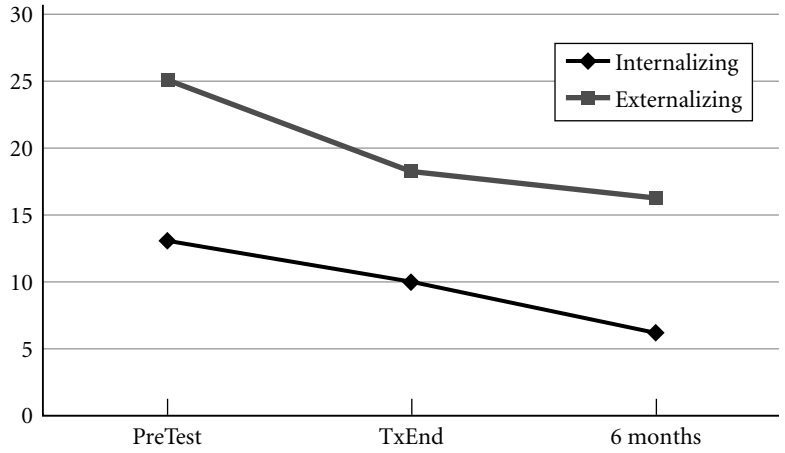

Figure 3.1. Change in Internalizing Versus Externalizing Symptoms with Theraplay

(for example, Social Problems and Attention Problems for boys), suggesting that therapeutic learning and change within the family system was maintained over time. Results are summarized in Figures 3.2 and 3.3.

The study included videotaped administration of the MIM at baseline and after completion of therapy. A method of rating interactions based on Theraplay dimensions of structure, challenge, engagement, and nurture was used, although the method was not described. They reported improvement on all dimensions.

Two available Theraplay studies have explicitly measured change in attachment. Margot Mahan (1999) conducted detailed pre- and posttest case studies with fraternal twins (boy and girl) adopted from an Eastern European orphanage, both diagnosed with attachment disorder. After treatment with Theraplay both children showed significant improvement on the Randolph Attachment Disorder Questionnaire (Randolph, 1999), each showing symptom reduction of over 50 percent. The male twin showed nominal to no significant change on Internalizing and Externalizing features of the Child Behavior Check List (CBCL), whereas his sister showed significant improvement on both Internalizing and Externalizing scales. In a separate study, the Kinship Questionnaire was used as a pre- and

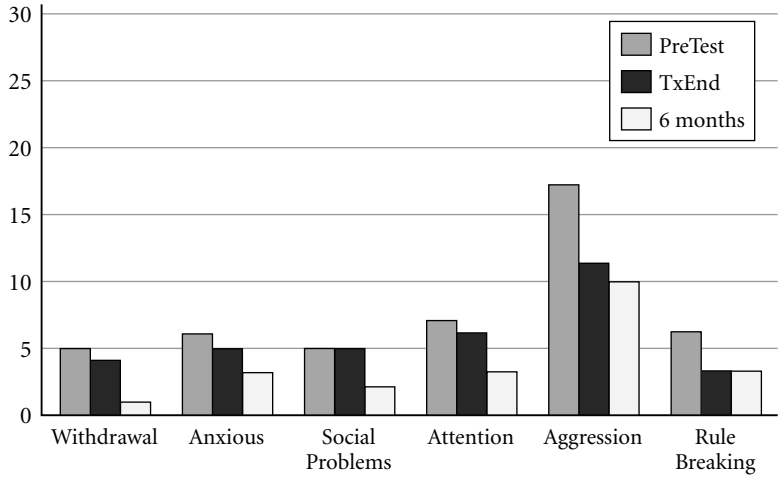

Figure 3.2. Subtest Change for Girls on CBCL

posttreatment measure to assess attachment (Meyer and Wardrop, 2005). Nine of the ten children in the study showed improvement in scores. A t-test comparison for the aggregate pretest to posttest scores was statistically significant, despite the small sample size. Limitations of the studies included small sample size and lack of control groups.

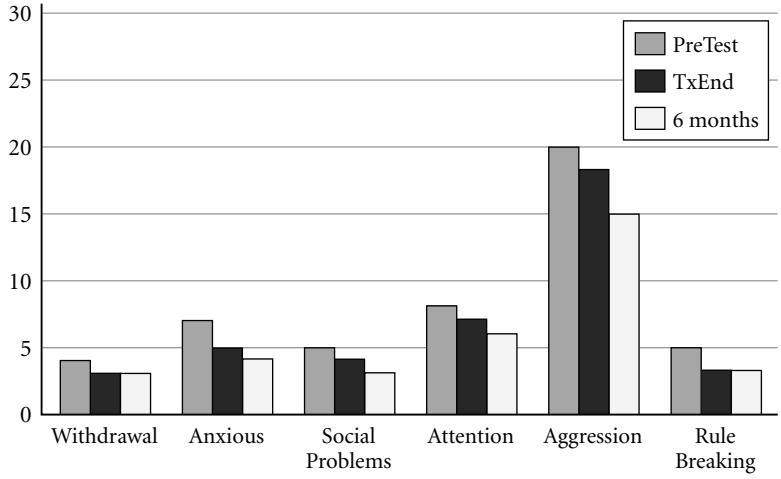

Figure 3.3. Subtest Change for Boys on CBCL

PERSONALITY VARIABLES: EXTERNALIZING AND INTERNALIZING FEATURES

The study by Mäkelä and Vierikko (2004) described above showed significant improvements in both externalizing and internalizing characteristics of children with serious mental health and behavioral problems. However, prior to their project, Catherine Morgan (1989) demonstrated the power of Theraplay to positively affect the personality variables of self-esteem, self-control, self-confidence, and trust of others. Sixteen children were studied over a five-month cycle of therapy at the York Center for Children, Youth, and Families in Ontario, Canada. Lacking a control group, the study utilized a pretest, posttest design. Ratings of the four personality dimensions were done by therapists, session observers, parents, and teachers on simple Likert-type scales designed for the purpose. Improvement was graded in terms of very positive (two Likert scale points up), somewhat positive (one Likert scale point up), no change, or negatively (drop in Likert scale ratings). Statistical analysis was primarily limited to a binary (improved–not improved) listing of overall positive or negative outcomes, which varied between rater types, with cumulative percentage of clients improved. Teacher and parent ratings were very similar, both showing 90.9 percent of clients improved, while therapist ratings resulted in 62.5 percent of clients improved.

The rates of improvement were very promising, especially considering that eight of the children had a clear psychiatric diagnosis (including ADD or ADHD, Learning Disability, Depression, or Developmental Delay), and the others had presenting behavioral problems that included social deficits, aggression, anxiety, defiance, and tantrums. The authors noted that parents tended to rate self-esteem, self-confidence, and trust as most improved, whereas teachers most often rated trust and self-control as improved. Limitations of the study included lack of a control group, missing data for parent and teacher ratings on some children, and a highly heterogeneous clinical group. Number of sessions ranged from four to thirty-four, with a mean of seventeen. The positive findings were impressive considering the small number of sessions involved for many of the children, suggesting that Theraplay can truly be a short-term therapy for many children, but also raising the question of whether those youth rated as unimproved might have demonstrated

gains with a longer course of treatment. Another weakness was lack of blind, third-party ratings, or other objective data to demonstrate improvement. It is certainly possible that knowing that a child was in therapy created positive expectations for parents and teachers that resulted in better ratings.

Change in internalizing characteristics, as measured by the CBCL, and improvement in self-esteem, as measured by the Culture-Free Self-Esteem Inventory, was further studied in a Hong Kong sample of forty-six children presenting for therapy who had obtained clinically elevated scores on the CBCL (Siu, 2007, 2009b). By using standardized measures for all variables, using a wait list control group, randomly assigning subjects to groups, and focusing the study on a relatively homogenous sample, Siu addressed some of the weaknesses of previous studies. Twenty-five boys and twenty-one girls between grades two to four participated in the project.

Results are summarized in Table 3.1 and Table 3.2. Eight sessions of Group Theraplay were conducted by certified Theraplay therapists. Mothers were included in sessions, first as observers and then as participants. The intervention was associated with significant improvement in Internalizing scores, suggesting improvement on scales of social withdrawal, somatic symptoms, and anxiety-depression. All variables from the Culture-Free Self-Esteem Inventory-III were significantly improved as well.

Improvements in self-esteem were also found in a study conducted with Korean children in Seoul (Hong, 2004). Twelve children living in a group home because of abuse by their biological parents were assessed with the Self-Esteem Inventory. Six children served

Condition	**Time**			
	Pre-Intervention (T1)	***Post-Intervention (T2) T-Scores***		
	Means (SD)	Means (SD)	Eta-Squared	F
Theraplay	64.68 (3.40)	57.68 (2.37)	0.26	15.46*
Wait list Control	64.50 (3.18)	64.16 (2.89)		

Table 3.1. Paired T-Tests of Pre- and Post-Intervention of CBCL Internalizing T-Scores for the Two Conditions

Note: * $p < 0.01$

Source: Siu, 2009b, used with permission.

Condition	Time		
	Pre-Intervention (T1)	*Post-Intervention (T2)*	
	Means (SD)	Means (SD)	t
Social			
Theraplay	10.90 (1.23)	13.77 (1.23)	−11.93*
Wait list Control	10.16 (1.30)	10.08 (1.41)	0.49
Parental/Home			
Theraplay	6.77 (1.50)	8.00 (1.60)	−5.64*
Wait list Control	7.08 (1.28)	6.50 (1.03)	3.07*
General			
Theraplay	6.31 (1.67)	8.54 (1.62)	−11.32*
Wait list Control	5.20 (1.88)	5.54 (1.79)	−1.88

Table 3.2. Paired T-Tests of Pre- and Post-Intervention on CFSEI-III Subscales on Social, Parental/Home, and General for the Two Conditions

Note: * $p < 0.01$

Source: Siu, 2007, used with permission.

as controls and six underwent twelve sessions of Group Theraplay delivered over twelve weeks. Despite the small sample size and the limited number of sessions, statistically significant results were obtained, indicating improvement in self-esteem in the group receiving therapy.

Emotional Intelligence, measured with the Emotional Intelligence Checklist, was significantly improved in a nonclinical group of preschoolers, who received Group Theraplay for twelve sessions over six weeks (Kwon, 2004). Pretesting showed no differences between the treatment and control group, whereas posttesting found differences in the capacity for self-awareness, self-control, awareness of others, and overall EQ. These latter two studies strongly supported the idea that Theraplay can work quickly to improve various dimensions of social-emotional functioning.

AUTISM

Little experimental work was done to validate the use of Theraplay with children with autism until quite recently. Theraplay techniques were regularly used by individual therapists as part of more comprehensive programs for children with autism that addressed treatment needs in domains of communication, community integration, social

play, and self-care and domestic skill building (Coleman, 2009; Bates, personal communication, 2002). A recent study at Texas Christian University conducted pre- and posttesting with eight children diagnosed with either PDD-NOS or mild autism, who received a course of Theraplay treatment (Franklin et al., 2007). Neurotransmitter assays were obtained from the children (urine samples), along with various behavioral measures: GARS-2 (Gilliam, 2006), Parenting Stress Index (Abidin, 1995), Sensory Profile (Dunn, 1999), and MIM. Children received a two-week intensive course of Theraplay (daily Theraplay) with certified Theraplay Therapists. Testing was done at baseline, immediately following therapy, and at a three-month follow-up. MIM ratings were done by raters separate from the therapy team.

Key findings are outlined below:

- No significant change on the GARS-2 subscales or Autism Quotient
- Absence of change on the Parenting Stress Index
- No change on the Sensory Profile
- Significant improvements across MIM dimensions
- Normalization of epinephrine levels for both children and parents

Although symptoms typically diagnostic of autism (communication deficits, stereotyped behaviors, and social deficits) failed to show improvement over the short course of therapy, there were indications of improvements in the parent-child relationship as measured by the MIM. In particular, parents demonstrated increases in affective expression, responsiveness to the child, gaze fixation, and positive guidance of the child. The children demonstrated increases in vocalization, seeking proximity with the parent, gaze fixation, and acceptance of parental guidance. Overall MIM scores were significantly improved. Levels of neurotransmitters, dopamine, serotonin, GABA, glutamate, and phenylethylalanine remained unchanged, but epinephrine and the epinephrine-to-norepinephrine ratio were significantly changed toward the normal range. This may indicate an improvement in physiological stress level of both the parent and child. Histamine levels in the children showed a change approaching statistical significance ($p < .08$).

The study was limited by the small number of subjects, which reduces statistical power and decreases the likelihood of finding statistically significant change, and by the lack of a control group. (Therefore, it is remarkable that significant findings were documented on the MIM and neurotransmitter levels.) Though MIM raters were kept separate from the therapeutic team, they cannot be said to be blind, as there was no control group. Autism spectrum disorders affect multiple domains of functioning, and typically require a range of services over a period of years. Thus, it is not surprising that a short-term, albeit intensive, course of therapy would find few or no changes in overall symptoms, especially those central to the disorder. In the context of the study limitations, however, the significant findings related to parent-child interaction and physiological variables were impressive, certainly suggesting the value of further, more detailed study.

DUAL DIAGNOSIS

Early case studies of Theraplay found it to be effective with both socially withdrawn children and with hyperactive, disruptive children (Jernberg, 1969, 1975). Furthermore, speech therapists reported integrating Theraplay with speech therapy techniques to positive effect (Kupperman, Bligh, and Goodban, 1980) with small numbers of children. In 1998 Herbert Wettig and Ulrike Franke set out to demonstrate that Theraplay could be effective for children with dual diagnoses of both language and behavioral disorders.

Two separate studies were designed: the first to examine the efficacy of Theraplay in a young, dually diagnosed population (language disorder and behavior problems), and the second to study the generalization and replication of results across multiple centers serving the same population (Wettig and Franke, 2004; Wettig, 2007). Study 1, named the Controlled Longitudinal Study (CLS), was designed with maximum control of the therapeutic conditions to protect against Type II errors (the potential error of not finding a significant difference when it does exist). Thus, subjects were recruited from a single institution in Germany, therapy was provided by a single, certified, very experienced therapist, and all sessions took place in the same room with standard materials. A traditional team method of therapist assisted by co-therapist was used, with one therapist working with the child and the second giving feedback to the parents while

watching through a mirror or by closed-circuit TV. Thirty children with a mean age of 4.6 years (twenty-two boys, eight girls), with no history of language, behavioral, or neurological problems, constituted a control sample against which change in the clinical samples could be compared. The German version of the Clinical Assessment Scale for Child and Adolescent Psychopathology (CASCAP-D), a widely used scale with established reliability and validity, was utilized to evaluate child behavioral and psychiatric symptoms (Doepfner et al., 1999) before and after treatment, and at follow-up assessments. All children selected for study had been diagnosed with receptive or expressive language disorder. The CASCAP-D was used to categorize children among various behavioral dimensions, including Inattentive type of ADD, ADHD-combined type, Oppositional Defiant Disorder, and excessive shyness or social anxiety. Sixty children with clinically significant language and behavioral disorder ultimately participated in therapy.

Improvements associated with therapy were dramatic. At baseline, shy, socially withdrawn children were significantly different from the normal control children on measures of overconformity, mistrust, and social seclusion, in addition to the differences in receptive and expressive language. After an average of seventeen to eighteen sessions (though in a few cases as many as forty-three sessions) their scores on overconformity and mistrust were no different from the control group, and social seclusion had significantly improved (Wettig and Franke, 2004). Although expressive language had not improved, receptive language had significantly improved relative to the children's baseline. As part of the longitudinal design, the children were evaluated again two years post therapy. At this time, behavioral and language improvements had been maintained.

It is important to note that of the sixty children in the CLS sample, many had multiple behavioral concerns. Fifty of the children were classified as having symptoms of inattention significant enough to be classified with Attention Deficit Disorder. Approximately 42 percent of the sample had clinically significant impulsiveness while 32 percent of the sample had clinically significant hyperactivity. Approximately 70 percent of the sample scored in the elevated range on items for oppositional and defiant behaviors. In all categories and dual diagnostic combinations, oppositional and defiant behaviors were significantly diminished through therapy. Scores on items for attention and impulsivity were also significantly improved.

Receptive language was consistently improved across subject groups. Improvements were maintained at the two-year follow-up. Indeed, for children with a primary classification of Oppositional Defiant who also had symptoms of inattention, ratings on inattention continued to improve by the two-year follow-up.

The results of the CLS study were highly promising but could not necessarily be separated from possible therapist effects because only one therapist worked directly with the children. The goal of Study 2, called the Multicenter Study (MCS), was to examine whether the results would generalize across centers and therapists. Therapists from nine separate centers in Germany and Austria were recruited and intensively trained in Theraplay by the original therapist. Identical criteria of language disorder with combined behavioral disorder (dual diagnosis) were used for inclusion in the study. A traditional team method of therapist assisted by co-therapist was again used. The same neurologically healthy control group from the CLS study was used.

From an initial sample of 333 children, 167 children with combined language disorder and severe shyness were treated. The sample was demographically and clinically similar to the previous CLS sample, but scored slightly worse on the overall scale for social shyness. Improvements from baseline were statistically significant for all items related to severe shyness (overconformity, social withdrawal, mistrust of others, and lack of self-confidence). Furthermore, mistrust was no longer different from the normal control group. Both receptive and expressive language improved significantly in this sample. Attention problems and concentration, which were also clinically elevated at baseline, had normalized, no longer showing any difference from the control group upon statistical testing.

Similar to Study 1, Study 2 (MCS) group comparisons were also made at baseline to posttesting for subjects with symptoms of inattention, hyperactivity, and oppositional-defiant behavior. These groups were also compared to the normal control group. Results were similar, again showing significant improvement from baseline on item ratings for oppositionality, cooperation, inattention, impulsivity, hyperactivity, and receptive language. In summary, Study 2 supported the hypothesis that the improvements in the dually diagnosed children were Theraplay specific and were not limited to specific therapists or institutions. Furthermore, Theraplay was supported as an effective treatment for multiple concerns, including both social withdrawal and more impulsive, disruptive types of behaviors. Analysis of

session length found an average of eighteen sessions required for the gains achieved in the study, although one severely shy client required sixty-six sessions. Thus, Theraplay's claims of being a comparatively short-term therapy were supported.

Some limitations of both studies included lack of a clinical control group and reliance on parent ratings of behavior. Inclusion of a wait list or placebo control group could have ruled out the argument that improvements were due to developmental maturation only or to placebo effects. The dramatic improvements noted over a short time span make it unlikely that developmental maturation was responsible for the improvements, but without a clinical control this cannot be definitively ruled out. The reliance on parent ratings is a concern because parental stress level can affect Likert-type scale ratings to some degree. Thus, future studies can be strengthened by using additional, more objective measures, such as behavioral frequency or severity ratings by a blind rater.

This chapter provides beginning research evidence for the effectiveness of Theraplay in a wide range of clinical situations, including attachment disorders, autism, and internalizing and externalizing features in personality and language disorders. Further necessary research is being carried out at present and we expect to have more evidence of the success of this modality in the near future. The research presented here is clearly not exhaustive but is an encouraging beginning, fleshing out the enormous anecdotal evidence from therapists around the world.

PART TWO

Strategies for Theraplay Treatment

Part Two is a manual for therapists who want to learn how to practice Theraplay. These three chapters are designed to be used as a guide in conjunction with the training program that is available through The Theraplay Institute and their certified trainers. Although we have attempted to make the process as clear as possible, it is essential to complete the full training course in order to become a skilled Theraplay therapist. Information about procedures for becoming certified as a Theraplay therapist is available on the Theraplay Web site: www.theraplay.org.

Chapter Four describes the overall treatment process. Chapter Five describes how to work with the child. Chapter Six describes how to work with parents and guide their involvement in treatment.

CHAPTER FOUR

Structuring Theraplay Treatment

In this chapter we describe the structure of Theraplay treatment, from preparing for the intake interview to completing the posttreatment evaluation and the follow-up visits. We describe

- How to arrange the setting, including arranging the room, preparing for observation, deciding on the number and timing of sessions, and deciding who should be included in sessions
- How to organize the therapist roles, including when working alone and when working with two therapists
- How to do an assessment, which includes an intake interview, an observation session using the Marschak Interaction Method (MIM) (Booth et al., 2005), and a feedback session with the parents
- How to plan Theraplay sessions and structure treatment

Each step of the process, from intake to follow-up, is illustrated with transcripts of a single case study.

ARRANGING THE SETTING

Theraplay treatment is structured to facilitate the work with both the child and the parents. You need to consider your room setup, arrangements for parents to observe as well as participate, the number and timing of sessions, and whom to include in sessions.

Setting Up the Room

The physical arrangements for Theraplay treatment are very simple. The intense focus on the relationship between child and adult makes it possible to work effectively in less than ideal circumstances. In the early years when we worked in Head Start centers, we did Theraplay with children under the stairs, in utility rooms, and between the inner and outer entrance doors to the school. Ideally, however, you should have a simple, uncluttered space approximately ten feet by ten feet with an easily cleaned floor or gym mat. Large floor pillows or a beanbag chair and small throw pillows are essential. Because not all parents can sit on the floor, a small couch is useful. Access to a sink for water play and cleanup is helpful. Toys or other objects that might distract the child should be out of sight. Any materials that you need for the day's planned activities, such as lotion, baby powder, bubbles, tinfoil, or newspaper, should also be out of sight in a bag or basket but easily available to you when you need them during a session.

Arranging for Observation

You need to have some arrangement for parents to observe and discuss sessions with you. An observation room with a two-way mirror and sound equipment is ideal. A cable hookup or a wireless connection are both good inexpensive alternatives. If an observation room is not available, the parents—and the second therapist if you have one—can sit in one corner of the Theraplay room to observe the session. If the parents are in the room, it should be larger than the size listed above.

A camera is also very useful for recording both the MIM interaction and the Theraplay sessions themselves. We recommend filming sessions for a number of reasons. You can review the video to get a better sense of what went on during the session and where you need to go next with the child. When you have no viewing arrangement,

you can show the session to parents and discuss the interaction with them. You can use the tape for supervision while you are in training and at any later time when you want to consult with a colleague about the progress of a difficult case. Finally, you will have a record of exactly what happened during your session in case anyone challenges you about the nature of your interaction.

Determining the Timing, Frequency, and Length of Treatment

The basic course of Theraplay treatment for mild to moderate issues is eighteen to twenty-five weekly forty-five minute sessions, with four follow-up sessions at quarterly intervals over the next year. The first session is an information-gathering interview with the parents. The next one or two appointments, depending on whether one or two parents are involved in treatment, are observation sessions using the Marschak Interaction Method (MIM) in which the child and one parent at a time perform a series of interactive tasks together. The interactions are videotaped and later analyzed by the therapists in preparation for a fourth session with the parents. In that session the therapists and parents discuss their observations of the interaction and together agree on goals for treatment. Sessions five through twenty involve direct Theraplay with the child and her parents, beginning with a few sessions in which the parents observe. After every third Theraplay session, a session is scheduled for the therapists and the parents to meet without the child to discuss progress and goals. As the agreed-on termination time approaches, parents and therapists meet to assess progress and decide whether to end the sessions or continue for a few more sessions. The final session ends with a good-bye party.

We recommend a follow-up MIM plus a feedback session with the parents in order to document the changes that have occurred during treatment and to reinforce for the parents the effectiveness of their new ways of interacting with their child.

In recognition of the greater needs of children who have experienced separation, loss, trauma, multiple caregivers, or institutional care, the treatment period can be extended in length and intensity. Sessions may be as long as an hour and a half and may be scheduled twice a week. A treatment period of twelve to twenty-four months with such children is common.

Young children with Autism Spectrum Disorder benefit from a more intensive arrangement of two or three sessions per week; the treatment period is longer for these children as well.

Deciding Who Should Be Included in Sessions

Parents are actively involved in Theraplay sessions as soon as the child and the parents are ready. At some point during treatment you need to consider whether to include other adults who have caregiving responsibilities for the child, for example, grandparents, child-care providers, and teachers. In some cases you may decide to include siblings. In the following section we discuss each of these options and the rationale for including them.

PARENTS. There are important reasons for including parents in treatment. The kinds of relationship problems that Theraplay addresses are inextricably connected with the interaction between parents and their child. Parents need to learn how to carry on at home the new approach that you are demonstrating and practicing in the sessions with their child. Although we have had success working with children whose parents were unable to participate, the most effective Theraplay treatment includes the primary caregiver at the very least. Therefore, if parents are available, you should always attempt to include them as an integral part of the Theraplay team.

There are so many varieties of caregivers these days that specifying who should be included is difficult. If there is only one parent, he should of course be included. If there are two parents, both should attempt to be present. If one parent says that she is too busy, you can say, "It is very important that both of you understand and agree on the new approach we are going to be practicing. You are both equally important to your child and you can help him best by both being here." The reality is, however, that many families cannot manage to have both parents come to all sessions. You can be successful working with only one parent present at each session if both parents can work well together. It is possible to have them come to alternate sessions, or have one come for several sessions and then switch to the other. When parents are unable to come at the same time, occasional joint meetings with parents are essential.

In the case of amicably divorced parents with joint custody, both parents, as well as their current partners, need to learn about and be in agreement on the new approach. It would be too confusing, however,

to have all four adults in the playroom at the same time. Each set of parents, therefore, should attend alternate sessions. From time to time you should schedule a meeting with all four of the parents to discuss progress and to coordinate strategies. Again, the reasoning is that everyone who has any responsibility for the care of the child should be part of the treatment process in order to learn what works well for their child and to coordinate their approach.

The more people who are sensitively attuned to the child's needs and able to follow the Theraplay approach with him, the greater the advantage for the troubled child. You can change a child's view of himself and how he expects others to respond to him much more quickly if his experiences with all of his important caregivers are health promoting. You might consider, for instance, inviting the child's teacher, babysitter, or grandparents to participate in a session or two.

SIBLINGS. Unlike family therapy, which often includes all the siblings from the beginning, Theraplay focuses primarily on the parent-child dyad. Just as it is with an infant, the intense, focused interaction between a child and her parents is essential to the formation of a secure attachment. If there is more than one child needing therapy, begin Theraplay treatment with the child that you and the parents have identified as needing the most help. An alternative would be to work with the child that you and the parents think will respond most readily to the treatment. It is our experience that when parents are involved in treatment, their attitude changes not only toward the child who is participating in Theraplay but toward their other children as well. When the work with the first child is completed, you can bring in the other child for a series of his own sessions.

Once a good relationship is established between the parents and the child, you can decide whether siblings should be included in sessions. The reasons for including them would be to help the child with whom you have been working to learn how to interact with her siblings in ways that are healthy, and to help the parents learn how to respond to all their children in a group.

ORGANIZING THE THERAPIST ROLES

Theraplay can be practiced successfully by a single therapist or by a team of two therapists. When there are two therapists, the Theraplay therapist works with the child, while the interpreting therapist works

with the parents. When working alone, you will play both roles. Chapter Five discusses in more detail how to work with the child and Chapter Six explains how to work with parents.

Coordinating the Work of Two Therapists

When you have a partner, you must work as a well-coordinated team. Right from the beginning you are equal partners in developing an understanding of the family and a plan for treatment. The teamwork begins with the initial intake interview, where both of you participate in asking questions and following up on issues. Though only one needs to be present for the filming of the MIM, ideally this should be the Theraplay therapist so he can meet the child before the first Theraplay session. The two of you should work together to analyze the MIM, share insights, and prepare feedback for the parents. Being present together for the feedback clearly conveys to parents that you work as a team. You should make it clear that you will be sharing information between you as you work with the family.

Before each session, you should meet to plan your strategy based on your shared understanding of the child's needs. This planning is essential because the interpreting therapist will have to explain what the Theraplay therapist is doing and why. The interpreting therapist should share information from discussions with parents about what has happened since the last session, so that the child's therapist can adapt her activities and approach to the child's current needs. Occasionally parents will report something that needs to be addressed during the session. If there has been an upsetting or significant event, the interpreting therapist must let the Theraplay therapist know immediately. Current family crises, special problems, or triumphs of the week may warrant a change in plan or at least a response from the Theraplay therapist. In that case, the interpreting therapist enters the playroom and speaks directly to her partner. She might, for example, say, "Alex won his wrestling match yesterday," or "Marita is not feeling well today." Some issues do not need to be spoken aloud to the child but simply written on a note so that the Theraplay therapist can take them into account.

The typical arrangement when the parents enter the Theraplay room is that the Theraplay therapist continues to focus on the child and lead the activities. The interpreting therapist is responsible for the parents, supporting their involvement and being alert to any

difficulties they might be having. Because she knows the parents well, she can suggest changes of plan or special activities to fit the parents' needs. It is very important that you coordinate your activities and be clear about your goals—though in a smoothly working team, if either of you becomes aware of an issue that needs to be addressed, you can signal to the other for a change of plan. If one of you notices, for example, that Dad seems to be sitting back and not participating, you might say, "I think it's Dad's turn to feed Marita." However you divide up the responsibilities, you must both be aware of the need to give clear instructions to parents about their role, while continuing to attend to the child's needs.

Before bringing parents into sessions, you must decide whether to have one or both parents in during the early sessions. Having four adults in the room requires careful planning and choreographing of activities to avoid confusion and mixed cues. Some children will be too stimulated by having four adults in the room; in that situation, one parent and the interpreting therapist should remain out of the room. In most cases you should begin treatment with the parent whose relationship most needs to be strengthened. Occasionally, however, you should begin with the parent who has an easier relationship in order to have time to make the child feel more comfortable and to give the struggling parent more time to reflect on the child's issues and needs. The Theraplay therapist assumes responsibility for directing activities for all participants. If you work alone, of course, this will always be the case.

Following each session, take a few minutes to talk together about how the session went, to share information that the parents have given you, and to think about what the child needs for the next session. Feedback comments such as the following are useful: "Alex seemed to be slumping down on the pillows a lot today. Next week let's have him stand up and do more active games," or "I notice that Mom is very hesitant when she gives the signal for Jenny to do something. Next week let's play 'Mother, May I?' "

This post-session discussion is the time to consider any problems that might have arisen between the two of you about who should be leading and how to coordinate the activities. It is also an appropriate moment to discuss any disagreements about the approach to take with the child. Does the child, for example, need a gentler, quieter approach or a livelier, more engaging one? The Theraplay therapist has the best view of how it feels to be with the child, whereas the

interpreting therapist has a broader view of the whole picture. These two views need to be coordinated. The longer you work with a partner, the more smoothly your collaboration will go. If you do not find that you are working smoothly together, consult with a supervisor or trusted colleague who can help you straighten things out.

After each session, you should make a brief record of what happened, of how the child and the parents responded, of any countertransference responses on your part, and of your ideas and plans for the next session.

Working Alone

If you are working on your own, you will be both Theraplay therapist for the child and interpreting therapist for the parents. The following are some suggestions for ways to incorporate both roles into the work of one therapist.

While a session is taking place, parents can observe on their own. You can give them an assignment to help them focus their observations as they watch. You might ask them, for example, to note how they think their child is feeling at particular points in the session, list the activities that their child likes best, or identify the times when their child relaxes and gives good eye contact. Because they are on their own, you may include them in sessions sooner than the usual fifth session. If parents are observing in the therapy room, they can be invited to join in a final nurturing activity at the end of the very first session. With children under three, it is possible to do some sensitive explanation to the parents of what is happening as you work with the child. For example, "Alex is getting very excited right now. I see that I need to find something calmer to do."

You will need to schedule a separate time to meet with the parents and respond to their questions. It will help these discussions if you show part of the video of the session to focus your discussion of what went on. This arrangement leaves the parents on their own as they watch the session but provides an opportunity for later reflection.

An alternative to having parents observe on their own is for you to watch a video of the session with the parents at a later time. In this arrangement, you are present to comment on the interaction as it is played out on the tape. You can then respond immediately to parents' reactions, just as you would if you and the parents were observing

the session together while it occurs. Some parents, however, will find it difficult to be left out of their child's treatment and will probably do better watching the session in the room as it takes place.

Once the parents begin to join you and the child for the second half of each session, they must be readily available to respond to your signal that it is time to enter the playroom. By this point, they should be able to watch the beginnings of sessions without your support. Opportunities for parent-therapist conversations can be made either by telephone or during the fifteen minutes before or after a session if there is some appropriate place for the child to be during this time. It is especially important that you have a way to learn about anything that has occurred between sessions that might affect the child's response in sessions. A telephone call on the day of the session can take care of this need.

Whatever arrangements you make for meeting with parents, the general plan must include a regular time to review tapes of previous sessions, talk about how to manage behavior that occurs at home, discuss how well the parents are working as a team, and discuss plans for the next session. If parents will be joining the session, you can practice Theraplay activities that will take place in the upcoming session.

As you can see, there are many possibilities for a single therapist to work both with the parents and with the child. If it seems that these alternate arrangements take a great deal of time, remember that the standard Theraplay treatment takes the time of two therapists. In effect, two treatment sessions are occurring at the same time: one for the child and one for the parents.

DOING AN ASSESSMENT

The first step in the treatment process is to do an assessment of the problem and make a plan that is appropriate for this particular child and family. We have parents fill out two standardized measures in advance of the intake interview: the Child Behavior Check List (CBCL) (Achenbach, 1991b; Achenbach and Rescorla, 2001) and the Parenting Stress Index (PSI) (Abidin, 1995). These give a measure of each parent's concern about the child as well as a sense of the parent's level of stress. The intake interview takes place with the child's parents, without the child. An assessment of the relationship

between the child and her parents is then carried out using the Marschak Interaction Method (MIM).[1] The process is concluded with a feedback session.

At the conclusion of treatment, you should repeat the MIM (as well as the standardized checklists) in order to assess progress. After the final MIM you can meet with the parents and show them selected parts of the first MIM and the follow-up MIM in order to help them see the growth that has occurred.

Conducting an Intake Interview

The intake interview covers a range of topics but focuses especially on attachment and relationship issues. It should provide you with useful information regarding the child's biological strengths and weaknesses, the family environment, and the parents' expectations of the child. The following is an outline of the areas that you should explore:

- The reason for the referral
- The developmental history
- Parents' expectations and attitudes, including their attitude toward attachment issues
- Parents' experiences within their own families
- Parents' relationship with each other

REASON FOR REFERRAL. The first step toward discovering how to help a family is to understand how they define the problem. The CBCL will give you a view of how they perceive their child's behavior, but you will want them to describe in their own words the problem as they see it. You can also ask how other adults involved with the child, such as teachers or a pediatrician, see it. You need to learn when the problem first started and why they have decided to seek help at this specific time. Finally, you should ask how they have tried to cope with their difficulties.

DEVELOPMENTAL HISTORY. Your inquiry into the child's developmental history should include a strong emphasis on factors that might influence the child's attachment relationship. In the following discussion, sample questions are given to illustrate how you might explore each

issue. You can begin with questions about the pregnancy: "How did you feel about being pregnant? What was your pregnancy like? What were your hopes and expectations for your baby? Did it turn out like that?" For parents of a child who is adopted or in foster care, the questions would be about their expectations and preparation for the child they welcomed into their home. Answers to these questions can give you an initial picture of how well the parents were prepared to respond to their baby.

Information about the delivery and the health of the infant and the mother at birth is important to an assessment of factors that might affect the parents' ability to respond to their baby's needs and, equally important, the baby's responsiveness to her parents. "How did feeding go? How easy was it to calm or soothe your baby? Was she an irritable or colicky baby?" These early experiences set the stage for ease or difficulty in the attachment process. Again, parents of children who are adopted or in foster care may not know about this early period, but it is useful to discuss what the child's experience might have been in order to begin building greater understanding on the parents' part. See Chapter Nine for more information about how to work with families where children have been adopted or are in foster care.

Answers to questions about developmental milestones, such as age of walking and talking, give clues to the rate of the child's physical and cognitive development. Questions about time and method of weaning and toilet training, expectations of cleanliness and conformity, and parental attitudes toward exploration, autonomy, and independence tell us the degree to which the child has been allowed to "become his own person."

Information about the child's medical history is important for determining whether health problems have interfered with the child's development or have resulted in hospitalizations or painful medical procedures. You need to assess how such experiences have affected the parent-child relationship.

It is also important to gather information about other disruptions in the relationship such as prolonged separations due to absence or illness of a parent. You should ask about the child's experience with other caregivers. "Who took care of your child when you went to work? When did he first go to day care or preschool? How did he respond to early separations?" All of these questions tell us something about factors that might influence the security of his attachment.

The child's relationship to his siblings also needs to be explored. "Do you have other children? What are their ages? How did this child respond to the birth of later siblings? How do they get along now?"

To assess the child's current functioning, ask about his eating and sleeping patterns. Ask parents to describe a typical day.

Finally, you should ask parents to describe their child: her personality, her favorite activities, what they like best about her, and how they enjoy spending time with her.

PARENTS' EXPECTATIONS AND ATTITUDES. Explore the parents' attitudes toward their child's developmental needs. This is a complex area and will require you to follow leads as the discussion develops. The following aspects might be explored: How do they respond when the child is whining or irritable, hurt or afraid? How intense is their need for the child to achieve? In their family is it expected that children will stay close and be babied a long time? Do they expect their child to be well behaved and quiet or do they encourage freedom, spontaneity, and nonconformity? Do they enjoy their child? How do their family or cultural expectations relate to the child's current problems?

PARENTS' EXPERIENCES WITH THEIR OWN FAMILIES. Parents' experiences growing up in their own families strongly influence how they raise their children. In the intake interview, you will need to explore each parent's attitude toward their own attachment history and their current relationship with their families of origin. "What was it like growing up in your family? Where do you fit in the sequence of your siblings? What was your role? How did your parents handle discipline? What were your parents' expectations for you? How supportive are your parents and siblings now?" You should also explore the family history of problems similar to what the child is experiencing.

PARENTS' RELATIONSHIP WITH EACH OTHER. You should evaluate the current state of the parents' relationship, how similar their attitudes are about child rearing, and how well they are prepared to work together to help their child. "Are there differences between the two of you in your approach to child rearing? Are you able to discuss these differences and come to an agreement? When you are feeling bad, can you turn to your partner for comfort?"

At the end of the intake session, you should tell the parents that the next step in the assessment procedure will be a videotaped

observation session in which each parent and the child will play some simple activities together. Explain that you are interested in seeing how their child responds to a variety of simple activities. "Instructions for the activities will be written out on cards. We will videotape the interaction and then look closely at the videotape to learn more about how to help your child and you get along better. You can tell your child that you are bringing him here so that you and he can learn how to have more fun together."

THERAPLAY IN PRACTICE

The B. Family's Intake Interview

The following is a summary of the intake interview with the B. family, who brought their only child, Adam, for Theraplay treatment. They were concerned both about his inability to separate from his mother and about his demanding behavior. Although the family lives at some distance from The Theraplay Institute, the urgency of their need led them to make the trip to Chicago for a weeklong, intensive, five-session course of Theraplay treatment. We used the two-therapist model of treatment. The intake interview and the MIM both took place on the first morning. While the family went out for lunch and relaxed in a nearby park, we analyzed the MIM. When they returned, we met with the parents to give them feedback. During the feedback, Adam was in the care of his regular caregiver who came along for this purpose. Following that we had the first Theraplay session. We had one Theraplay session on each successive day. The family returned for follow-up sessions once a month for four months (a total of nine sessions). In this case we did not do a follow-up MIM because of the distance they had to travel.

Adam is an appealing, freckle-faced, curly-haired boy who will be four years old in a month.

Reason for Referral

Adam's parents described him as having a very short attention span: he can't stay with anything longer than two

minutes. "He's easily revved up. It's very hard to get him to go to bed. He insists on sleeping in our bed. If we try to stop him from doing something, he becomes very angry and hits and scratches like an angry cat. He has to have everything his own way." But perhaps the most urgent problem for the parents is that he refuses to let his mother out of his sight except to go to his babysitter, who has cared for him since he was a baby. Since Adam is now old enough to go to a very good preschool program near their home, his parents would like to resolve the separation problem so that he can be enrolled at the end of the summer.

Developmental History

Adam was the product of a healthy, planned pregnancy and an easy delivery. His mother chose to bottle-feed him because "I didn't want to be tied down." Adam was a good baby who "slept a lot and ate a lot." His parents were very proud of how rapidly he developed. He smiled, held his head up, and talked early. "Once he started talking you couldn't stop him." When Adam was six weeks old, his mother went back to work and he was cared for by a friendly neighbor; she still cares for him while his mother is at work. They describe this caregiver as "giving Adam the run of the house." Weaning from the bottle was late, but potty training was early. "He trained himself before he could walk."

The one dark cloud in an otherwise healthy development was that Adam developed eczema when he was nine months old and for two years he was miserable. "We did everything the doctors told us to do to keep him from scratching and making it worse, but nothing seemed to work. He was very unhappy during that time. When he was two and a half it got better. What a relief to all of us."

Parents' Families

The parents have good support from their own families, but no one seems to have the solution for Adam's difficult behavior.

Parents' Relationship

The parents are supportive of each other and get along well. They have some disagreement about discipline. "He thinks I should spank him, but I don't agree. Besides he can't bear to spank him himself. I talk to Adam like a grown-up, 'If you won't listen, go to your room.' " The father admits that he backs down when Adam starts crying. Adam's behavior often makes each of them angry.

When asked what they liked best about Adam, they both agreed that they like that he is smart and quick at learning, and that he is energetic and lively.

When asked what their goals were for treatment, both parents agreed that they wanted Adam out of their bed, they wanted him to be able to separate from his mother, and they wanted him to be able to go to the preschool program rather than continue being cared for by the babysitter.

Observing the Parent-Child Interaction Using the MIM

The second step in the assessment is to observe each parent with the child, using the Marschak Interaction Method (MIM). This is a structured technique for observing and assessing the relationship between two individuals, for example, biological parent and child, foster or adoptive parent and child, teacher and child. It consists of a series of simple tasks designed to elicit interactions in the four Theraplay dimensions. It allows you to evaluate the parent's capacity to

- Set limits and to provide an appropriately ordered and safe environment (Structure)
- Engage the child in playful interaction while being attuned to the child's state and reactions (Engagement)
- Meet the child's need for comfort, calming, and care (Nurture)
- Support and encourage the child's efforts to achieve at a developmentally appropriate level (Challenge)

It is equally important to look at the child's response to activities in each dimension.

In addition to allowing a close look at problem areas in the relationship, the MIM provides a unique opportunity to observe the strengths of both adult and child and of the patterns of interaction in their relationship. Parents often are unaware of these patterns and cannot tell us about them. Therefore, there is a great advantage in viewing the interaction firsthand rather than relying solely on parents' reports.

SETTING UP THE MIM. Basic MIM observation sessions are dyadic and include the child with first one and then the other of her parents. In many cases the two sessions can be scheduled on the same day. A young child who is easily tired will need to have them scheduled on separate days. If both MIMs are done on the same day, you can reduce the number of tasks for each parent to five or six and have three activities at the end for the child and both parents to do together. If there is more than one child in the family, you can have a few activities for the whole family together in order to observe how the presence of the other children affects the interaction. You should be aware, however, that the addition of more players in the interaction increases the complexity of the analysis and should not be attempted until you have become experienced in interpreting the simpler, two-person MIM.

MIM sessions are conducted as follows. Parent and child sit side by side at a table that is the appropriate height for the child. They can sit slightly facing each other at a circular table or across the corner of a rectangular table. They should not face each other across the table because they need to be close enough to interact easily. A parent with an infant or a toddler can sit on a sofa or on the floor supported by pillows with the child in her arms or beside her. The session is observed through a two-way mirror and videotaped for later analysis. If you don't have either the two-way mirror or video equipment, you can sit unobtrusively in the room and take notes. A stack of cards with instructions for each activity is placed face down on the table in front of the parent. Materials needed for the tasks should be placed in labeled envelopes or boxes near the parent. An alternative that helps families keep the tasks and materials in order is to provide a set of envelopes numbered from one to ten, each containing the instructions and any needed materials.

Activities consist of structuring tasks such as "make a block structure just like mine," engaging tasks such as "parent plays Peek-a-Boo with child," nurturing tasks such as "feed each other raisins," and challenging tasks such as "adult engages child in three rounds of thumb wrestling."

CHOOSING THE TASKS. When you first begin using the MIM, you should follow the basic recommended task list (see Appendix A) for the age level of your client. These lists serve as a model for how to choose the basic tasks and how to order the sequence. If you use the same set of tasks for a number of different families, you will begin to get a sense of the range of responses that can be made to similar tasks and therefore have a better idea of how to understand the interaction that you are seeing. When you are ready to branch out a bit, you can turn to the *MIM Manual* (Booth et al., 2005) for a longer list of activities from which you can choose special tasks to help you answer questions about a particular parent-child pair based on the hypotheses you formulated during and after the intake interview. Lists of tasks, designed for the following age levels, are available through The Theraplay Institute: prenatal, infant, toddler, preschool, school age, and adolescent. Within each level, tasks are designed to set the stage for interaction in each of the four Theraplay dimensions of structure, engagement, nurture, and challenge, as well as playfulness.

In setting up the MIM tasks, you should alternate playful and nurturing tasks with difficult or challenging tasks. The "parent leaves the room" task, which can be stressful to both parent and child, should be placed in the middle of the sequence and followed by a task that will help the parent and child reconnect around a playful or nurturing activity. In order to make inferences about differences in the child's responses to each parent, some of the tasks should be the same for each parent. However, some of the tasks should be different so that the child doesn't become bored by having all the activities be the same. For example, you can have one parent build a block structure and the other make a drawing; both require the child to copy a model.

INSTRUCTING THE PARENTS. As the family enters the room where the MIM will take place (which is usually the treatment room as well), you can point out the camera and show the family where you will be as you observe. "I will be filming the session so that my co-therapist

and I can look closely at it later. At the end of the session I will ask you to sign a release form granting permission for us to use the videotape for treatment planning." Clients twelve years and older must be asked to sign the permission form as well. Obtaining the signed agreement after the session is completed ensures that the participants know what is on the video when they sign.

The Theraplay permission form includes the additional option of using the videotape for training other professionals. Parents are, of course, free to reject this option, though few have done so. Very occasionally a family asks that we not videotape at all. All records including videos must be kept confidential and must not be shared without valid, signed releases.

The instructions that you give to the parents should be simple and straightforward: "Here is your chair, Adam. Mom, you sit in the other chair. This is a stack of cards that will tell you what to do. Pick up the cards in order one at a time. Read each out loud so that we know which activity you are doing. Some of the activities require materials that are in the numbered envelopes here beside the table. Your session is scheduled to end at ____ time; keeping that in mind, take as much or as little time as you feel necessary to complete each activity. There is no right or wrong way of doing these activities. I will be behind the two-way mirror [or here in the room by the camera] if you have a question. Let me know when you are finished and I'll come in to ask you a few questions." If you must stay in the room, make yourself as inconspicuous as possible and answer questions very briefly in order to encourage the parent and child to interact with each other and not with you.

At the conclusion of each parent's MIM, ask the parent the following questions:

- Is this the way it is at home for you? Did we get a good picture of how things go between the two of you at home?
- Were there any surprises?
- What was your favorite activity? Why?
- What was your least favorite activity? Why?
- Without asking your child, what do you think she liked best? Why?
- What do you think your child liked least? Why?

Responses to these questions can give you insight into the meaning of the activities to both participants.

EVALUATING THE INTERACTION. A close look at the MIM interaction should enable you to answer the following questions:[2]

- What would it be like to live with this child or this parent twenty-four hours a day?
- What works in the relationship and can be encouraged?
- What doesn't work and needs to be changed?
- What does the child need from the parent?
- What does the parent need from the child?
- How strong are they and what help will they need to be able to change?

THERAPLAY IN PRACTICE

Choosing the MIM Tasks for the B. Family

For Adam's family, we chose activities that would give us insight into the parents' ability to nurture and calm him as well as to provide structure and to challenge him. We were interested in their ability to respond to Adam's need for calming and comfort as well as his need to become more confident and independent. At the same time, we wanted to look at Adam's responses to their efforts in these areas.

Adam's two MIMs were performed one after the other, using five tasks for each parent plus three tasks in which both parents participated. The following is a list of the instructions for each of the tasks.

Mother with Adam

1. Adult and child take one squeaky animal. Make the two animals play together.
2. Adult teaches child something he doesn't know.

3. Tell child about when he was a little baby.
4. Adult leaves the room for one minute without child.
5. Adult and child each take one bottle, apply lotion to each other.

Father with Adam

1. Adult and child each take one squeaky animal. Make the two animals play together.
2. Adult teaches child something he doesn't know.
3. Adult and child comb each other's hair.
4. Adult leaves the room for one minute without child.
5. Adult asks child to tell about when he's grown up.

Both Parents with Adam

1. Make a stack of hands together.
2. Adults and child put hats on each other.
3. Adults and child feed each other.

We chose a playful activity as the first task for each parent ("squeaky animals") because it has the potential of engaging the participants and helping them get past their discomfort at being observed and videotaped. The "teach" task allows us to assess how appropriate the parents' expectations for achievement are and how well the child responds to their expectations. (Because the "teach" task puts parents on the spot to come up with something to teach, we now place this task later in the sequence of MIM tasks, substituting a more clearly structured activity such as "build a block structure and have child copy it." The new sequence is reflected in the recommended lists in Appendix A.) The "leave the room" task provides a wealth of information about the parents' ability to prepare the child for separation, how the child handles the stress of the separation, and how the two reconnect. We were

particularly interested to see how Adam handled the separation from his mother. We were also interested to see how they related around nurturing activities, and therefore chose the task "rub lotion on each other" (mother), and "comb each other's hair" (father). "Tell child about when he was a baby" was chosen to give some insight into his mother's view of the early relationship between herself and Adam. "Ask child to tell about when he's grown up" provided an opportunity to see how Adam and his father might deal with issues around his growing up and becoming more independent. To see how both parents work together to handle Adam's clinging to his mother and rejecting his father, we chose three tasks that called for playful cooperation and nurturing: "stack of hands," "hats," and "feed each other." All of the tasks gave us an opportunity to observe how well the parents could engage Adam, structure the interaction, set limits, and follow through.

THERAPLAY IN PRACTICE

The B. Family's MIM Sessions

In this transcript of the MIM conducted with Adam and his family, you can see how quickly the pattern of interaction between Adam and each of his parents emerges. To give you a sense of the interaction, we give full transcripts of three tasks with Adam and his mother, two with his father, and two with both parents.

As in Chapter One, the comments in bracketed italics throughout the transcript indicate our inferences about what is going on. A question mark indicates the tentative nature of the inference, which must be confirmed or denied by further observation. At the end of the transcript of each task we summarize our interpretation of the interaction so that you can see how to move from observation to inference and analysis.

Adam with His Mother

Mother sits at a table next to Adam with the stack of instruction cards in front of her. Adam looks expectantly at her and seems interested in what is to come.

1. Squeaky Animals

MOTHER: (picks up a card and reads) Adult and child each take one squeaky animal. Make the two animals play together. (takes the animals out of the envelope) You get one and I get one. *[Hopeful?]* What do you want to play? Do you want to make them meet each other? What's his name? Come on, what's his name? Don't you want to play? *[Disappointed?]*

ADAM: No. (sullen, pouty look)

MOTHER: Well come on . . . what's his name? You don't want to play? Why? You don't like this game? *[Pleading?]*

ADAM: No! (puts the animal down and crosses his arms defiantly)

MOTHER: Well, I like it. (picks up both squeaky animals and begins to play by herself) *[Trying a new tactic? Thinking "Maybe if I play, he will join in."]*

ADAM: You put them back in the envelope! (angry, scolding tone)

MOTHER: Are you going to play nice? ("walks" her animal across the table toward Adam; talks with a teasing tone) He's going to take your money . . . (referring to some coins Adam is holding; Adam smiles) *[Playful teasing engages Adam in spite of himself.]*

ADAM: (murmurs inaudibly and hides his face in his mother's arm) *[Can turn to her for comfort after being intrigued by her playfulness?]*

MOTHER: Come on. (gently but insistently turns Adam back toward the table)

ADAM: Push me in! Push me in! (Mother pushes Adam closer to the table) Read another card!

MOTHER: We're doing one at a time. *[Stays firm.]*

ADAM: (inaudible)

MOTHER: No, we did that card already. (annoyed tone of voice; she picks up another card) *[Is she feeling challenged?]* Let's see what this one says.

[Mother starts the interaction by offering choices to Adam: "What do you want to play?" "What's his name?" Adam immediately becomes resistant and demanding. He scolds his mother as though she were the child and he the adult. After the brief moment when her playful teasing engaged him, he turns to her for comfort. In spite of how difficult he is being, Mother swallows her annoyance, remains calm, and persists in her efforts to engage him. We see already that it must not be easy to be with Adam, but that playfulness can help to win him over.]

2. Teach

MOTHER: (reads) Adult teaches child something he doesn't know. What don't you know that you want me to tell you? I've got to teach you something. *[Shifts responsibility to the cards for making this demand?]* What do you want to know? *[Shifts responsibility to Adam for choosing.]*

ADAM: (sullenly) Nothing.

MOTHER: How about if I teach you how to play with two pigs? (picks up squeaky animals) *[A put-down?]*

ADAM: No, you can't do that! You put them back! *[Annoyed by the put-down?]*

MOTHER: Stop!

ADAM: You have to put them back. (visibly upset) You put them back.

MOTHER: Stop. *[Agitated, then pulls self together?]* How about if you put them back in the bag. (picks up the envelope) I'll teach you to clean up after yourself. That's something you don't know. Let's clean up the pigs. *[Another put-down?]*

ADAM: (throws the animals into the envelope, one by one)

MOTHER: Nicely, please. *[Correcting him.]* (Adam puts his elbows on the table, rests his face in his hands, and looks defiantly at mother) That's something you don't know. *[Sarcasm.]*

ADAM: (points at one of the envelopes) I want to see what's in there.

MOTHER: No, you have to wait.

ADAM: (points at his mother) No, not for you!

[Like many parents faced with this open-ended request to teach something to their child, Adam's mother turns to him for

ideas. When he doesn't respond, she offers suggestions, but her suggestions are couched in hesitant terms: "How about if I—?" Adam responds to all of her questions negatively. Has Adam's demanding behavior made Mother hesitant or has Mother's hesitance led to Adam's becoming demanding? Adam's angry resistance stirs up some anger in his mother: "I'll teach you how to clean up. That's something you don't know." Yet in spite of this, she calms herself and keeps trying to engage Adam. It is good to see that Mother can be firm in the face of Adam's demands: "No, you have to wait."]

3. Baby

MOTHER: (picks up a card and reads) Adult tells child about when he was a baby. (Adam smiles and looks attentive) You know about when you were a baby, don't you?

ADAM: Yes. (smiles) *[Hopeful?]*

MOTHER: What did you use to do? You used to be so quiet and you used to *sleep* all the time. (Adam looks distracted) Are you listening to me? Don't you want to hear about when you were a baby? *[Disappointed?]*

ADAM: No, I don't want to hear about that. *[Doesn't like the message?]*

MOTHER: You're not being any fun today.

ADAM: I want to do something else; I want to see what's in that bag. (points to the envelope)

MOTHER: Well, when we get to that card . . . you used to be *patient* when you were a baby. *[Response to his impatience?]*

ADAM: Tell me some more. (Smiling) *[Looking eager and expectant.]*

MOTHER: Tell you some more? You like that one, don't you. *[Misses his meaning?]*

ADAM: Yeah . . . just tell me what's in that bag. Let's do another one.

MOTHER: You were so quiet when you were a baby. And when Mommy was a baby she used to play all by herself in a corner.

ADAM: Why? *[Intrigued.]*

MOTHER: Why? Because I didn't like to go near other people. But it's *fun* to be with people.

ADAM: (restless) Come on, just read the card. What's in the card?

MOTHER: Well, we'll find out.

[Adam looks pleased at the idea of hearing about himself as a baby and Mother seems relieved at his change of mood. But as soon as she says that he slept all the time, Adam loses interest. Mother's disappointment is reflected in her statement, "You're not being any fun." One could speculate that such a passive description has no interest for Adam. He might have hoped for a livelier picture of her pleasure in him as a baby. She carries on the passive theme—"You were so patient" and "You were so quiet"—emphasizing her dissatisfaction with the present impatient, demanding Adam. And when she reveals that she was a quiet baby who preferred to be alone (followed by her quick reversal, "But it's fun *to be with people"), we begin to see why she is so concerned about Adam's difficulty separating from her to go to preschool. Perhaps she fears that Adam is just like her and that, like her, he will miss out on the fun of being with other children.]*

When his mother reads the card about leaving the room, Adam bursts into tears and begs her not to leave him. After pleading with him to let her go, Mother tries once to leave, then quickly gives up on the task. When Mother attempts to rub lotion on his arms, Adam becomes agitated and pulls away and becomes angry and demanding. It is clear that he cannot tolerate either the messy lotion or her gentle touch. It is certainly not soothing to him.

At the end of the MIM interaction, we asked Adam's mother our standard questions. She said that we had seen a good example of Adam at his fussy worst. Sometimes, when they are alone together and she is not trying to get him to do things her way, they have more fun. It was hard for her to choose a favorite activity; none of them had gone very well. She likes telling Adam about when he was a baby, but is distressed when he won't listen. She doesn't like using lotion on him, because he can't stand the messiness. "Neither can I," she said. It was hard for her to decide what tasks Adam liked best or least. He had been so very resistant to all of them.

Adam with His Father

Father and Adam sit side by side at the table. Adam is crying from the outset, but never gets off his chair. His father leans toward him in a concerned, caring way. He tries to maintain his composure and remain focused in spite of Adam's angry crying.

1. Squeaky Animals

ADAM: I want to get out of here!

FATHER: (picks up a card and reads) Make animals play together.

ADAM: That's the pig. *[Forgets himself for a moment? Stops crying and takes charge.]*

FATHER: (picks up the envelope) Oh is it? Show me. *[Grateful for his participation?]*

ADAM: (grabs the envelope out of his father's hands and removes the animals; cries) I want to get out of here! (throws the animals down on the table) I don't want to play.

FATHER: Don't you want to play with the pigs?

ADAM: (turns his back on his father) No! I want to get out of here. *[More anger than distress?]*

FATHER: Adam, Adam, let's play with the pigs, okay? (soft, pleading tone)

ADAM: No! I don't want to.

FATHER: Why?

ADAM: You have to let me see my Mommy!

FATHER: No, Mommy's going to be all right.

ADAM: I don't want to stay here. (Adam is in tears and father gently wipes the tears from his cheek. Adam stops crying, leans forward and lets him do this.)

FATHER: (picks up the animals) Come on, let's play with the pigs.

ADAM: (knocks the animals over, then turns his back on his father) No, you leave me alone. I want my Mommy.

FATHER: (speaking to the therapist) Should I move on to the next card?

THERAPIST: (speaks from the background) You can decide.

FATHER: We'll put the pigs away, OK?

ADAM: (nods) But I have to get out of here. *[Calmer as he settles in?]*

FATHER: No, no, no, not yet. We're going to play a little bit. (puts the pigs away, then picks up another card)

[Adam tries to direct his father's actions, at the same time that he demands to leave. In spite of this, Father is calm, patient, and reassuring ("Mommy's going to be all right"). But his tone is pleading ("Let's play with the pigs, OK?"). It must have been very difficult to have Adam reject him so angrily in front of the camera, yet he maintained his focus on trying to reassure and engage Adam.]

2. Teach

FATHER: Adult teaches child something he doesn't know. . . . Let's see . . . what don't you know?

ADAM: (turns his back on his father) Nothing.

FATHER: (smiles with frustration; addresses therapist) Well, right offhand I can't think of anything he doesn't know. He's pretty well advanced, I think. *[Feels hopeless to engage Adam? Appreciates his intelligence.]*

ADAM: (still crying) I don't like this . . . get me out of here!

[Like his wife, Mr. B. turns to Adam for suggestions. But since Adam, in his present mood, is unlikely to help him out, it is not surprising that his father gives up on the task.]

As might be predicted from these two tasks, Adam refused to let his father comb his hair, complained that he wanted to be with his mother while his father left the room, and was unresponsive to the request that he talk about what it would be like when he's grown up. Mr. B. shrugged his shoulders at the end as if he did not feel that he and Adam had done well.

In answer to the questions at the end, Mr. B. admitted that Adam's behavior is typical when he has to be separated from his mother. "This is what we were telling you about. He can be even more demanding at home." It was not possible for Mr. B. to decide which were his own or Adam's favorite or most disliked activities.

Adam with Both Parents

Mother and Father sit at the table with Adam between them. Adam is still pouting but no longer crying. Father reads tasks they are to perform together.

1. Stack of Hands

MOTHER: Want to make a stack of hands? *[Cheerful effort to engage Adam?]*

FATHER: Me first. (puts his hand in the middle of the table) *[Supporting his wife?]*

MOTHER: Then me. (puts her hand on top) We'll see how tall we can make it. (turns to Adam) Now you put your hand on there.

ADAM: No!

FATHER: Come on, put it on top. Want to see Daddy put his hand on Mommy's? (puts his other hand on top of the stack)

MOTHER: Mommy and Daddy are going to play. *[Thinking "Maybe if we just go ahead, he'll join in"?]*

ADAM: (crying) Take your hands off there (tries to remove his mother's hand from the pile) . . . I'm mad at this game. (crosses his arms defiantly) *[Resents their closeness?]*

MOTHER: You're mad at this game? Why? *[Trying to be understanding?]*

ADAM: Because I don't like it.

FATHER: Why? It's just hands . . .

ADAM: No!

MOTHER: (to father) Next.

FATHER: Next. (picks up another card)

MOTHER: (to Adam) If you don't like that game, fine.

[*Once again we see how difficult it can be to be with Adam, as he continues his resistance to the activities. He seems to resent Father's involvement with Mother. Both parents support each other in their efforts to find ways to engage Adam in the activities. Both try to be understanding ("Are you mad at this game? Why? It's just hands."). Adam's anxious responses frustrate all their efforts.]*

2. Hats

FATHER: (reads) Adults and child put hats on each other. (Adam continues to cry)

MOTHER: (smiling) Hats!

FATHER: (picks up funny hats, laughing)

MOTHER: Oh boy, which one do you want? I want to be the wizard!

ADAM: No, *I'm* the wizard! *[Mother's assertion engages Adam's opposition? Or are the hats somehow more engaging and less threatening than parents touching each other?]*

MOTHER: Okay, you be the wizard. (puts the wizard hat on Adam) Which do you want me to be?

ADAM: (points to the sailor hat) *[For a minute, Adam joins in.]*

MOTHER: I'll duck down and you put it on me. (Adam puts the hat on his mother's head.) What do I look like?

ADAM: Nothing.

FATHER: Which do you want me to be?

ADAM: I don't like this. (knocks the wizard hat off his head)

MOTHER: Then I'm going to be the wizard.

ADAM: No! I'm the wizard.

MOTHER: Then why did you knock it off? (puts the wizard hat back on Adam's head)

ADAM: I don't like this!

MOTHER: Which one do you want Daddy to wear? (Adam points to one of the hats)

FATHER: You have to put it on me.

ADAM: No.

MOTHER: Do you want me to put it on Daddy? You tell me which one. (Adam points to a hat)

ADAM: Mommy has to do it. *[As long as he directs it, it's okay?]*

MOTHER: (looks at Adam) You look like a wizard. (no response) You don't want to look like a wizard? You were a wizard for Halloween weren't you?

ADAM: (begins to cry)

[When mother chooses the wizard hat, Adam demands it for himself. For a moment Adam forgets himself and allows his

mother to put the wizard hat on him. He even points out hats for her and his father. But very soon he pulls back, saying "I don't like this," knocking the wizard hat off his own head. Even as he cooperates a bit, he insists on running the show ("Mommy has to do it"). Nonetheless, this playful interactive game has briefly overcome his resistance to being involved.]

Therapist's Assessment

As we look at the interaction between the family members, we wonder how things got to this state. The parents are caring and loving, they are trying very hard, and they have a lot to offer. How did it happen that such a little boy should come to sound like a scolding adult? He can't bear to be separated from his mother, yet when he is with her he becomes rejecting and angry. How did his father get pushed so far into the background of Adam's interest? What can we do to get them back on track?

To demonstrate the process of looking at an MIM and studying it carefully, we now give our answers, based on our observations of Adam and his parents, to the six questions with which we began.

1. *What would it be like to live with this child twenty-four hours a day?* Our immediate answer is that it would be very hard. He is so easily upset and has such a desperate need to be in control. It would always feel like walking on eggshells. At any moment something might trigger his angry resistance.
2. *What would it be like to live with these parents?* Although we understand that it would not be easy to remain firm in the face of Adam's demands and temper tantrums, we wonder whether Adam would not welcome their taking greater control. Could their patience feel like weakness to him? Might he be asking himself, "How can they take care of me if they can't stand up to me?"
3. *What works in the relationship?* Both parents are able to remain calm and to persevere in their attempts to engage Adam. Playfulness seems to be a key to engaging Adam and making him feel relaxed and accepting. Though there are hints that he might

enjoy a more nurturing relationship, at the moment he is very resistant to any overtures.

4. *What doesn't work and needs to be changed?* The most obvious problem is Adam's anxious need to be in charge and his parents' inability to provide the confident guidance that would relieve him of that burden. Although his parents make attempts to assume their appropriate parent role, Adam does not make it easy. We need to find a way to reassure Adam and to give his parents confidence in their ability to provide the guidance and structure that he needs.
5. *What does the child need from his parents?* Adam needs both the clear firm structure and the nurturing care that would help him feel confident that his parents can provide a secure base that he can rely on. His anxiety in holding on to his mother probably stems from his uncertainty that she will be available to meet his needs. Though initially Adam is likely to resist efforts to change these patterns, he should be able to respond to new, surprising ways of engaging him and breaking through his negativity.
6. *How strong are they and what help will they need to be able to change?* Both of Adam's parents care a great deal about him and are highly motivated to change. But they lack a clear direction in which to move. They seem open and eager to participate in treatment. Adam is a bright, engaging child who, though certainly resistant, is sturdy enough to accept the challenge that change will present. Adam's parents need to learn that his negativity and irritable behaviors are miscuing them about his underlying needs. Beneath his bossy, demanding behaviors is the fear that adults cannot take charge, keep him safe, and guide him to a calmer, more satisfied state.

Giving Feedback to the Parents

The feedback session should be scheduled within one week in order to minimize the parents' anxiety. These sessions are typically sixty to ninety minutes long. The child is not present for this session. If there are two parents, both should be present. The only exception to this rule would be separated or divorced parents who are in too much conflict to listen and share the information together. Separate feedback sessions would be required in that case.

In preparation for the feedback session, analyze the MIM carefully, assess what dimensions need special focus, and make a plan for interpreting your observations to the parents. Choose two or three segments of the videotape to show to the parents in order to illustrate your interpretation. These segments should emphasize the positive interactions as much as possible. Chapter Six explains in more detail how to plan and execute a feedback session.

In the feedback session you begin the process of helping parents to view their child in a more empathic, understanding manner; you point the way toward new and more effective ways of relating to their child; and you outline the process of treatment. Parents should leave the feedback session with renewed optimism that they will be able to have the relationship that they have longed for with their child.

FOCUSING ON POSITIVES. A major focus of the feedback is to point out the positive aspects of the relationship and highlight the interactions that went well. For example, we pointed out to Adam's parents that they were both very patient and calm in the face of his angry, demanding behavior. "It must not be easy. Every time you offer some lovely, playful activity, he turns you down." We showed Adam's mother that her persistence in finding ways to engage him in the squeaky-animals activity had paid off and had given him a strong message that she really wanted to play with him. We showed his father the videotaped segment when Adam responded to his effort to take care of him (reaching out to wipe a tear from his eye) by leaning toward him and stopping crying. Clearly, he is able to comfort Adam. His ability to remain calm and reassuring when Adam was so upset was also very helpful. We pointed out that supporting his wife by joining the hand-stacking game had led to Adam's becoming more cooperative in the later tasks.

Sometimes children respond more positively to one aspect of their parent's behavior than another. For example, a child who resists her mother's usual educational or intellectual approach may be much more cooperative and responsive when her mother shifts to a more nurturing style. With Adam, his mother's playful, teasing approach engaged him most effectively. For the mother, seeing this difference on videotape and discussing it with the therapist had a profound effect. Being able to relate her child's more cooperative response to something she had done spontaneously in the interaction made

it much easier for her to understand the difference and be able to replicate her behavior in the future.

HELPING PARENTS REFLECT ON THEIR OWN BEHAVIOR. Discussion during the feedback session often leads parents to fresh insights into their own responses and to a new understanding of and willingness to deal with their child's behaviors that typically "turn them off." We pointed out to Adam's mother how eager he had been to hear about himself as a baby. We showed her the videotape of that part and asked, "What do you think it was about your response that changed his mood?" She was able to see that talking about his being such a quiet baby had somehow disappointed him. "If I had told him what a cute baby he was and how much I loved holding him and cuddling him, do you think he would have kept on being interested?" she asked.

HELPING PARENTS UNDERSTAND THEIR CHILD'S NEEDS. In the feedback session you also can begin to help parents understand more about their child's feelings and needs. For example, we commented to Adam's mother that even though she was very gentle as she rubbed lotion on him, Adam was reluctant to have it on his skin. "You have so much to offer, and yet Adam is unable to accept it because he is so sensitive to touch. We will be experimenting to see what kind of touch works best for him."

With Adam's parents we underlined the need for them to take charge of the interaction more firmly. We pointed out to both parents that Adam's invariable answer to every question was "No!" Given this, we recommended that they reduce their questions to a minimum. When asked how they would feel about taking more control of their interaction with Adam, they both agreed that they would like to learn how to do this.

We shared our assumptions about why Adam had developed such a need to be in control. "When he was only six weeks old, you had to go back to work and leave him with a babysitter who was unable to take charge and make him feel safe. In addition, his eczema must have led him to believe that no one could consistently meet his needs for comfort and calming. Over the years he has come to express his distress by being angry and demanding rather than sad and open to accepting comfort. Now when you and Adam are together, his irritability and rejection upset you and you must feel hurt. It's clear

that you are trying very hard to remain calm and to engage him in playful ways, but it's really hard not to respond negatively. Then Adam feels rejected in return.

"Adam's insistence on taking charge does not make him feel secure and able to grow up. His therapist, Madelyn, will look for ways to make him feel more secure, to soothe and calm him as well as to engage him in playful activities. While she works with him, I [the interpreting therapist] will be helping you understand what she is doing and how Adam is responding. From time to time we will give you homework assignments, so that you can practice the new ways we find that work well with Adam."

At the beginning of treatment, a decision has to be made whether to have the parents watch the first few sessions while the Theraplay therapist interacts with the child or whether to include at least one parent in the child's session from the very beginning. See Chapter Five for a discussion of the reasons for having parents observe. This decision should be discussed during the feedback session. In Adam's case, we decided to have the parents observe the first two sessions. We judged from our observations that his resistance was not based on panic or extreme distress over separation and that he was secure enough to handle the separation. During the MIM, we had seen many signs that even when he was fussing and showing his distress, he could easily move out of it to a more comfortable engagement. We believed that having a parent in the session would delay his acceptance of the new approach. We also believed that his parents would benefit from watching for a while. They could see what the new approach looked like and gain insights into Adam's needs. His parents felt that if one or both of them came in from the beginning, he would just remain stuck in his usual pattern of clinging and fussing.

We asked Adam's parents to predict how he might respond to their not being in the session and to the playful, insistent presence of the therapist. They predicted (rightly, we soon discovered) that he would be upset, that he would protest and complain and use all his very competent verbal skills to take charge of the interaction. We agreed that this might happen and reassured them that his therapist would pay special attention to whether he was getting too upset. If that happened we would call his mother into the session. We asked how they would feel about his distress. "We don't like to see him upset, but we really need to make a change. Things can't go on any longer as they are."

We told them that most children who come for Theraplay treatment go through a period of resistance. "For some (and Adam will probably be one of those), it comes right at the start. For others it comes after a few sessions. We handle it by remaining calm, by staying with the child, and by finding as many ways as possible to engage him and help him have fun."

MAKING A PLAN FOR TREATMENT. At the end of the feedback session you should come to an agreement with the parents about whether to embark on treatment. In some cases, you may not recommend Theraplay treatment, either because you judge that the child would benefit more from another treatment modality, because you believe that the family can carry on without treatment, or because you believe that the family is not stable enough to have Theraplay as the only intervention (see Chapter Five for a discussion of this issue). If you do recommend treatment, the feedback session should include a description of what Theraplay entails, a discussion of treatment goals, and an agreement about timing and length of treatment.

In planning treatment for any child it is essential to provide the kinds of reparative emotional experiences the child needs, as judged from the nature of the parent-child interaction and your understanding of the problem. If it is clear from the observed interaction, for example, that a child has younger emotional needs, you should explain to the parents that in treatment you will be finding ways to meet those needs by using younger kinds of activities in all the dimensions.

Adam's parents were eager to try Theraplay treatment. They were desperate for a solution to their problem with Adam and were hopeful that Theraplay might help. It was understood from the beginning that there would be five Theraplay sessions during the weeklong, intensive treatment, followed by four more sessions spaced at longer intervals when the family could return to Chicago. The goals for Adam's treatment were modified somewhat from the parents' original list of practical changes (getting him out of their bed, helping him separate from his mother, and preparing him to enter preschool). The goals we developed at the end of the feedback session were to help him feel more positive and motivated to be cooperative and to help him trust that letting his parents initiate and take the lead can be fun and more relaxing for him. When this is achieved, he will no

longer need to control the interaction: he will be able to sleep in his own bed, separate from his mother, and make a good adjustment to preschool. For his parents, the goals were that they will find ways to respond to his needs for nurture and reassurance and that they will be more firm in setting limits. We want the family to regain the sense of pleasure in their interaction that had been lost early in Adam's life.

Adam's treatment will strongly emphasize nurturing activities because he needs to have the calming, soothing experiences that he was unable to accept as a baby and that his current hypersensitive and hyperreactive state requires. He needs many experiences that will lead to his feeling safe and secure. Finding ways to engage him but not overstimulate him will be important. We also will want to provide a very clear structure, both to help him accept having adults take the lead and to help him learn better emotional self-regulation. Whereas challenging activities might be useful in catching his interest, this pseudomature little boy does not need challenge to encourage him to grow up any faster. We did not see his clinging to his mother as a sign that he was afraid to grow up, but more as a sign that he was not convinced that she would be available to him when he needed her.

PLANNING THE SEQUENCE OF A THERAPLAY SESSION

Once you complete the Theraplay assessment and feedback, schedule the first Theraplay session as soon as possible. In preparation for each session, make a plan of the activities you want to use, and the sequence in which you want to use them. Keep in mind the dimensions you want to emphasize for this particular child and consider what will be the best way to capture the child's interest. It is essential that you have a repertoire of playful, enticing activities for engaging the reluctant child in treatment in order to provide a well-structured and well-planned session.

Although sessions must be planned in advance with the goals of treatment and the child's current needs in mind, the plan is always subject to change based on the child's response. Responding sensitively to the child must always be your top priority.

The well-planned Theraplay session includes the following elements. Variations may occur depending on the child's immediate needs.

- The Opening
  - Greeting activities
  - Checkup activities
- The Session Proper: depending on need, a mixture of
  - Structuring activities
  - Engaging activities
  - Nurturing activities
  - Challenging activities
- The Closing
  - Parting
  - Transition to the "outside world"

The Opening

The opening includes both greeting activities and checkup activities. In Chapter Five we discuss the importance of greeting activities in introducing the child to the overall nature of treatment. Here we describe how you begin each session throughout treatment.

GREETING ACTIVITIES. The object of greeting activities is to allow the child to experience pleasure at being discovered. This initial greeting takes place at the moment when you first meet the child in the waiting room. The greeting should be cheerful and personal. In voice, facial expression, and choice of words, you communicate your delight at meeting a new friend or being reunited with an old one. The model for the manifestation of this pleasure is, once again, found in the parent-infant relationship. A mother may greet her baby when she wakes with an eager, "Good morning Merry Sunshine!" "Let me see how big you are today!" Or "I'm coming to get you! Here I come!" The Theraplay therapist uses the same happy, engaging approach. The following are samples of appropriate and warm greetings with which you can usher the child into the Theraplay session: "Oh! If it isn't my friend Paige!" "Hi Ryan, I've been waiting to see you all day!" "I'll give you a piggyback ride into our playroom!"

If you have decided to include a parent in the session from the beginning, the parent is included in the greeting and encouraged to join the activity that will lead into the playroom. If the plan is to have

the parents observe for the first few sessions, you should make the separation as easy as possible. If either the parent or the child looks anxious as they separate, you can tell the parent, "We'll be back to see you in a little while, Mom. You wait right there (in the observation room) until we get back." You can tell the child, "Your mom and dad will be watching us through the two-way mirror. We'll come back to get them when we're finished."

In this way, separations are usually accomplished easily. If they are not, you can invite the parent into the Theraplay room for a few minutes, "Let's show Mom how good you are at balancing before she goes back out to wait for you." Mother can then watch one activity, be helped to applaud, and then ushered out.

CHECKUP ACTIVITIES. The purpose of checkup activities is threefold: (1) to reconnect after the week's separation, (2) to give the child a sense of consistency of self as you show that you remember and can still find the same special freckle or the same strong muscles that you found before, and (3) to convey to the child that she is capable of growth as you compare this week's measurements with last.

The session begins with a checkup during which you examine the child carefully, looking for all his special qualities. These might include the color of his eyes, the way his hair moves when you fan him, or the dimples in his cheek. You can check how big his smile is, whether his bright brown eyes sparkle as much as they did last week, or how many cotton balls he can pick up with his toes. If the child is uncomfortable with this much closeness, make the checkup more active or postpone it until later in the session. Most children welcome a playful "I wonder what's inside those socks!" or "Let's see how high you can jump and put a sticker on the door."

The Session Proper

As you plan your session, you should choose activities from the dimensions that fit the child's needs. It is rare that you would focus on only one dimension. The following is a short list of activities characteristic of each dimension. There is a longer list of activities in Appendix B. Many activities address more than one dimension. For purposes of descriptive clarity, however, it helps to ask, "What is the primary goal for this activity?" Peek-a-Boo, for example, may serve both to engage and to challenge. The purpose for which it is being

undertaken and the manner in which it is carried out determine whether in this particular situation it should be classified as engaging or challenging.

- Structuring activities include "Wait till I count to three, then jump," "Mother, May I?" Stack of Hands, and drawing around hands or bodies.
- Engaging activities include hand-clapping games, counting freckles, Hide-and-Seek, Row, Row, Row Your Boat, and hiding cotton balls on the child for parent to find.
- Nurturing activities include feeding, applying lotion or powder, cuddling, singing a lullaby, and rocking in a blanket. For older children, these can include giving a manicure, painting faces, and making footprints with powder or paint. The latter, of course, requires some gentle foot washing when the job is done.
- Challenging activities include having the child balance on a stack of pillows, arm or thumb wrestling, paper punch, tug-of-war, and cotton ball free-for-all.

Each dimension serves a distinct purpose, but their underlying unity is in their ability to foster an alliance between the child and the adult. All the activities can serve to (1) offset the child's chronic experience of mistrust, loneliness, and isolation; (2) negate the child's "bad," worthless, alienating, or impotent self-image; and (3) allow the child to view himself as a contributing team member.

Planning the Sequence of Activities

Having chosen activities according to the dimensions the child needs, you should also plan the sequence of activities within the session so that there is a good rhythm and balance between active and quiet. After the quiet checkup activities, move into some lively, playful activities; slow down for some soft, gentle, calming ones; build up to a lively crescendo again; and end, possibly, with feeding and singing in a quiet, integrated mood. Throughout the session, you provide structure by confidently moving from activity to activity, making sure that the child is safe, and clearly defining the rules when needed. Within this general format, specific issues (for example, the child's fear of new experiences, his avoidance of body contact,

his discomfort with body disequilibrium, or his restlessness and hyperactivity) are dealt with through activities especially designed to help these problems. In Chapter Five we give more details about how to tailor your approach to the specific needs of each child.

Of course, sessions need not follow this suggested format unvaryingly. Sometimes, for example, a child may appear for his session in such an agitated state that it is best to begin, after the greeting, with nurturing activities that calm him. Sometimes his life has been such a series of confrontations and conflicts that he requires only order and predictability (structuring activities).

Both greeting and closing, however, are essential elements of any Theraplay session. Children who require Theraplay often lack spatial and temporal demarcations in their lives; bedtime and mealtimes may, for example, be unpredictable. The opening and closing of treatment sessions, as well as their physical location, should therefore be clearly articulated. A child who is permitted to wander in at the beginning and drift out at the end of his sessions or who is given sessions that are haphazard may feel even more confused as to his identity and may have an increased sense of diffuseness about the world.

The Closing

There are two aspects of the end of a session: the parting from the therapist, and the return to parents.

PARTING. The goal is to provide a transition back into everyday life, while helping the child to carry the experience with him and maintain an ongoing sense of the relationship. While putting the child's shoes back on, you and the child can recall what was fun about the session and suggest some continuity during the week ahead. For example, "Kevin, I really liked the way you did that tiptoe game today. I hope you will try that with some of your friends this week," "Mom, can you and Sally sing that special song each night before she goes to sleep?" or "I'll be thinking about you."

RETURN TO PARENTS. As a final step, put on the child's shoes and socks and help her with her jacket in preparation for returning to "the outside world." Remind her, "I'll see you on Wednesday." If the parents are in the session, they can help with this process. Make sure

that she and her parents stay connected as long as possible, "See if you can hold hands all the way to the car." Do not leave the child alone in a waiting room or allow her to run on her own ahead of her parents to the exit. You want to give a message that her parents provide the continuity between you and her home world. If the parent has not been in the session, hold the child's hand and help her reconnect with her parents. "Mom and Dad, Sarah's got some fun things to do with you when you get home." As part of your preparation for parents to manage this transition, you should advise them not to ask the child about his experience, but simply to be open to whatever the child volunteers.

DOING TREATMENT: SESSIONS ONE TO FOUR

In the following sections, we discuss the sequence of treatment and how it is structured.

During the first four Theraplay sessions, the parents sit in the observation room with the interpreting therapist, who helps them reflect on and understand what is going on with the child and his therapist. If you have decided to include a parent from the beginning, she will be in the room, perhaps with the child in her lap or sitting beside her on the pillows. The Theraplay therapist takes the active role and encourages the parent to take turns interacting with her child. As treatment goes on, parents will spend more time in the room and will be more actively involved.

From session five on, parents join the child in the Theraplay room for the second half of each session. Although it is not invariable, most children go through a predictable sequence of phases in their response to treatment. There is a period of tentative acceptance in which the child seems to be saying, "This is interesting. It's a bit strange, but it could be fun." Following this comes a period of resistance. At this point the child may pull out all the stops in his efforts to resist engaging with the therapist and his parents in this new way. It is as though he were saying, "I never trusted anyone before, so why should I trust you?" Following this is a phase of increasing trust in which the child seems to be saying, "Well, I guess this really is all right. I think I can trust you." When this phase is well established and the parents have become part of the playful interaction of treatment sessions and are able to carry on at home, it is time to plan for termination. See

Chapter Five for more information about how you can guide the child through these phases of treatment.

Although Adam's treatment was shorter than the usual pattern, it can serve to illustrate what takes place at each step in the process. In Adam's case, we brought his mother in at the end of the third session and both parents for the final two sessions.

Adam skipped the tentative acceptance phase and started right in with strong resistance.

THERAPLAY IN PRACTICE

Adam's Treatment

Although we anticipated some resistance to separating from his mother, we began sessions without either parent so that the Theraplay therapist could establish the new way of relating before they joined the sessions. We did not, however, create a completely separate situation: both parents were sitting across the room, partly visible to Adam, observing the session from behind a TV monitor.

To make the separation as easy as possible, Madelyn, his therapist, planned an intriguing beginning: walking on tiptoe together into the playroom. She planned to check him out for freckles, color of eyes, and strength of hands and legs, hoping to get him to kick a pillow with his feet or push her over with his hands. Following the active pushing and kicking games, she planned to do some calming activities, such as making lotion handprints and feeding him some chips. In the face of his resistance, she was unable to do many of these activities; however, in spite of his protests she continued to attempt to engage him with active games, some of which caught his interest and interrupted his resistance. During the first fifteen minutes, Adam frequently turned toward his mother and called for her, but he never tried to leave Madelyn and go to her.

Session One: Resisting Engagement

The session begins, as his parents predicted, with much protest on Adam's part: "I want my Mommy!" Madelyn

reassures him that his mother is just across the room and that after they have played a few games, he will be with her again. Because Adam's protests show more anger than anxiety and fear, Madelyn calmly persists in her efforts to engage him, first asking him to kick pillows with his feet, next having him push her over, cooling and soothing him when he is hot, offering him a drink of water, all to the accompaniment of encouraging positive statements: "I'll take good care of you," "You're okay," and "How strong you are." When Adam's anger becomes particularly intense, Madelyn mirrors his intensity as she says, "You're mad! You're really mad!" Suddenly, in the midst of his protest, Adam stops short and asks, "What's your name?" In spite of his discomfort, he has realized that here is someone he can relate to.

Parents Observing

Although his parents are pained by his resistance, they agree that his cries are not a sign of genuine panic or distress, and they understand the need for persisting in the face of it. The interpreting therapist points out the moments when Adam's interest is captured by an activity, the few times that Madelyn's firm touch calms him, and the fact that in spite of his protest, he does not leave the treatment area to run to them. His parents express amazement at the therapist's resourcefulness in finding interesting activities to engage him and in her perseverance in staying with him and not getting angry. The interpreting therapist says, "We want him to feel that he's a great kid just the way he is. What he expects is that Madelyn will give in, or give up on him and reject him. Having her persist and remain positive is something totally contrary to Adam's expectations."

In the Session

The following scene takes place about fifteen minutes into the session. His therapist sits facing Adam; her voice is soft and soothing.

MADELYN: (rubbing lotion on Adam's hands) Oh, you have beautiful hands.

ADAM: That's too much cream.

MADELYN: It's lots and lots and lots. Oh, I like this little boy.

ADAM: Didn't my Mommy tell you I have to go home?

MADELYN: You will be going home soon. . . . Look at this, look what I have. (holds up a strand of curly, blond hair) I've got a wonderful piece of Adam hair. (Adam continues to resist, but therapist remains undistracted) Okay, Adam, here's a piece of paper. Now I need to put a little more lotion on your hands, on your soft, soft hands.

ADAM: (momentarily interested, he accepts lotion then turns away from therapist) Mommy? I want my Mommy.

MADELYN: (presses Adam's hand onto the piece of construction paper) There's a thumb . . . and this is your pointer . . . and here's your little finger. (holds up the piece of paper, which now has an imprint of Adam's hand) Oh! Look at that! It's Adam's hand! Now we'll make a picture of your foot. (begins to take off Adam's sock)

ADAM: No! (hesitates for a moment; points to his toe) Look, I have a little boo-boo.

MADELYN: Look at that, you do have a little boo-boo there. Well let's take care of that. Let's put some lotion on it. (rubs some lotion on Adam's foot) Adam, you have five toes! You're just right!

ADAM: I am not. (stops crying for a moment and shows interest)

MADELYN: You have one, two, three, four, five toes. Adam, you have just the right number of toes. (rubs more lotion on the bottom of Adam's foot)

ADAM: Mommy! (therapist continues) What kind of lotion is that? It smells.

MADELYN: (places Adam's foot on a piece of paper, making a footprint with the lotion)

Parents Observing

Adam's parents comment on how hard he is working to maintain control of the situation. "It's just like at home." The

interpreting therapist points out that with the introduction of the lotion, Adam stopped crying for a moment and shifted to using his highly developed verbal skills to control the interaction: "That's too much cream;" "Didn't my Mommy tell you I have to go home?" "But notice," the interpreting therapist says, "that though she acknowledges that he is asking questions, she doesn't let them stop her. When she made the print of his hand, Adam was really interested. And it seems as though Madelyn's focus on his body has made him more aware of it. See how he points out a 'boo-boo' on his toe and asks her to look at it. In spite of his protests, he is beginning to see Madelyn as someone who can take care of him."

In the Session

Just before the end of the half-hour session, Madelyn cradles Adam in her arms and sings:

Twinkle, twinkle little star,
What a handsome boy you are.
Curly blond hair and soft, soft cheeks,
Bright blue eyes from which you peek.
Twinkle, twinkle little star,
What a special boy you are.

Adam attempts to distract her with questions, but Madelyn stays focused on making him feel well cared for.

In this first session, Adam's resistance takes the form of angry crying, verbal threats, and sophisticated talk and questions designed to engage his therapist in an argument. Madelyn is able to capture his attention at several points and he relaxes and engages briefly with her. Adam has such an extensive repertoire of ways to take control that it is no wonder his parents have had difficulty being firm with him.

As the family leaves the Theraplay room, Madelyn says, "I'll be looking forward to playing with you tomorrow. I'll be thinking about your bright blue eyes, and your very special

freckles. I'll have some fun things planned for us to do." Then, placing Adam's hand in his mother's, she says, "Mom, be sure to hold Adam's hand all the way to the elevator. Dad, help him push the button to call the elevator."

Session Two: Protest and Tentative Acceptance

In planning for this second session, Madelyn takes into account two things she has learned from her first session with Adam: He is very easily overstimulated by fast-paced or exciting activities, and he responds well to challenging activities. She therefore plans to modulate her tone of voice and the speed with which she does her activities, to find as many activities as possible that are calming and soothing, and to add challenge to the quiet nurturing activities to keep him engaged. To forestall his efforts to run the show, she will have him wait for her playful signal before doing an activity. Her plan includes a game of Cotton Ball Blow, which Adam had enjoyed the day before, playing Cotton Ball Touch (the challenge is for Adam to close his eyes and tell where he is being touched), and Row, Row, Row Your Boat, an activity that lends itself to modulations of tempo.

In the Session

Madelyn greets Adam with a challenge: "I'll bet you can't walk on your hands into the playroom." Intrigued, Adam puts his hands on the floor and allows her to pick up his legs and guide him the few steps into the room. Only then does he remember to protest, but this time the protest is less intense.

Five minutes into the session, Madelyn and Adam sit on the floor, face to face, legs outstretched. Madelyn places a cotton ball in the middle of a large pillow that rests between them.

MADELYN: You see if you can blow the cotton ball under my arm, and I'll see if I can blow it under your arm. Ready, set, go. (Adam blows the cotton ball under the therapist's arm and off the pillow) Oh Adam, you're a great blower!

ADAM: (as if startled by her enthusiastic response, begins to call out) Mommy! Mommy!

MADELYN: (continues with the game, placing the cotton ball in the middle of the pillow) Ready, go! (Adam immediately stops fussing and blows hard; he wins again)

ADAM: (in response to Madelyn's excited praise of his success) Mommy! Mommy!

MADELYN: You have two big blows and I don't have any yet! (sets up cotton ball) Okay, Adam, blow when I say go. . . . Go! (Adam stops crying, blows, and wins again) Great job! You blew really hard!

Parents Observing

The parents report that immediately after yesterday's session Adam said he never wanted to come back again; but this morning, he made no protest about coming. They are proud of having been firm about putting him to bed last night. "He settled right down once he realized we really meant it." They notice that in this second session he is calling out to his mother much less often. When Adam and Madelyn play the cotton ball hockey game his father says, "He's really getting into it, isn't he? It seems like he's enjoying it."

In the Session

Madelyn and Adam sit facing each other, playing the Cotton Ball Touch game, which proceeds as follows: After the therapist touches Adam somewhere with a cotton ball, Adam must point to where he was touched. Though Adam follows Madelyn's directions (he closes his eyes when asked and identifies where he was touched), he still calls for his mother from time to time, but with less frequency and intensity. Madelyn moves smoothly from one round to the next, and Adam settles without fuss.

Parents Observing

The interpreting therapist says, "Notice how he's able to close his eyes while he waits for Madelyn to touch him with the cotton ball. That takes a lot of trust. One reason she chose this game is that it is a good way to help Adam accept soothing

touch without having to protest about it. Although he is still calling for you, there seems less and less urgency about it." When each successful touch is followed by a wail for "Mommy," the interpreting therapist says, "Anytime the action stops for a moment, he calls for you. It's almost a habit."

In the Session

The therapist holds a now comfortably relaxed Adam on her lap and feeds him frozen yogurt with a spoon.

ADAM: It's melting (referring to the yogurt).

MADELYN: It sure is melting. (continues feeding) Mmmm, yummy.

ADAM: (points to a spoonful) That's too much!

MADELYN: (ignores this comment and goes on feeding)

ADAM: Too much. (eats the yogurt)

MADELYN: (looks at Adam) You have sparkly blue eyes.

ADAM: What's that white stuff?

MADELYN: (continues feeding) Mmmm.

Parents Observing

The interpreting therapist says, "Even though, at each mouthful, he is complaining about something, he accepts the food. He is beginning to feel much less anxious. Do you think you could do what Madelyn is doing? Avoid getting caught up in his criticism of what you do? It won't be easy. He's so very good at choosing just the right thing to say that might catch you up. Could you two remind each other when you see that Adam has distracted one of you with his questions?"

In the Session

Adam and Madelyn sit face to face, holding hands. They rock back and forth in a "rowing" motion while she sings "Row, Row, Row Your Boat." Madelyn sets the pace, sometimes slow and sometimes fast. Adam clearly enjoys the game. When the session is over, Madelyn brings Adam to his parents and gives one of his hands to each parent, asking them to hold on until they get to their car. "Have a good evening. I'll see you

tomorrow," she says. Adam smiles and walks out with his parents.

Session Three: Growing and Trusting

Since Adam has begun to be more comfortable in his sessions, Madelyn can spend less time trying to engage him and more time doing calming, nurturing activities and playful give-and-take games. She plans to repeat the Cotton Ball Touch game, this time asking Adam to touch her as well. She wants him to play some active games such as kicking the pillow over to see whether she can help him modulate his excitement even while being very energetic. Because this is the middle session in Adam's short treatment, Madelyn will have Adam's mother come in at the end to do some nurturing activities with him.

In the Session

Madelyn scoops Adam up in her arms and gives him a piggyback ride into the playroom. For the first time, Adam makes no protest when he leaves his parents. They again play the Cotton Ball Touch game. This time, however, they alternate roles; first the therapist touches Adam with the cotton ball while Adam guesses, then Adam touches the therapist with the cotton ball while the therapist guesses. Adam smiles and giggles with pleasure.

Parents Observing

The interpreting therapist points out to the parents that Adam is now trusting Madelyn and is able to engage in lively give-and-take games. He no longer calls for his mother after each action. His parents report that Adam said he liked Madelyn: "She has lots of good games to play." The evening had been calmer and more pleasant than usual.

In the Session

Adam sits facing Madelyn with his feet tucked under a large pillow. On Madelyn's signal, he kicks the pillow and it flips over.

MADELYN: Look at that! Oh boy! How about two pillows?

ADAM: (smiles and nods; he is clearly having fun) Yes!

MADELYN: (picks up another large pillow) Oh, this is a very heavy pillow. Feel this . . . it's too heavy. (puts it aside)

ADAM: Yeah.

MADELYN: (places another pillow on top of the first) You have very strong legs. Okay, now when I say . . . What would you like me to say?

ADAM: Apples.

MADELYN: Apples. Okay, ready . . . peanut butter . . . chocolate . . . strawberry . . . apples!

ADAM: (kicks the pillows and they fall over)

MADELYN: Look at that! My goodness, incredible!

ADAM: (turns around to grab another pillow; Madelyn gets the pillow for him instead)

MADELYN: With your very strong legs, I think you can do three pillows. (stacks three pillows on Adam's feet)

ADAM: (smiling) It's going to be heavy.

MADELYN: I know. Okay, the signal is watermelon. (Adam nods) Peanut butter . . . chocolate . . . watermelon!

ADAM: (kicks the pillows and they all fall over)

MADELYN: Wow! Fantastic! (with a bright smile)

Parents Observing

The interpreting therapist says, "I'm sure you've noticed that Madelyn often gives a signal before she asks him to do something. That helps Adam learn to wait before he jumps in. She always makes it funny or surprising, using words like *peanut butter* and *strawberries* as signals, so that it's not boring. Adam is getting better and better at waiting. One of his problems is that he is so fast and so easily excited that he needs help to slow down. I want you to practice this at home. . . . Did you notice that one time she gave him the responsibility for giving the signal? Since Adam is no longer insisting on taking charge, Madelyn can allow him some say in the proceedings. . . . Adam is so proud of his ability to kick the pillows. Did you see that Madelyn avoided the heavy pillow? That's because she wants Adam to feel successful. While we want Adam to

accept being taken care of, we also want him to feel very competent and very good about himself."

To the mother she said, "Madelyn will be calling you to join them toward the end of the session today. She will tell you just what to do. Sometimes children become more resistant when their parents first come into the session. They seem to have to test whether their parents can be as firm as their therapist has been. If that happens, don't worry. Madelyn will help you handle it." To both parents she said, "Tomorrow both of you will be joining in for the last half of the session. So dress comfortably."

In the Theraplay Room

Adam's mother is called into the playroom to help put his shoes on. He asks to sit in his mother's lap, but Madelyn says, "Mom needs to sit there (facing him) so that she can put your shoes on." Adam accepts this and, at the end, leaves the session happily with his mother.

DOING TREATMENT: SESSIONS FIVE TO TEN

The format for the first fifteen minutes of each remaining Theraplay session proceeds as before: parents and interpreting therapist observe Adam and Madelyn so that they can learn more about what is going on. For the last fifteen minutes, however, the parents join the fun in the Theraplay room.

Because we want parents to enter the Theraplay room in a lively, upbeat manner, the Theraplay therapist often hides with the child under pillows and blankets for the parents to find them. Another variation is to hide notes or special treats on the child for the parents to find. See Chapter Six for more details about how to guide parents in their interactions with their child in the Theraplay room.

It is important to plan well for the ending of treatment. At the third-to-last session you should announce that there will be three more sessions and that the final session will be a party. Preparations for the termination party should be made during the next-to-last

session. You might give two choices for what the child would like to eat, such as cupcakes or cookies. "What color balloons would you like?" The joyous, upbeat nature of the party, rather than elaborate arrangements, should be emphasized.

THERAPLAY IN PRACTICE

Adam with His Parents

In Adam's case, of course, we were not able to give three sessions' notice. We all knew from the beginning that we would have only five sessions in this intensive series. We also did not have a party because there had been so few sessions and we would be seeing him again very soon. The plan included four follow-up sessions one month apart.

Session Four: Parents Enter the Room, Preparation for Termination

Our goal for Adam's last two sessions was to give his parents practice taking charge in a playful and engaging manner, regulating his excitement, nurturing him and, above all, having fun with him. We chose to have his mother come in alone, rather than both parents at once, because establishing Adam's relationship with her on a more secure footing was essential to the healing of the whole family. Having both parents join the session at once would have been too stimulating for an easily dysregulated child like Adam.

In the session

At the beginning of this session, Madelyn reminds Adam that they will be having just one more session this week. "Then I won't be seeing you until just after your birthday." (Because a month is meaningless to a child Adam's age, his therapist described the time in relation to something Adam could understand, his birthday.) Adam accepts her announcement with no comment. He enters happily into the games she has chosen to play with him.

Fifteen minutes into the session, Madelyn says, "It's time to have your mom come to play with us. Let's hide so she can find us. . . . Mom, close your eyes so you can't see where we're hiding." With lots of giggles and excitement, Adam and Madelyn build a fort with pillows and hide inside it under a blanket. "Call your mom. Call her real loud. Say, 'Come and get me!' " Adam calls with enthusiasm, "Come and get me, Mom!"

The interpreting therapist and his mother come into the room and pretend to look for Adam.

INTERPRETING THERAPIST: I thought Adam was here, Mom. Let's look around . . . do you think he's under this mat? No . . . look at that! I saw those pillows wiggle a little . . . Adam? (Therapist and mother peek into the fort) There he is! Look at his smiling face! Mom, give Adam a big hug. (Adam and Mom embrace, bright smiles on their faces)

A few minutes later, Mother, Adam, and the two therapists sit in a circle and make a stack of hands. At first they go slowly, then faster and faster. Adam becomes excited and pulls his hands out of the stack out of sequence.

MADELYN: Oh! That was exciting. Let's see if we can do it very slowly. (They start again, stacking hands carefully and then, with exaggerated slowness, each hand is moved from bottom to top; Adam goes along very well with the slower pace, looking proud of his accomplishment) That was great! Now let's see whether we can go from the top down. That's a lot harder, but I'll bet you two can do it. (Adam needs help with the unexpected order, but he manages without getting too excited) Mom, look how well he does that. Could you two do that at home? Remember to do it fast and then slow and see if you can manage not to get mixed up. (Adam smiles; he has obviously enjoyed the game and likes the idea that he can do it again at home)

To give Adam's mother practice in taking charge and making sure that he follows her directions, the therapists next set up a game of "Mother, May I?" With prompting from the interpreting therapist, Mrs. B. directs Adam to take giant steps and baby steps and to do so only after asking, "Mother,

May I?" Adam is so pleased with the game that he begins to take over—"How about tiptoes?"—but Mrs. B. remembers that the object of the activity is to practice having Adam follow her lead, and she gently says, "No Adam, it's my turn to be the leader."

Toward the end of the session, Madelyn and the interpreting therapist rock Adam gently in a blanket and then carefully place him in his mother's lap. She cuddles Adam in her arms as she feeds him a cookie and gives him some juice. The interpreting therapist puts her arm around Adam's mother and helps her rock slowly to the tune of the "Twinkle" song ("What a special boy you are"). Adam relaxes into his mother's arms. It is a lovely, quiet moment, which all enjoy.

At the end of this session, Adam sits in his mother's lap, facing his father.

MADELYN: Dad, Adam needs you to put his socks on. First you need to put a kiss on each foot! (Father kisses each foot, and then quickly puts Adam's socks on. Adam giggles with pleasure. He is now much more comfortable with his father and is no longer resisting contact with him.)

Final Session

The emphasis was on Adam's favorite activities and all the wonderful things that Madelyn and his parents had discovered about him.

In the Session

Madelyn greets Adam warmly and says she has been looking forward all day to seeing him. She takes note of all the special features she has discovered about him: his curly hair, his special freckles, his strong arms. She then revisits some of Adam's favorite activities, such as kicking the pillows over and Cotton Ball Hockey. She mentions again that this is their last session together until after Adam's birthday. She will remember him during that time and look forward to checking whether he has any new freckles or whether he has grown taller.

In preparation for bringing Adam's parents into the session, she hides four notes on Adam. His parents will find them and lead the activities that are described in each. Adam finds the hiding a bit ticklish, but mainly is excited by the prospect of hiding something for his parents to find. Once the notes are hidden, Adam sits on Madelyn's lap facing his father. He has an expectant look as he waits for his father to find a note. He is so excited that he can't wait for his father to find the note and points to the place where one of them is hidden.

FATHER: (reads note) Pop cheeks.

MADELYN: Do you know how to pop cheeks?

FATHER: (nods and moves closer. Adam puffs up his cheeks with air. His father then gently presses them together with his fingers; everyone laughs)

ADAM: Mommy. Mommy's turn. *[He can't yet give up trying to direct things.]*

MADELYN: Okay, this time a tad closer so he can blow right on you. Get a little closer; he's ready for you!

FATHER: ("pops" Adam's cheeks; everyone laughs again)

MADELYN: Okay, now it's Adam's turn. Dad, make your cheeks pop up . . . (Adam leans over and, with a hard, impulsive gesture, pops his father's cheeks) Dad, help him do it very gently. (Father holds Adam's hands and guides him so that he "pops" his cheeks gently)

Adam's mother found a note telling her to play Peek-a-Boo with him. Adam sits in Madelyn's lap facing his mother. She peeks at him from behind her hands, then puts her hands over Adam's eyes and has him peek. The interpreting therapist suggests that mother play Peek-a-Boo with Adam's feet. Adam grins with pleasure at the silly variation.

Father's final note tells him to have Adam push him over (an activity that Father has seen Adam and Madelyn do together). Adam sits on a pillow in front of his father. The two are holding hands.

MADELYN: Give him a signal, Dad.

FATHER: Okay, when I say "peaches." Ready . . . apples . . . grapes . . . peaches! (Adam pushes and his father rolls back,

supporting Adam on his knees above his head; Adam laughs with delight as he looks lovingly into his father's eyes)

Parents Observing

Adam's parents are delighted with the progress that they and Adam have made during this brief five-day intervention. They report that Adam is much more willing to do what they ask him to do. He let his father put him to bed last night. They are hopeful that he will be ready by the time school starts at the end of the summer. They are especially pleased with what they have learned. Mom said, "I think it had become so hard to be with him, that even when I was with him, I was pushing him away. Now that we are more relaxed together, I enjoy being with him much more. He's more fun to be with. That feels really good." Dad said, "There's a big difference for me. I was worried that he would never let me do anything with him. Now we can have fun together."

The family left knowing that they could call us during the month before their first checkup session but feeling that they probably wouldn't need to do so. It was a delightful scene as they skipped away down the hall, holding hands all the way to the elevator.

DOING CHECKUP VISITS

Because of the concentrated, intense format of Theraplay, remarkable changes often occur in a short time—as was clearly demonstrated with Adam and his parents. In order to help families maintain the new ways of relating, checkup visits are an integral part of the treatment plan. Typically we schedule visits once a month for the first three months and then once every three months to complete the year. Some families return later for an occasional visit. All are encouraged to phone should problems arise in the meantime. Most often these problems are handled in telephone consultation. Occasionally the whole family is signed up for a special session or two.

When there are two therapists, parents spend the first half of the checkup session talking with the interpreting therapist to bring her up to date on what has been going on. They then join their child

in the playroom. When there is one therapist, a parent conference should take place before the session, either by telephone or in person. In either case, the Theraplay session follows the format established during treatment. At the outset, the Theraplay therapist expresses her delight at seeing the child again and looks for familiar characteristics as well as those that have changed. "Oh good! You brought your freckles with you . . . except, guess what? Here are some brand-new ones. These must have come from those weekends at the beach." "Look at that, you brought your wonderful smile along. And look! Two new teeth! What beauties!"

Children seem to love the checkup visits. Parents often report, "We don't know why we bring him. There really hasn't been anything wrong. But he does love to come back here." In their talk with the interpreting therapist, parents update her on recent developments and may ask for advice on, or approval of, what they have been doing. "We've been having special playtimes together [setting firm limits, doing surprise activities, and so on] whenever he gets tense and driven [or wordy and legalistic, or too disorganized], just as we learned to do here. Is it still what we should do?"

THERAPLAY IN PRACTICE

Adam's Checkup Visits

Because Adam's treatment was so brief, we scheduled our checkup visits once a month for four months. Adam's four checkup visits followed the format described above. On the first one, he came eagerly into the room flexing the strong muscles he had developed. "Look at my big new muscles!" Madelyn measured his muscles and height. She found that he had grown a quarter of an inch and that he could now jump and touch a spot on the wall a full inch above the earlier mark they had established. During the session, Adam and Madelyn played many of the games they had enjoyed before and some new ones that she had designed especially for him. In his eagerness, Adam tried to direct the show from time to time, but there was none of the anxious, demanding tone that had so characterized the first sessions of his treatment.

Adam's parents said he had been looking forward to coming. They too were eager to return, because they felt the need to bolster their new skills of taking charge and responding to Adam's needs for calming and nurturing. They recounted their successes (and their failures), emphasizing that they felt very hopeful about the success of the new approach.

The final three checkup sessions went much as the first one. Each time Adam seemed more accepting of his parents' attention and more comfortable letting them take charge. Just before the third session, Adam successfully entered the preschool program in which his parents had hoped to enroll him. His mother took time off from work to make the transition go well, staying for the first two days, and then shortening her stay until he was able to remain in school for a full day without her. This was the school's standard procedure and not a special concession for Adam. In later phone conversations, his parents reported that his adjustment to school had been very good. "He now goes happily to school. He has made a friend and he seems content. We are very happy with the outcome of our work with you."

Notes

1. For more details about the administration and interpretation of the MIM, consult the *Pre-school, School Age MIM Manual* (Booth et al., 2005).
2. For more information about questions to consider for each dimension see the *MIM Manual* listed above.

CHAPTER FIVE

Working with the Child

Having described the basic structure of Theraplay treatment in Chapter Four, we now provide more specific guidelines for creating the therapeutic experience into which you invite the child and her parents. We discuss

- The typical phases of the child's response to Theraplay treatment
- How to tailor treatment to the needs of each individual child
- How to handle the child's resistance
- How to handle therapist countertransference
- Treatment guidelines for the therapist

GUIDING THE CHILD THROUGH THE PHASES OF TREATMENT

Although Theraplay emphasizes the importance of responding to each child individually—an emphasis that might lead one to expect that treatment for each child would be very different—in fact, in terms of the child's level of engagement and acceptance the course of Theraplay treatment unfolds in a fairly predictable pattern.

Theraplay treatment falls roughly into the following six phases:

- Introduction
- Exploration
- Tentative acceptance
- Resistance
- Growing and trusting
- Ending

Though the sequence may vary according to the child's age and the nature of the problem, it is useful to look at the child's responses in terms of these levels of acceptance. It is particularly helpful to be aware of the likelihood of the resistance phase. It can be reassuring to you and to parents to know in advance that the child may have a period of testing this new relationship before increasing trust and acceptance lead to improved behavior.

We cannot estimate precisely how long a particular phase might last. Because Theraplay is a relatively short-term treatment, a child is unlikely to remain very long in any phase. Typically, children begin by being intrigued, though slightly bemused, by this new way of interacting with adults. Often the resistance phase begins after the second or third session. As we saw with Adam in Chapter Four, however, some children protest right from the start before moving to tentative acceptance. Children with attachment problems may begin with a "honeymoon" period of cheerful compliance and superficial engagement. Then, as they feel themselves becoming connected with their therapist and their parents, they shift to patterns of avoiding closeness and taking charge, patterns that have helped them survive in the past. For such children, defensive resistance will be an issue throughout much of treatment.

Introduction Phase

Although they are never spelled out verbally, the ground rules are clearly set at the very first session:

- Theraplay sessions will be fun.
- They will be guided, organized, and kept safe by the therapist.

- They will be focused on achieving moments of attuned connection between the child and the adults, rather than on talk and exploration of issues.

At your first meeting, as at the beginning of every session, you should quickly assess the child's readiness to engage and choose your approach to attune to his availability. Does he need to hide behind his mother's legs for a moment before accepting your greeting? Or is he ready to take your hand and take big steps into the playroom? Whatever attuned approach you choose, it should convey to him "I know you're basically a strong, fun-loving, and fun-to-be-with person, and right from the start I'm going to present you with the most appealing picture of the world I can conjure up."

After announcing, "I'm Melissa," you might say, "Let's see if we can take giant steps together all the way to our room," or "I'll take one hand and Mom, you take her other. Let's see if we can swing Jane with us into the play room. One, two, three, swing!" Thus connected, you and the child leave the reception area and head for the therapy room with the parents in tow. If you have a second therapist, he will accompany the parents into the observation room. In this case, you can show the child where they will be and say, "Mom and Dad will be watching us from this room. We'll come get them when we're through playing." The action is confident and engaging. There is little opportunity for the child to dwell on doubts or to verbalize reservations, thus reducing the period of anxious anticipation to a minimum.

Such a lively greeting or energetic way of moving to the treatment room may not always be possible. It may be too noisy to begin in such an active manner in a public reception area. If that is the case, you can invite the child and her parents to come with you to the Theraplay door and at that point begin the active, playful introduction of the child into the nature of Theraplay itself. Sometimes the child is not ready for such a sudden introduction to Theraplay and will need her parents to be with her in sessions from the beginning. Very young children and children who have been traumatized or abused or have had many foster placements should have their current caregivers with them from the beginning and the introduction to Theraplay will be quieter and more sensitive. It is always important, however, to be confident and positive and to engage the child in some activity from the start. See Chapter Nine for a discussion of how to adapt Theraplay

to meet the needs of children who have experienced neglect, trauma, and loss.

Throughout the course of treatment all Theraplay sessions have this same confident, upbeat, playful quality. There is no need to explain the nature of Theraplay to the child (though you will have explained it carefully to the parents); every attuned, playful action teaches her a little bit more. If you sense that the child is anxious or uncertain, you can slow down and take steps to make her more comfortable, but you should remain steady in your plan to show her the nature of the experience you are embarking on together.

Exploration Phase

In the exploration phase of treatment, you and the child actively get to know each other. This is a crucial step toward beginning to create change in the child's inner working model of himself and others. This exploration begins in the very first session as you look for the child's many interesting physical characteristics: "Let's see what you brought with you today." This is analogous to a mother's checking out her newborn baby by counting his fingers and toes, feeling his soft hair, and seeing how his arms and legs move.[1] You can check the color of the child's eyes, count his fingers or his freckles, discover whether his hands are warm or cold, and feel how strong his muscles are. In the process of looking for the child's special characteristics, you may find small bruises or scratches. These should be carefully attended to; rubbing lotion or powder around the spot, having the parent kiss the spot, and commenting in a sympathetic tone that you know that must have hurt and you want to take good care of him. Do not announce your Checkup as "Let's look for hurts." The focus should be on looking for positive qualities. If a hurt is found, take care of it. Checkups continue to be part of the beginning routine of most sessions throughout treatment.

The exploration phase will probably extend over more than one session as you learn about the child and the child in turn learns about you and the nature of the new relationship you are offering. In the process, the child comes to view herself in a new light. She may not have known before that the hairs on her arms stand up when you blow on them, that she can jump gracefully off a table into your arms, that she can touch the ceiling while balancing on a stack of pillows, or that she has twenty-eight knucklebones. You can turn even negative behaviors around to find a more lovable side. When

the child defiantly goes limp, you might use a paradoxical approach, telling her what a skillful "rag doll" she is. Or when she turns her head to avoid eye contact, you might say, "You surprised me. Where did your eyes go?" She may not have known before that she is lovable even at her most resistant. Through your accepting interest in all her qualities, she is learning that she does not have to be a "good girl" or master difficult tasks in order to be accepted by you and her parents.

During the exploration phase, the child must become aware of you as a distinct person, including your facial features, your voice, and how confidently you move. It is very important that the child leave each session with a clear image of you. Your goal is to achieve moments of intense, joyful connection and awareness of each other that will be held in both your minds throughout the week.

The impact of an early exploration session on one little boy was clearly demonstrated when he greeted his therapist the following week with "Look, I found another freckle!" Throughout the week he had remembered his therapist and the fact that she was intensely interested in his special freckles.

Tentative Acceptance Phase

Following their initial surprise at the special nature of the Theraplay sessions, many children move into a tentative acceptance phase, which may begin in the first session and extend into the following sessions. On the one hand the child may go along with the activities, but reserve is the underlying tone. You must be sensitive to the child's uncertainty and understand that her involvement may be only on the surface. On the other hand, children who handle their insecurity by being indiscriminately friendly with strangers may respond to the initial sessions with enthusiasm and apparent intimacy. This response, however, should not be taken as evidence of a genuinely relaxed engagement. Rather, it may be a self-protective stance that preserves the child's sense of safety in this unfamiliar situation.

During this period, you should continue to be a clear, persistent presence: sensitive, responsive, appealing, and fun. You should not be seduced by apparent acceptance into backing away from your efforts to engage the child in a more genuine and trusting relationship.

Resistance Phase

At some point the child may become actively resistant to any further efforts you make to connect with him: the honeymoon is over. The

child who had previously appeared so accepting—if not outright enthusiastic—may suddenly become limp and mute or actively resistant and negative. This period of resistance stems from the child's need to maintain some level of control until he feels more trusting. It signals that he is genuinely affected by your presence, but as yet is uncertain that you will take his needs into consideration.

Your response to the child's resistance should continue to be matter-of-fact and engaging, conveying to the child that you will attend to his needs, that you will stick by him no matter what, and that the games you want to play with him will be fun. You need to let him know that his reluctance or refusal to join in does not upset you. The resistance may continue over a few more sessions in the same way or with variations. In the face of your firm perseverance and implied hopefulness, however, the resistance will diminish in intensity and it will eventually disappear. The first clues to its reduction often come in the form of surreptitious eye contact, moments of calm engagement, or even a fleeting smile that appears as though it had broken through in spite of itself.

Though it is helpful to be prepared, not every child goes through a resistant phase. Some children are so open to what Theraplay has to offer that they enjoy every minute of it. Don't think that you haven't reached the core of the problem if you have not met with resistance. You should never provoke resistance just because you think it a necessary part of the healing process.

For those children who do resist, however, getting past their resistance is central to the outcome of treatment. Because parents often find it hard to watch their child go through a difficult struggle, it is important that you prepare them in advance for the possibility. Resistance may show up both in the session and at home and school in the form of an increase in the behaviors that led to the need for treatment.

Growing and Trusting Phase

With your warm, persistent, and calm but firm help, the child eventually moves beyond the resistant phase and becomes ready to progress into growing and trusting. During this phase, the child first begins to experience the pleasure of interacting with another human being in a mutually satisfying way. She begins to develop confidence in herself and trust in the world.

At first, the moments of closeness are fleeting. As you and the child make progress, there is reciprocal laughter, mutual give-and-take, and harmonious times of sitting close and playing games. Once the two of you are this comfortable with each other, it is time for the parents to take a more active role in order to expand the child's awareness that others can respond to him with as much pleasure and support as you do.

If the child's parents have been observing from the beginning, they will now join the play for the second half of each session and become increasingly involved in leading the activities. Chapter Six presents the many ways you can help parents prepare to take over the role of Theraplay therapist for their own child.

Ending Phase

In one sense, the ending date has been planned from the start, as part of the initial agreement that you and the parents made for an estimated number of sessions. Sometimes external factors determine the number of sessions the child can have: cost, contracts with child protective services for treatment, or the financial resources of the family. Whenever possible, however, the decision to end treatment should be based on how well the child is doing. If the child is not ready for termination when the expected final session approaches, the original agreement should be renegotiated. Once you and the parents decide to end treatment, the termination process should begin during the fourth session before the end. Although it encompasses a relatively short span of time, the termination of Theraplay treatment consists of three distinct phases: preparation, announcement, and parting.

PREPARATION. You should schedule a meeting with the parents to decide whether it is appropriate to end as planned. Together you can decide whether the goals agreed on at the beginning have been met. The child's increasing comfort and self-confidence are signs that she is ready for treatment to end. The parents should be taking more and more initiative during sessions and be successfully incorporating the Theraplay approach at home.

Although the child's relationship with you has become meaningful and intimate and the sessions themselves have become important in her everyday life, the termination period must not be ushered in with gloom, nostalgia, or tentative misgiving.

ANNOUNCEMENT. In the fourth week before sessions are to end, announce the termination plans in the context of gains the child has made: "You and your mom and dad are having so much fun together that you don't need to come to see me so often." Then, after a pause to make sure the child has understood, you set the date. "We'll have three more sessions, next week, the week after that, then the week after that on Thursday we'll have our last session." Depending on your plans for follow-up, you should make it clear that you will see him a few more times in the future.

For the next two sessions, the emphasis is on the child's favorite activities, such as Balance on Pillows, Cotton Ball Hockey, Blanket Swing, or playing Red Light, Green Light. Parents will take an increasingly central role—planning the sessions, showing you activities that they are doing at home with the child, and consolidating what they have learned about how to meet their child's needs. The object is to make sure that the relationship is on a secure footing, that the treatment goals are solidified, and that the parents are prepared to carry on this healthy way of interacting after treatment ends.

After each of these last two sessions, remind the child of how many more times you will play together. For most children you do not need to explore hidden reactions to separation. But as you have been doing all along, be alert to and comment on any signs of emotional response. A child who has suffered many losses in the past will need more time to process the meaning of this loss.

During the next-to-last session, remind the child, "Remember, Jennifer, next Thursday will be our last time together." During the quiet time near the session's closing, you can plan for the final party by asking her preferences for food and for special activities. At the end, you should remind her again that the next session will be her last one.

PARTING. By the time of the termination party, the main focus should be on the relationship between the child and her parents. You should have disengaged into the position of friendly participant and guide. The theme of the party is a future-oriented reaffirmation of the child's strengths and identity. You and the family can wear party hats, share party treats, and sing songs about the child's unique attributes. You can make lotion handprints on paper or brightly painted handprints on a T-shirt to send home with the child. Or you might make a life-size drawing of the child with a listing of all

the special characteristics that you have discovered about him during his Theraplay sessions. A photograph of you and the child and his parents is also a helpful reminder of this special experience. Although regular sessions are ending, the experience should continue to be vivid in everyone's mind.

At the end of this final session, act as anyone would at the close of a meaningful relationship. Give the child a warm hug, tell him how much you have enjoyed playing with such a special person, that you will be thinking about him, and that you know that from now on he will be having fun with his parents and friends. The session ends with a reminder about the date of the upcoming checkup visit. If a follow-up MIM is planned, that too should be mentioned.

TAILORING TREATMENT TO THE INDIVIDUAL CHILD

Even though Theraplay can be useful for a broad range of attachment and relationship problems, it must be tailored to meet the needs of each individual child. In Chapter One, we described how to use the Theraplay dimensions to tailor treatment to meet children's needs. Here we focus on how to respond to specific behaviors and needs that the child might have. An understanding of the child's developmental history is essential in making decisions about how to focus treatment. A child who has experienced many separations and losses, for example, requires a very different approach from a child in his biological family who has come to "rule the roost" because his parents do not know how to set limits.

We first discuss how to decide whether the child needs her parents in sessions from the beginning and then discuss behaviors that require a modification of the general Theraplay approach. Finally, we consider ethnic and cultural values as well as family lifestyle differences that require different kinds of Theraplay responses. Sensitivity both to the meaning of particular behaviors and to various cultural and family influences is essential if you are to respond appropriately to the special needs of each child.

Deciding Whether Parents Should Be in Sessions from the Beginning

The basic pattern for Theraplay treatment is to have parents observe for the first four or five sessions before joining in. There are three

circumstances, however, in which the parent should be with the child from the very beginning:

- A child under two years of age needs a parent with him to help him feel safe in this new situation. This need far outweighs the benefits (which we discuss in Chapter Six) of having the parent observe the first few sessions.
- A child who has been traumatized by past separations and losses will need the reassurance of having a trusted caregiver with him from the start.
- And finally, if a child has recently been adopted or brought into foster care, the new parent should be with him from the beginning. Being separated may stir up earlier separation issues and make him fear that this is a preparation for yet another move.

Responding to the Child's Behavior

It is essential that you monitor the child's responses carefully during the Theraplay session for signs that you need to revise your treatment plan. The following are examples of behaviors that require such a change: physical discomfort, overexcitement, unhappiness, eroticized perception, requests for information, and sharing an unhappy experience.

PHYSICAL DISCOMFORT. Occasionally a child will come to a session with a stiff neck, a sore leg, or a painful cut or scratch. You will want to be particularly gentle and careful to avoid touching the sore spot while providing as much comfort and care as possible.

Some children are so inherently sensitive to touch that they respond to physical contact with genuine distress. The following discussion assumes that the sensitivity to touch is not the result of earlier experiences of physical or sexual abuse. See Chapter Nine for a discussion of how to adapt Theraplay for children who have experienced abuse. Although a reaction of distress to physical contact does not rule out the eventual use of touch, you should begin with activities that do not require touch, such as Peek-a-Boo, singing to the child, tossing a beanbag, or blowing cotton balls back and forth to each other. Then introduce touch gradually in whatever form the child can tolerate. If the child is very uncomfortable having lotion

on her hands, you can use powder instead. Firm touch may be more acceptable than light touch for some children, and it has the additional benefit of providing deep pressure to the muscles, pressure that is both soothing and organizing for many children. A child who responds to deep pressure will enjoy being firmly snuggled between two large pillows—a special "Sarah sandwich"—whereas she could not tolerate being touched with a feather or having you run your fingers lightly up her arms "all the way home" at the end of "This Little Pig Went to Market."

If you think the child has a sensory integration problem, you should make a referral for an evaluation and possible treatment with an occupational therapist trained in techniques specifically designed to help the child overcome her discomfort and organize her sensory experiences.[2] Chapter Seven includes a discussion of how to adapt Theraplay to the needs of a child with sensory integration difficulties.

DYSREGULATION. Some children are so easily overexcited that you must monitor your activities very carefully. These may be children whose regulatory difficulties (irritability and sensory sensitivities) may have contributed to their attachment and relationship problems from the very beginning. Some children may have missed out on the co-regulating experiences provided by an attuned mother, or they may have experienced neglect and trauma. In general, you must reduce the stimuli presented to such a child, making sure he feels safe. You will need to monitor his response so that you can help him remain calm. If his behavior does escalate out of control, you should try to restore regulation as soon as possible. We describe how to do this later in this chapter when we talk about how to handle angry, out-of-control behavior. Parents may be able to help with this by soothing the child in their own familiar way.

Being aware of the child's difficulty with regulation, you will want to provide activities that give him an opportunity to practice modulation. Activities that excite the child within the limits of his tolerance and then help him return to a calmer state can be helpful. You can play Row, Row, Row Your Boat slowly, then faster, then faster still, and finally with exaggerated slowness, ending with a firm touch on the child's shoulders to make sure that he is fully settled after the excitement. After many experiences of being helped to manage excitement successfully, the child will be capable of more self-regulation.

CRYING. Before you can respond appropriately to a child's crying, you need to determine the reason for it. If the child seems genuinely upset, you must evaluate whether the crying is a function of illness, sadness, or fear.

Illness. If the child is ill, you must assess how severe it is. Minor discomfort calls for slower activity and an increase in efforts to soothe and comfort. Major discomfort calls for discontinuation of the session altogether and making sure the child is safely in the care of his parents. If you provide home-based Theraplay or work in a hospital, you can visit an ill child at the bedside. You can do many Theraplay activities with the child sitting quietly propped up by pillows. Cool cloths on the child's forehead, games of Peek-a-Boo, "messages" drawn with your finger on the child's back or pictures on his hand with powder, for example, can help the child feel an ongoing, comforting connection with you, a connection all the more necessary during times of illness and the concomitant isolation and worry.

Sadness. If the child is sad, you must communicate, both verbally and nonverbally, that you understand how he is feeling. You or his parents should hold him, rock him, and talk in a comforting way to him. You should not attempt to cheer him, distract him, or tell him he "will be feeling better soon." You should add playful games only after he is feeling a bit better.

Fear. If the child is frightened, you must do everything you can to reassure him and move slowly in your efforts to engage him. You must consider the possibility that a fearful child has been traumatized in the past or has never felt secure. Acknowledge his fear: "I see that scared you. I'll make sure you are safe." Then take steps to make him feel comfortable, which could include bringing a parent into the sessions with him to provide the security that he needs before he can accept the positive experiences that you want to give him.

EROTICIZED PERCEPTION. In rare instances, the child responds to Theraplay activities by becoming sexually stimulated. When this happens it is usually because the child has had experiences (sexual abuse or exposure to adult sexual behavior) that have made him sexually responsive to physical contact. Even your appropriate, matter-of-fact touch can trigger these children into their earlier pattern of associating comfort with sexual stimulation.

If a child becomes sexually aroused during a treatment session, you must acknowledge what happened, "Something about that made you feel uncomfortable [use the child's word for the feeling if you know it]. I don't want to make you feel that way. I want you to feel safe." If you know the child's history of sexual abuse, you can acknowledge that as well. Then you must shift your activity so that it no longer triggers the feelings. If the child makes suggestive comments or touches you inappropriately, you can calmly help the child distinguish between appropriate touch and sexually arousing touch. You can say, "I won't let you touch me there. You can touch me on my hand, or shoulder." You should continually seek ways to provide the child with the experience of safe touch while avoiding touch that seems to arouse the child.

REQUEST FOR ENLIGHTENMENT. The child may ask for information, not as a means of avoiding connecting with you, but because he has a genuine need for information. Theraplay techniques are held in abeyance until you have met the need. An obvious example would be if the child is uncertain about something important to his security, such as "Will my mother pick me up today?" It is less obvious when a child asks, "What's inside your closet?" In that case you must decide whether he is worried about something he thinks might be there and needs reassurance or whether his question is an effort to avoid the activity you are offering. Knowing as much as possible about the child's history and his general level of anxiety will help you discriminate between these two situations.

SHARING AN UNHAPPY EXPERIENCE. The child may tell you about something that happened at home or school that upset him, not as a way of avoiding what you are doing together, but because he has a genuine need to talk about his unhappy feelings. For example, his father may be ill, his pet may have died, or a bully may have teased him at school. Although our usual focus in Theraplay is on the immediate, here-and-now experience, this is a moment when you must put aside your playful activities and help the unhappy child deal with his worries. Sometimes just talking about it at the moment is all that is needed. But you should consider the possibility that the child would benefit from ongoing opportunities to talk about and process disturbing experiences. If so, you should incorporate into your overall plan a treatment modality designed to help him do this. In Chapter

Nine we describe how Dyadic Developmental Psychotherapy can be combined with a modified Theraplay approach to help children who have experienced trauma.

Using Touch to Meet the Child's Needs

As you plan your sessions you will be incorporating touch in various ways to meet the needs of each child. Touch can be organizing and modulating in structuring activities; it can be playful and inviting in engaging activities; it can be calming and comforting in nurturing activities; and it can be used to support or guide the child in challenging activities. Touch should never be used coercively. At all times you should be attuned to the child's reaction and finds ways to make the touch acceptable to an anxious or touch-aversive child.

STRUCTURING TOUCH. Theraplay sessions provide many opportunities to use touch in a structuring way. You can use a playful, interactive entrance activity—having the child walk in like a wheelbarrow or holding hands and taking steps into the room together—to organize the beginning of your session. You can use touch to help settle the child, or the child and her parents, on cushions or on a couch in a comfortable position. You can hold the hand of the child as you play active games, such as Ring-Around-a-Rosy or Motor Boat. You can put your hand on a child's knee or shoulder to calm her and to coordinate your movements. Touch can give the child a new experience of her body as you play Cotton Ball Touch, or make aluminum foil prints of her feet and hands.

ENGAGING TOUCH. Touch is an important modality for creating relationships and communicating safety, acceptance, playfulness, and empathy. If the child needs help to engage with you or his parents, you can use activities that naturally require touch in order to make a connection with the child, for example, hand-clapping games or making a stack of hands.

NURTURING TOUCH. Nurturing touch is essential to the co-regulation of arousal that constitutes a major aspect of the early parent-infant relationship. Many experiences of gentle, reassuring touch form the basis of the child's later capacity to soothe and calm herself. When you notice the child's scratches or bruises and take care of them with lotion or Band-Aids, you are using touch in a nurturing way. In

order to calm and comfort the anxious or distressed child you or her parents can put an arm around her shoulder or rock and comfort her. Most children welcome these kinds of touch. If a child resists being touched, you must find another way of getting close and providing the nurturing, calming experience that she needs.

CHALLENGING TOUCH. Challenging activities are usually physically active and are carried out cooperatively rather than competitively. They often require physical assistance or guidance to help the activity turn out successfully. For example, you can use touch to help the child balance safely on pillows or to catch him in your arms when he jumps off the pillows.

Taking Ethnic and Cultural Values into Account

The model of healthy parent-infant interaction on which Theraplay is based is strongly influenced by American and Western European cultural values and styles of parenting. We emphasize the importance of eye contact in promoting the development of attachment and we value "looking each other in the eye" as a sign of honesty and straightforwardness. In some cultures, however, mothers have little eye contact with their babies and it is considered rude for an older child to look directly at an adult. We westerners often downplay the importance of touch, whereas in some cultures babies are never out of touch with their mother's bodies. In that case, there is relatively little eye contact between mother and baby. American parents play with their children with a higher level of activity and excitement than is acceptable in many other cultures. If an American child is shy, quiet, and withdrawn, we wonder whether she is happy. In some cultures, however, such behavior is entirely acceptable, even valued.

Consideration of a family's cultural values is crucial to the planning of treatment. If the parents want help for their child and if they agree that part of the solution could be a change in the way they and the child relate to each other, then it should be possible to find ways of engaging the child that are congruent with their cultural values. By discussing with parents what is acceptable to them, it is possible to modify Theraplay treatment in ways that accommodate cultural differences and yet achieve the goal of helping the child. Theraplay has been used successfully with many different ethnic and cultural groups throughout the world with modifications that make it acceptable to each culture.

Taking Family Lifestyle into Account

When mapping out a Theraplay strategy for a particular child, not only must the child's relationship problems and any cultural differences be taken into account, but family lifestyle differences must also be considered. Our responses to two contrasting types of parenting will illustrate the importance of avoiding hard-and-fast rules in Theraplay treatment. Some families structure arbitrarily and enforce rules punitively, seeing the child's needs and wishes as of only secondary importance. These parents often deal with their children in a practical, short, authoritarian manner that does not accommodate the child's true needs. In a more indulgent type of family, children's needs and wishes are paramount, but structure, rules, and clear authority may be virtually absent. These parents may be overly concerned with "understanding" and with encouraging open expression of feelings. In the process they risk giving in to their child's every mood, demand, and wish.

The difference between the two groups can be seen in their response to suggestions made by the interpreting therapist. The no-nonsense, authoritarian parent asks, "What do you mean, 'let him play?' Life is hard. It wouldn't be right to play with him now that he's a big boy. He would never want to stop playing." The permissive parent says, "Who are we, his parents, to think we have the right to make decisions for him or tell him what to do?" The results of the two approaches, of course, are quite different and each has its negative side. The strictures enforced by the authoritarian parent may make the child feel impotent. The freedom offered by the permissive parent may make the child anxious. Thus, the child of restrictive parents needs his parents to allow him more stimulation, movement, and freedom to explore and to play, and the child of permissive parents often needs his parents to provide more safety, structure, and limits.

You may encourage expressive, indulgent parents to do less listening, discussing, or reasoning with their children; and you may advise authoritarian parents to do more listening and discussing. While observing behind the two-way mirror as their child is engaged in a Theraplay session, you might point out to a permissive parent, "See how Aaron keeps trying to engage his therapist in a discussion of why he can't do this and that? Notice how she handles it." The parent may answer with some surprise, "Why, yes, she doesn't respond. She just goes on about the game she's playing with him. Why doesn't

she answer him?" The interpreting therapist explains, "If she responds to each topic he brings up, he will be in charge of the session. He will not have the experience of being guided and supported by someone who can keep his world safe and well regulated."

However, you may ask authoritarian parents observing their child in Theraplay, "Notice how Kevin is being encouraged to ask questions and to tell how he feels about what's happening?" The parents may be puzzled: "Why does she want him to do that?" The interpreting therapist explains, "She wants him to learn that his ideas, feelings, and wishes are important. She wants him to understand that he is capable of making an impact on his world." Homework assignments, for both kinds of parents, include having parents practice the kinds of behavior and attitudes toward their children that they have observed in the Theraplay sessions.

HANDLING THE CHILD'S RESISTANCE

As we discussed at the beginning of this chapter, most children go through a resistance phase in which they test the new relationship with the therapist and her parents to see whether it is really safe and trustworthy. Such testing can pose problems for even the most experienced Theraplay therapist. It can certainly be daunting when you first start practicing Theraplay and have had little experience taking confident control of difficult situations. It is, therefore, important that you understand the reasons why resistance might occur, some general principles for handling it, and finally, specific suggestions for how to deal with resistance as it relates to the dimensions of Theraplay.

Understanding Why Resistance Occurs

As we have said earlier, if Theraplay is to be effective, it must challenge the child's negative view of herself and of what she can expect from others as well as her unhealthy patterns of relating. A resistant response is the child's way of dealing with her discomfort in the face of your efforts to change her views of herself and what she can expect from others. Inner working models have taken years to develop and are not easily changed. Until she feels safer, the child will resist and continue to fall back on her accustomed defenses and ways of relating. It will take many repetitions of these good experiences before the long-established patterns can change.

We believe that the resistance phase signals that the child is beginning to be hopeful about the new relationship but needs to test the reality of the commitment. She seems to be asking, "If I am going to risk getting close, can I really trust that I won't be hurt again?" or "Will you stick by me if you see my angry, resistant part as well as my happy, compliant part?" Children with a long history of abuse and neglect are in a continual state of panic and must test their parents' commitment at a very deep level.

General Principles for Handling Resistance

As a first step in handling resistance you must evaluate whether the child's resistance stems from a state of fear or panic, rather than from a state of mild anxiety or discomfort with the unfamiliar interaction. If the child is frightened, it is important to acknowledge his fear and do everything you can to make him feel safe. He may need to sit close to his parent, or have you reduce the intensity of your approach. Once a child is feeling calmer and more secure, you can begin to engage him in some quiet activity such as blowing a cotton ball back and forth or popping bubbles.

If you recognize that the child is easily dysregulated, you should monitor the level of stimulation carefully, reduce the intensity of your approach, and attune to the child's moods, reactions, and regulatory issues.

If you believe that the child is not frightened or overstimulated, there are many things you can do to work around the resistance and help him become more comfortable with your efforts to make a connection. For any child, the basic principle is that you should accept his behaviors and avoid the negative responses that he has come to expect. Over and over in the past, he has heard, "No," "Stop," "Come back here." Instead of this you must surprise him by your interested, positive response. In order to do this you need to be proactive, and stay one step ahead of the child.

WORKING AROUND THE RESISTANCE. When resistance first appears in treatment, there are three approaches that can be helpful as you attempt to work around it: accept the behavior as something interesting to be pursued; prescribe the behavior using paradox; or reverse the activity that the child rejects and suggest that he take a turn doing the activity to you.

Accepting the Behavior. You should accept the behavior as something interesting that can be incorporated into a shared activity. If the child pushes you away, you can say, "Oh, you are so strong." Then organize it into a pushing game. "Let's see if you can push me over. One, two, three—push!" After some good strong pushing, you can then surprise the child by falling over on your back and lifting him into the air on your knees. Few children can resist this invitation. Instead of the negative response he expected, he has experienced a delightful surprise that intrigues him and brings him closer to you.

Using Paradox. Another useful response to a child's resistance is to prescribe the behavior in a playful, accepting manner. When efforts to calm a wiggling child are to no avail, you might say, "See whether you can wiggle all over. That's right! Wiggle your tongue too." The child then has two choices. She can resist the paradoxical injunction and stop wiggling (which is what you wanted in the first place) or she can wiggle even more and thus comply with your request. If the child uses a very loud voice to push you away, you can play a game of Peanut Butter and Jelly. Explain to the child that you will say "peanut butter" in a special way and she should say "jelly" in a way that matches yours. You can start with a very loud voice, even louder than the child had used before, then as the child gets into the game of matching, you can soften the tone and play around with gestures, pitch, and intensity. Soon the child is engaged in spite of herself.

Do not overdo paradoxical methods. Used too frequently, this approach loses both its effectiveness and its potential for humor. Also, be sure that the child understands that your paradox is just another invitation to play.

Having the Child Do the Activity to You. If the child resists having lotion put on his hand, you can say, "You can put it on me first" or "Let's do it to Mommy first. You can help me put lotion on her hand." The child who doesn't want to have you beep his nose might be willing to beep your nose.

ACKNOWLEDGING THE RESISTANCE AND MODIFYING THE TASK. Another important way to handle resistance is to acknowledge it and then either modify the task or carry on with your plan. When a child rejects a particular activity you need to consider what the underlying reason might be. It may be too hard for him, it may be too intimate

for him, or it may involve tactile sensitivities that he cannot tolerate. In any of these cases you can show curiosity about why he doesn't like it, and find another activity that is more comfortable for him.

- "I think it is hard for you to sit so still. Let's see what would make it easier. Oh, I know, let's play a game of Ring-Around-a-Rosy."
- "I'm glad you told me you don't like that kind of lotion; thanks for letting me know. Let's try powder instead."
- "I know it's hard right now for you to let Mom feed you. Let's see if you and Mom can each take a bite of your cracker at exactly the same time."
- "I know you don't want to stop right now. It's really hard to say good-bye when we are having such a good time. But it's time to end our session now. I will remember the special freckle you have on your hand and will check to see if it's there next week."
- To the child who comes up with many ideas for games and how to play them, you can say, "You have good ideas, I'll remember that game. Now we're going to play this game."

HANDLING ANGRY, OUT-OF-CONTROL BEHAVIOR. Although you should focus your efforts throughout your sessions on helping the child interact in a calm, well-regulated manner, it is not always possible to avoid having a child escalate out of control and become a danger to himself or others. If he tries to hit you or otherwise attempts to cause physical harm, stop the child from the harmful act and say, "No hurts! I know that made you really angry, but I won't let you hurt me. I won't hurt you. I'm going to keep both of us safe." You may need to hold the child's hand until he is calm enough to stop trying to hurt you. This is usually enough to end the hitting and you can release the child's hand. At that point it is crucial that you change your tone, facial expression, and body posture to upbeat and open, in order to indicate that the rupture in the relationship is over and that you still feel connected and approving of the child. This cannot be emphasized enough. If you sit hunched over, with a pensive, deflated look on your face after the episode, the child will stay in his negative state. Having achieved this more open, accepting attitude, you can quickly move on to another activity.

If the child has not responded to other efforts to calm him and has escalated into dangerous behavior, you must immediately take steps

to keep him safe. This may involve containing the child in some way.[3] The most comforting position for an upset child is to cradle him in your lap, holding him so that you can see his face. If the child seems more provoked by seeing your eyes, holding him on your lap facing out may be more effective in helping him calm down. It is important that you find a position that provides security for both of you and that is as comforting as possible.[4] You should reassure the child that you will stay with him until he feels better (thereby letting him know that he is safe and that this behavior does not make him "bad" in your eyes). Offering him something chewy to eat or juice to drink from a straw can be very effective in short-circuiting the child's tantrum. You should constantly monitor the tension in the child's body and release your hold as soon as possible. You should then attempt to repair the break in the relationship caused by your having to contain him, using words that convey that you know he was upset, that you are not angry with him, and that you will always stay with him and help him through such hard times.

As soon as the child settles, you can move on to other activities. If a parent is available and can be calm and reassuring, she should be the one to contain the child. Alternatively, she could be the one to feed him or give him some juice to soothe him. At the end of such an episode the child often cuddles into his parent's comforting arms. The model for this approach is that of a parent who holds an overtired, overstimulated, or frightened toddler in order to calm him.

Whether it is you or the parents who provide this reassuring containment, you need to feel confident in your ability to hold the child in a safe and secure position. Parents of children who often have "meltdowns" at home need to learn ways to provide safe containment.

Handling the Situation When Containing Is Not an Option. There are some circumstances in which physical containment may not be an appropriate option because: (a) you may not be able to contain the child safely, (b) there may be a policy in your agency against containing a child, or (c) containment may not be therapeutic for the child, as it could lead her to feel trapped in a way that makes her already primal need for control even stronger. For these reasons, a nonphysical de-escalating approach may be the best intervention. To do this, you should try to remain physically close to the child but not pursue her. Make sure the child is in a safe area of the room; if she

crawls under a table or behind a couch, let her remain there while you sit quietly near her. Though not directly addressing the child, speak softly to the other adult in the room about the child's need for a break from the situation, saying that it's hard to do these kinds of games. This conveys the message that you understand and accept how hard this is for her. Eventually, the child may show some sign that she is feeling calmer (she may peek out, her breathing may slow down, or she may reach out her hand). At that point, offer the child some type of reconnection: a juice box to drink, a soft animal to hold on to, or put your hand gently on her back. If the child rejects these overtures, continue to sit quietly and periodically talk to the other adult in the room in a reassuring tone. If she accepts the overtures, bring out material for a calming activity such as Play Doh, or stickers (activities that do not demand intense eye contact or compliance). Once the child seems reengaged, take a brief moment to look at the child, sigh, and acknowledge calmly but reassuringly that it was hard to be so upset and that you are sorry it happened. Transmit through your body language that you are offering acceptance and reconnection. In order to do this you need to have a calm face and a reassuring tone of voice. Don't ask questions about what upset the child, as it is truly not possible for her to explain her primitive fear and pain. Furthermore, this is the same tack others have tried before. Reengaging through the Theraplay activities is likely to be the best therapeutic intervention you can offer.

After the session is over, review the video to identify any triggers that led to the tantrum. Share your hypotheses about what caused the outburst with the parents so that they can have a more empathic understanding of why their child reacts the way she does. This will also help you plan sessions to avoid the triggers and to address the child's needs.

Understanding Reasons for Containing a Child. The only justification for containing a child against his will is to keep the child safe. However, staying with an angry child in the ways that we have described has other benefits as well. He learns that you and his parents can accept his intense, angry feelings without condemning him for having them; he discovers that his anger does not drive you away. He learns that you can keep him safe when he is out of control, and that you can help him learn to handle his strong emotions and contain his aggressive or self-injurious impulses. When he is finally

able to relax and accept your comfort, you have created a strong bond with the child. The message is that it is all right to have strong feelings and that a safe and caring adult can help you deal with them.

Handling Resistance Related to Each Dimension

Having presented some general principles for handling resistance, we look now at ways to respond to resistance to specific dimensions of Theraplay.

Based on your observations during the MIM you will have chosen to emphasize the dimensions with which the child needs most help. With the rationale, "He's too uncomfortable when I come close," you may feel inclined to "cool" the relationship at first. If you consider, instead, that the intensity of resistance reflects an equally intense underlying need—whether it is for structure, engagement, nurture, or challenge—you will persist in your efforts to meet that need.

RESISTING STRUCTURE. Some children who have grown up in a family where they have been encouraged to follow their own lead find it difficult to accept adult guidance and rules. They are often perceived as difficult children when they get into a school setting. They will need experiences that make following the rules and accepting adult structure appealing and comfortable. The work with the parents will focus on helping them understand the child's need to be relieved of the burden of making so many choices. They need help assuming the role of the strong, caring adult who can convey to their child a sense of safety and guidance.

Children who have grown up in unresponsive, neglectful, or abusive homes do not trust adults to keep them safe. They have learned that the only way to survive is to take charge. With these children you will need to go slowly in establishing yourself as a person who can organize their experience. In the beginning they will need to feel some level of control. In the long run, all children need to learn that adults can be depended on to structure their world and keep them safe.

Behaviors of children who are struggling to take control of their world tend to be subtle and beguiling. Before you have a chance to recognize how it happened, for example, the child may have changed the rules. In order to help the child experience the safety and relief of being the recipient of someone else's rules and structure, you must be alert to the child's efforts to take charge. Such children try a variety

of strategies: attempting to take the initiative, refusing to participate in activities, or running away.

Taking the Initiative. Initiating may include telling you what to do or deciding what she herself will do. It is particularly hard to stay in charge with a child who is full of ideas for fun games to play. You need to be prepared to say, "You have great ideas, but today I want to show you all the fun things I've planned for us to do together." In the event that the child initiates what you were about to do anyway, for example, "Let's balance on the pillows like we did last week," you can say, "That's just what I was planning. Let's do it upside down today. Let's balance the pillows on your head."

Refusing Activities. When a child refuses activities, you need first to consider whether the activity is too hard, too cognitive, too unpleasant for the child who is tactile defensive, or too intimate for this child at this moment. If you decide that the activity is not appropriate, you should find an activity that is better suited to the child's needs. If you decide that the child is resisting as a way of staying in control or as part of his effort to test the relationship, you need to find a way to stay connected while still taking charge.

The following is a suggestion for turning direct refusal into a game. If the child says "No!" to everything you suggest, you can say "Oh, I know that song." Then sing to the tune of Twinkle, Twinkle, Little Star, "No, no, no, no, no, no, no, I don't want to, no, no, no." This song turns the refusal into a playful moment that may make it possible to move on to some other activity.

Running Away. Some children will resist your efforts to structure the session by moving away from you, running out of the room, or hiding under a desk. In anticipation of this possibility, you should provide a clearly defined space for your sessions and position yourself so that you can keep the child safely in that space.

An important part of providing structure for all children is that you have a clear "home base" to which you return after more active games. This should include a comfortable place for the child to sit in the corner of the room or against a wall. Whether you are sitting quietly in front of the child or standing for more active games, you should position yourself between the child and the door and be alert to the need to change the activity to keep the child with you. You need to stay one step ahead of a restless, active child, keeping a hand

on him until you are certain that he is calm enough to stay with you. He may need a more active game to organize his high activity level. If so, stand up, take his hand, and begin a game of Motor Boat or Ring-Around-a-Rosy. If you are alert and confident, you can generally keep him with you. If he does escape, however, you should remain calm, make sure he is safe, and return to home base as soon as possible.

RESISTING ENGAGEMENT. Because many children have been disappointed or hurt by the very people they depend on to take care of them, they will try to keep you at a distance, avoiding the closeness that engagement brings. There are many ways in which children resist engagement. Some may keep you at bay with their superficial charm, others by becoming passive, or still others by avoiding eye contact. Running away can be an effort to avoid both engagement and structure. After acknowledging how the child is feeling, you must continue your efforts to make him comfortable and to engage him in a playful manner. If there is a great deal of fear underlying the child's resistance, back off but continue your efforts to win his trust and entice him into engagement.

"Charming" the Therapist. The indiscriminate friendliness of many children with attachment problems is one way they avoid true connection. The child is superficially engaging and charming but it is not a genuine relationship. The attempt to "charm" may include "cute" behavior, flattery, telling amusing stories about something that happened at home, or bringing toys or books to share with you. You will need to keep your focus on establishing a real relationship rather than the superficial one the child is offering. Rather than pause to listen to the child's interesting talk, move right ahead with your planned activity. If she attempts to charm you with compliments, you can turn the conversation back to her. "You have the softest cheeks I've ever seen. Let's see how soft your nose is too."

Resisting Passively. If the child remains passively resistant, you can use a paradoxical approach, "My, you are quiet, you are as still as a mouse. Let me see whether your nose makes a noise when I touch it." Then, supplying the beeping noise, you explore the sounds that other parts of his body (ears, chin, knee) can make. Many activities, such as Beanbag Drop, do not require an active response from the child. When you place a beanbag on the child's head, even the slightest

move on the child's part will make the beanbag drop into your waiting hands and will start a game of give and take (See Juan's case below). Other activities that don't require a response from the child are drawing a "Weather Report" on the child's back or measuring the length of his arm, his feet, or his fingers.

Avoiding Eye Contact. If a child avoids eye contact, you can organize your games to encourage it in a playful way. Beanbag Drop, Peek-a-Boo, Patty-Cake, and Stack of Hands all require moments of spontaneous eye contact. Whenever possible, do your activities in the child's line of vision. Eye contact is important, because it makes the child aware of your presence and gives him an opportunity to read your emotional signals in an intense way. You can say to parents, "If he doesn't look at you, he will not see how much you enjoy being with him." As noted earlier, do not make eye contact a serious task and always be accepting of the child's need to turn away, reduce stimulation, and calm himself. Be ready to reconnect as soon as the child is ready.[5]

THERAPLAY IN PRACTICE

Engaging a Frightened, Resistant Child

In the following example, a mental health worker in the Head Start Program explains how she handled a child's panicky resistance to becoming engaged.

Four-year-old Juan shrank from the world as if expecting the worst. He ducked his head, he twisted his body, and he moved with awkward, jerky motions. When anyone approached him, he shrieked and ran away. Because his body appeared twisted and his movements jerky, he had been referred for a neurological examination. The neurologist, however, was unable to examine him, because Juan was so terrified. As his therapist, I was determined not to let him stay in his fearful, self-imposed prison where he couldn't learn about the world and couldn't get pleasure from being with others. Even the messages he got from his family were negative; his father said, "He just embarrasses me."

Seeing his pain, I approached him gently but persistently. I knew that I must entice him out of his isolation rather than leave him as he was. When he hid behind the block cupboard, I found him. When he crawled under the table, I crawled in after him. At one point I went too fast. I tried to pick him up to play with him, but he fought frantically to escape and would have thrown himself to the ground had I not held on. He had no sense of the danger, nor could he make use of my encircling arms to keep him safe. I saw this as a sign of his desperation and I realized I needed to go more slowly.

Gradually my quiet persistence paid off and he began to acknowledge my presence. I put a beanbag on his head, and when he ducked his head to get rid of it, it fell into my outstretched hand. I put the beanbag on my head and dropped it into his lap, or I held his hands so that the beanbag would fall into them. He began to be interested in this game, which had developed initially out of his effort to avoid the beanbag. He would wait for my signal to duck his head to let the beanbag fall into my hands.

When he tried to push me away, I gently pushed back until we had a pushing game going. He was interested when I drew around his hands and showed him how his hands matched the outline I had made. Almost in spite of himself, he began to have fun. He looked at me and laughed when I put a silly hat on my head. He allowed me to put one on him. We looked at ourselves in the mirror and I pointed out how tall he was, how strong he was, and how high he could jump.

After ten weeks of twice-weekly sessions it was time to say good-bye. Just at that point, his classroom had a party. As his father and I watched, we were surprised to see Juan volunteer to be the first to stand up and break the piñata. He stood proud and erect, his blindfold tipped cockily across his brow. He hit with all his might, breaking the piñata with one blow. What a difference our ten weeks together had made! His father watched him with obvious pride. I watched him with tears of joy in my eyes. I knew that the frightened, cringing little boy was gone forever. In his place was a sturdy, self-confident child who could look forward joyfully to whatever life presented to him.

RESISTING NURTURE. Nurturing experiences, with their potential for calming, soothing, and regulating a distressed child, are essential for all children, but they are especially important for children who need help with regulation. Many children who come for treatment need this dimension but cannot readily accept it for a number of reasons. Some children with sensory integration issues may have missed out on the calming, soothing experience of being held in their mother's arms because they find touch and cuddling aversive. Others have suffered medical procedures that have left them with a body memory of pain associated with touch. Some colicky babies have come to associate distress and discomfort with feeding. Others have had parents who were unable to respond to their needs for comfort, calming, and soothing touch. They have learned to associate such needs with their parent's rejection. Some older children have received the message that it is babyish to be taken care of. These children will not let you put lotion on their hands or feed them, saying, "I'm a big boy. I don't need you to do that." You can respond with "I know you are a big boy. You are very strong and you can balance on six pillows. But when we are here together, I (or your parents and I) like to do this for you."

You need to make every effort to provide children with the calming, nurturing experiences that they so desperately need if they are to learn how to establish self-regulation. More than any other kind of experience, however, nurturing activities must be offered gently, imaginatively, and playfully. At no time should there be pressure on a child to accept touch, to maintain eye contact, to eat, to be held, or to be rocked. There are many gentle and appropriate ways to help a child accept these important aspects of healthy parent-child interaction. Nurturing touch can be incorporated into a game with another purpose. A child who would not accept having lotion rubbed on her hands will accept it as part of the preparation for making a lotion handprint. A child who insists that he be allowed to feed himself may enjoy a Doughnut Challenge (place the doughnut on your finger and say, "See how many bites you can take without breaking the circle!"). You can offer a cracker to both the child and his parent and ask them to "crunch" together at exactly the same time, then lean close and listen to the sound of each other's crunch. The child will have a pleasant experience associated with food. The goal is that the child be able to enjoy the calming experience of having someone respond to his needs. Juice, water, or milk can be offered

in a glass, in a sippy cup, or in a juice box with a straw. Very young children may even accept being held by their parents and fed juice from a bottle. Many an adolescent who strongly denies his need for nurture will accept having aluminum foil prints made of a hand, an elbow, or a foot as part of an activity in which his parents must guess what body part the foil print represents.

RESISTING CHALLENGE. Some children resist challenges because they are afraid they will fail. For such a child you should present challenges that will produce immediate success. Newspaper Punch is a good choice. Use a single sheet of newspaper (you can ensure success by tearing it slightly at the top). Hold the paper stretched firmly to one side (so that a strong punch will not hurt you). Then say, "Let's see whether you can punch right through this paper. Make a fist. When I say *'punch,'* punch your fist right in the middle. Ready, get set, punch!" If the child is hesitant, help her move her arm back and forth in the gesture she needs to use. If she still hesitates, you can move the paper toward her fist. Most children can easily punch through tightly stretched paper and are delighted by the satisfying sound and very pleased with their success. If the first punch is successful, you can add a second sheet of paper. "This is harder. But you did so well with one sheet that I think you can do two. Ready, get set, go!"

THERAPLAY IN PRACTICE

Challenging a Child Who Acts Helpless

Some children have learned to avoid high expectations by acting helpless or babyish. When asked to stand, she sits; when invited to ask for something, she points.

In the following example, the therapist does not allow Tammy to stay in her helpless state. Although she is careful not to make her challenges too demanding, she continues to expect Tammy to rise to the occasion—and Tammy does. Her therapist describes the session as follows:

I went to put Tammy down, and she would not straighten her legs. I said, "Hey, let me see those strong legs of yours." She then straightened her legs, and we walked down the hall to our playroom. I told her what a big girl she was and tried to

guess how old she was. I started at seven and worked down to her true age of four. We did some bouncing, jumping, and flips. I took the flip in stages, first putting her up on my waist, and then letting her touch the floor backward. Next I put her on my shoulders and gave her a flip. Even after these successful experiences, she returned to her helpless stance when it was time to end the session. I told her again that it was time to go and that I would come back next week. She still remained passive, so I gave her a challenge: "Let me see how tall you can stand. Look how tall you are. Look at what a big girl you are. Come on, let's go." I had her jump down the steps. And we walked like soldiers back to her classroom.

HANDLING DIFFICULTIES ARISING WITHIN THE THERAPIST

We turn now to difficulties that you as the Theraplay therapist might bring into the treatment. You may feel uncertain about how to proceed because of inexperience with this new approach, you may feel uncomfortable taking charge because your earlier training has emphasized following the child's lead, and finally, you may get caught up in personal countertransference issues. Here we describe a few of the most common problems and give suggestions for how to handle them.

Feelings of Inadequacy

If you are new to Theraplay, the greatest threat to the treatment process may stem from your sense of uncertainty and doubt—your fear that you might run out of ideas, that others might criticize you, or that it is not right to take an active, leadership role.

FEAR OF RUNNING OUT OF IDEAS. The very best antidote to running out of ideas is to find a healthy child and play with him. Equally valuable will be to watch a mother and her young child as they play together. Not only will this feel refreshing, but it will also generate new ideas and new variations on old themes. It can also be helpful to watch a fellow Theraplay therapist, to share ideas with other Theraplay therapists, and to make use of the list of Theraplay activities in Appendix B.

When all else fails, you can turn to the child's own responses as a ready-made source of innovative ideas. If a child begins kicking at the pillows, you can organize a pillow kicking game. If the child hides his eyes, you can play Peek-a-Boo. If the child crawls under the pillows, you can turn it into a tunneling game. Make sure that your game is clearly structured and that you convey that you have fully adopted this new idea and can structure it and make it both interactive and rewarding.

HANDLING CRITICISM FROM OTHERS. If you work in a setting where boisterous, intimate, physical, and joyful interactions between child and adult are looked on with suspicion, you must expect criticism of your work. Before you introduce Theraplay into such a setting, you should let everyone know what you are going to do. You can present a brief introduction to Theraplay, explaining how it works, demonstrating some of the activities, and suggesting that people visit the Theraplay Web site to learn more about our work. Although such advance preparation is very useful, it will not prevent all later questions and interruptions of your work by people hearing loud noises and laughter coming from your treatment room. If you are questioned while you are in the midst of comforting a crying child or calming an angry one, you can tell the worried bystander, "Josie was upset, but she is going to be all right." Your confidence communicates, "I know what I'm doing." You should add, "I'll be happy to talk to you about it later." Given a response like this, few adults will continue their interruption of the session. They will be reassured that the child is in good hands. Be sure to follow up later by explaining more about the nature of Theraplay.

Discomfort with Taking Charge

Many traditional therapeutic approaches have emphasized the importance of following the child's lead. If you are trained in such an approach, you may feel very uncomfortable shifting to a more structured, adult-guided approach. It will help if you remind yourself of the reasons why each approach is stressed. Theraplay provides the same safe, structured, holding environment that good enough parents provide for their child. Parenting that takes all its cues from what the child "wants" does not provide the safety and guidance that children need. Child-centered therapy, on the other hand, provides a setting within which the child can explore and share her inner world

without being influenced by the therapist's direct intervention. With this distinction in mind, you should be able to move beyond your discomfort about taking charge of Theraplay sessions. Training in being able to understand the child and follow her lead allows you to bring special sensitivity to your adult-guided Theraplay treatment.

Dealing with Countertransference Acting Out

You must be constantly aware of your own countertransference responses, both as a source of information about what is going on between you and the client (which can be useful) and as a source of information about what is stirred up from your own past by the client's issues (which might interfere with your ability to respond appropriately to the client).

A therapy that involves such a strong use of relationship, as Theraplay does, will stir up countertransference issues more readily than one in which the relationship is less intense. Much of Theraplay's power to create change lies in being able to use this very intense countertransferential information in a positive way to tell you about your clients' underlying motivations and thereby deepen your empathy and effectiveness with them. Your capacity to resonate with and attune to the child's and the parents' feelings will help you gain insight into their experience; this is important information for guiding your work in Theraplay. In order to respond appropriately, however, you must be able to separate your own feelings and needs from those of the child or the parents. You must make certain that you are acting on behalf of the client's needs and not your own needs. It is a positive thing to identify with a client because you had similar struggles when you were a child. This allows you to have a natural source of empathy for the child. However you must be careful not to allow your interventions with the child to be guided by what you wish had been done or not done to you when you were young. In your interaction both with the parents and with the child, you must constantly consider the source of your reactions. Are you actually attuning to the child's or the parent's needs or are your own issues being stirred up? Do you find it difficult to work with this mother because she reminds you of your own mother? Does this child stir up angry feelings that belong to your relationship with your domineering older brother?

When working with children, perhaps even more than with adults, there is the strong temptation to reenact one's own childhood. The

physical contact and intimate interactions of Theraplay all invite many forms of countertransference acting out that must be carefully monitored. The rapidity with which activities are carried out and the amount of physical, mental, and emotional involvement leave little opportunity for on-the-spot self-exploration. Thus, for example, cuddling and feeding a child may stimulate your own longings to be cared for, or wrestling and competitive games may stimulate your need to win, but there is no time to inquire of yourself about the sources of your feelings. You must make it part of the ongoing therapeutic enterprise to investigate yourself.

Becoming aware of the problem and understanding potential dangers are the first steps in avoiding countertransference acting-out.

BECOMING AWARE OF THE PROBLEM. As you work, you must have a set of self-directed questions inside your head, an awareness of the possibility that countertherapeutic tendencies are being activated, and a quick resolve to take the matter up in more detail with yourself later on. The questions you must ask yourself include, "Whose needs are being served by this particular activity?" and "Why am I having this particular, uncomfortable reaction?"

Understanding Whose Needs Are Being Served. The answer to this first question must always be, "The child's. I'm doing it because this child requires it for her improved mental health." If it is prompted by your own needs, the activity should be discontinued immediately. If, for example, the reason for organizing a pillow fight is clearly that the child needs to experience competition in a nonthreatening situation, it is appropriate to continue. If your own competitive striving is the determining factor in the choice of a pillow fight, there is no justification for continuing the activity. The following questions can help you determine whether you are responding out of your own countertransference: "Am I using the child to reenact, act out, or attempt to resolve my own conflicts? Am I using her improved health or success and mastery for my own needs? Is my exhibitionism being fed by hope for public recognition of this child's accomplishments? Is my prolonging the treatment and delaying termination a function of my chronic anxiety over separation?" These examples are only a few of the many possible ways you might inappropriately "use" the child to satisfy your own needs.

Therapist styles present a subtle aspect of the question of whose needs are being met. Some therapists are naturally energetic, and

physically lively. They like vigorous activity and may focus on fast-moving, challenging activities as a result. Do they impose this style on all children no matter what the child's needs? Other therapists are quieter, more thoughtful and gentle. They may favor soft, nurturing activities and find it difficult to initiate more active play with a child who needs it. Will such a person be able to meet the needs of a lively, energetic child? Answering the question, "Whose needs are being met?" will help you make a decision as to what style to use for a particular child.

Looking at Your Uncomfortable Reactions. If you find yourself feeling uneasy during a session or a particular interaction, you need to explore the source of the discomfort. The important questions to ask are, "What about the child, the activity, or the interaction between us is making me have this uncomfortable feeling? If what I am doing is objectively appropriate for the child's needs, why am I *feeling* guilty, angry, anxious, or abandoned? If the activity I have chosen to do is appropriate, why am I *behaving* in an overprotective, competitive, neglectful, or clinging way?"

The answers to these questions will be as varied as there is variety in human personality. For some, the answer may lie in the therapist's identifying the child with some important figure in his own childhood (for example, a younger sibling), or perhaps with the therapist himself. For others, the answer may lie in the unconscious recollection of an early life experience touched off by the activity as such. Playing Peek-a-Boo, for example, may stir an infantile memory of a game with (or the disappearance of) the therapist's mother.

RECOGNIZING POTENTIAL DANGERS. Although other areas may also require alertness, you must be particularly aware of your responses to anger, dependency needs, sadness, sexual feelings, and guilt.

Anger. Anger is a natural reaction to someone's hurting you physically, challenging your self-esteem (for example, commenting about your areas of vulnerability, "Your breath smells"), or rejecting you. Your raw response to indignity, insult, physical pain, or abandonment will probably include anger. Indeed, anyone who denies having negative feelings toward the child who has just bitten her forearm or spat in her face is probably not fully in touch with her feelings. Of equal concern would be if your initial flare-up of reactive anger leaves you so shaken that you cannot deal with it, understand it, or

move beyond it. The goal is to experience the anger, understand its origins, then use it to help the child reintegrate. You should especially examine anger that is not a universal reaction to a particular stimulus (for example, if you become angry when a child acts babyish).

Dependency. Dependent longings are a natural reaction to fatigue, illness, separation, or seeing someone else being taken care of—so it should be no surprise if you find your own dependent longings stimulated by a child's termination of treatment, or by watching her pleasure in being taken care of. In order to avoid acting on such longings in a session, you need to take good care of yourself, avoid working when you are tired or ill, and be open to feelings of sadness and loss at termination.

Sadness. Many therapists are uncomfortable when a child displays unhappiness. They may interpret it as anger when it is fear or sadness. Or they may think that it is their responsibility to cheer the child up. If the child doesn't respond to their attempts to cheer him up, they may feel angry at him and send him messages that he is hurting their feelings or that they are angry. If this reaction occurs for you, it is important to explore what makes you unable to stay with and contain the child's sad feelings.

Sexual Feelings. Sexual arousal is a natural reaction to physical intimacy, seductive behavior, or verbalized sexual provocations or preoccupations. It is important to acknowledge to yourself the presence of such eroticized responses, then quickly neutralize them and move on, changing the activity if need be. Once the session is over, you need to explore the experience carefully so that you can understand what triggered the response and be able to avoid it in the future.

Guilt. Two kinds of guilt are of particular interest. First there is guilt over being assertive, intruding into another's life space, or "deciding what is good for someone else." This makes it extremely difficult for some therapists to take charge and do effective Theraplay. Underlying their difficulty may well be the fear of arousing their own infantile feelings of omnipotence or of the anger that assertiveness may imply to them. Second, there is guilt over "enjoying" your work. Because Theraplay can be such fun instead of dreary hard work, some therapists find themselves very uneasy. They may refuse pay, or they may turn the sessions into onerous burdens.

OVERCOMING COUNTERTRANSFERENCE ACTING OUT. There are a number of things you can do to avoid countertransference acting-out: preplanning sessions, supervisor or peer observation, supervisory discussions, role-playing, and personal psychotherapy.

Preplanning Sessions. We recommend careful planning for all sessions. This is especially important if you have had minimal Theraplay experience, or find it difficult to monitor your own emotional responses on the spur of the moment. Planning should include not only a list of Theraplay activities for the session but also an anticipation of what you will do if your plan goes awry (What if he bursts the balloon before he throws it? What if she spits the orange seeds at me rather than at the target? What if he doesn't want to be fed?). No amount of preplanning, of course, will account for all eventualities.

Having a Supervisor or Peer Observe. Having a supervisor or peer observe sessions and watch for any responses on your part that might be stimulated by countertransference is probably the best way to pick up on issues that need to be discussed and worked through. The observation can be conducted through a two-way window or by video. If necessary, observers can view the session from within the therapy room itself.

Arranging Supervisory Discussions. If direct observation is not possible, regular discussions with a supervisor, using videos of the session, will help you become aware of any moments when you might have lost sight of the needs of the child. A perceptive, nonthreatening senior therapist can help you trace the origins of a particular episode and help you find new solutions.

Using Supervised Role Playing. Supervised role playing of particularly troublesome client-therapist interactions will help you gain insight into the problem. At the moment of inappropriate action, you can stop the demonstration and explore the reasons for "doing what you did." Then you can discuss and practice a better solution—still within the role-playing framework.

Undergoing Personal Psychotherapy. Personal psychotherapy is highly recommended as part of the preparation for becoming a therapist in any therapeutic modality. Theraplay is no exception. Your work with the children and with their parents will be enhanced through your increased awareness and understanding of your own responses.

APPROACHES TO TREATMENT: GUIDELINES FOR THE THERAPIST

The following list of ways to approach treatment should be used as a guide only. The immediate needs of the child should always be your primary guide at each moment in the session. Though these rules are designed for you as a therapist, they will also be the model you will be helping parents to follow.

1. *Be confident and comfortable with taking charge.* Like a good parent, you must project a positive self-image and convey your ability to guide and protect.
2. *Take charge of the session at all times.* You need to be aware at all times of the safety and well-being of the child. You should confidently guide and structure the session from beginning to end. You do not need to ask permission, wait for approval, or apologize for taking action. Queries such as "Would you like to jump today?" or an "okay?" at the end of a statement about what you are going to do, communicate to the child that you are uncertain or that the control of the session is a joint endeavor. They invite the child to answer, "No."

   However, when working with children who have been traumatized it is appropriate to ask, "Does this feel safe to you?" "Is it okay if I put lotion on your hands?" While being alert to the possibility that some activities might trigger fear or panic, you must convey to the child your confidence that you can keep him safe.
3. *Be appealing and delightful.* You should be so spontaneous and engaging that any child will find himself inexorably drawn to join in your games.
4. *Make yourself the primary playroom object.* You—your actions, movements, words, and sounds—must be the major and indispensable "prop" of Theraplay. Initiate playful, engaging activities that capture the child's attention and create moments of true connection.
5. *Focus intensively and exclusively on the child.* There should be only one focus during your short session together: the child and her potential for health. You should lend your whole self, all your physical energy, and your emotional investment to making a meaningful connection with the child. This intensity of focus

replicates that of a parent with an infant. It forges a connection that less casual interactions could never do.

6. *Be responsive and empathic.* Like an attuned mother, you must match the child's moods and the vitality of her affect and, when needed, help regulate her arousal to an appropriate level. You should resonate with the child's joy as well as her sadness or anger.
7. *Identify and label the child's moods and feelings.* You should help the child become more aware of his inner experience without dwelling on it or asking him to comment on it. Use your capacity to read the child's intentions and feelings to label what you think he is experiencing. "Oh, you didn't like that. It was too fast. I'll do it a different way." "You are looking a little sad today, I'll help you feel better."

   When possible, you can connect the child's response to what immediately precipitated it. "You're upset because you wanted me to play that other game," or "You've had a hard day today at school. No wonder you aren't feeling very playful." Do not linger on these verbal observations as they may keep the child perseverating on the underlying feelings.
8. *Focus on the present and future but not on the past.* To consolidate the relationship between you and the child, convey the message that the present matters ("We're together now" or "You brought all your toes today"), that the future is good and imminent ("Tomorrow you're going to be tall up to here" or "Soon you'll be *so* strong"), and that what is really important to both of you is what is going on here in this very space you are sharing ("I knew I'd find you right here with me").

   If a child turns her attention elsewhere (telling you what happened at home or in school), your response should refocus her attention back to the two of you, and the Theraplay scene: "Your Mommy's at home? I'll bet she is at home. And I'll bet she's thinking about her little girl with these special freckles, and these curly eyelashes, and these ten wiggly toes." If the child tells you about a sad or troubling experience, however, you should listen carefully to what she has to say and clearly express your empathy and concern. When the child has finished talking about the experience, return to an appropriate nurturing or comforting activity.

9. *Use every opportunity to make eye contact with the child.* You should pursue the child's eyes with your own in an enjoyable, playful, and engaging manner. You can support eye contact by playing games that encourage looking at each other, such as Peek-a-Boo or putting stickers on each other's cheeks or noses. Never allow eye contact to become a task-oriented, serious matter between you and the child.
10. *Use every opportunity to make appropriate physical contact with the child.* Just as healthy parenting involves many opportunities for good touch, your sessions should include many opportunities for the healthy, physical contact that is essential to regulation, body awareness and making a connection with the child.

    Although tickling is part of many parents' playful repertoire, you should not tickle children because of the potential for overstimulation and sadistic excess. If your touch inadvertently produces a tickle, you should say, "Did that tickle? Let me see if I can do it without tickling."

    Even though you find the child delightful and lovable—as you should—do not use hugs and kisses to express your pleasure in the relationship. These very special signs of love and connection should be reserved for the parent and child.
11. *Attend to physical hurts.* However minor the bumps or scratches, nurse them tenderly, applying soothing lotion around them, rubbing the area gently and commenting on the feelings that must have accompanied the hurt. Let her know that you care about how she felt when she got hurt. Attention to hurts conveys a caring message that teaches the child to value herself and, in the long run, leads to appropriate self-care and circumspection.
12. *Use every opportunity to help the child see herself as unique, special, and valued.* You should help the child become more aware of her body by identifying and labeling her particular characteristics: "You have two good jumping legs," "Your nose is so warm!" or "What strong muscles you have." Avoid meaningless praise for qualities that the child has no control over, for example, "How pretty you are" or "What a pretty dress!" The goal is to help the child develop a strong sense of her own individuality, of her value and competence, and of herself as a person who can relate well to others.

13. *Accept the child just as she is.* Just as parents' love for their infant does not depend on the baby's performance or compliance, your regard for the child should be unconditional. Your response to the child should not depend on tasks performed, expectations met, or "good" behavior.

14. *Anticipate the child's resistant maneuvers and act before, not after, they are set into motion.* Children who are brought for treatment because of acting out behavior are very familiar with the experience of having adults chase after them saying, "No, don't do that!" or "Stop, come back here!" Make every effort to initiate action before the child's resistant behavior gets started. If you find yourself frequently saying "No" or constantly redirecting activity the child has already embarked on, you have delayed too long and initiated too little.

15. *Be responsive to cues given by the child.* Be alert to signals that indicate interest in meaningful kinds of activities. Picking up the child's cue and making it part of your interaction will convey your sensitivity to the child's needs and interests. Distinguish between situations in which the child is trying to take over and direct activities and those in which a genuine interest can lead to a shared activity. A child's suggestion, "Let's play cowboys today," should not provide the agenda for the session, but his coming in with boots or a cowboy shirt might prompt you to give him a horseback ride.

16. *Keep sessions spontaneous, flexible, and full of engaging surprises.* Although they are carefully planned to meet the child's needs of the moment, the activities within a session should flow naturally and spontaneously from one to another. The joyful spontaneity of the activities engages the child and challenges his negative view of the world. Be aware, however, that some children need sessions to be quite predictable in order to feel safe.

17. *Keep the session cheerful, optimistic, and health oriented.* You should face the child with a smile and convey your pleasure in being with him. If the child is unhappy, you should not get lost in his unhappiness, but rather attune to it and help to regulate it. As soon as possible you can begin to offer engaging activities and convey to him that the world is an appealing, happy place and that he, being basically strong, has the potential to enjoy it.

18. *Prevent excessive anxiety or motoric hyperactivity.* While keeping sessions lively and engaging, you must attune to the child's excitement and help modulate and regulate it so that it does not escalate beyond control. This may require slowing the pace or changing the activity to a calmer one. In order to give the child practice in self-regulation, you should provide opportunities for her to experience periods of high activity followed by quiet, so that with your help she can begin the process of learning to calm herself.

    For children who are in a state of constant hyperarousal, you must reduce stimulation and excitement to a minimum throughout the session and convey extra reassurance and calm leadership.

19. *Structure the session so that times, places, and persons are clearly defined.* Define the boundaries within which the session will take place and convey clear rules and expectations. Schedule sessions at a certain time each day or week. Each session should be approximately the same length. If the child is ill or tired, however, you can end the session early. The Theraplay space should be clearly limited to the Theraplay room or to the Theraplay mat. You must be the dependable person who predictably shows up to be with the child at every session. If you cannot attend a session, you should cancel the session rather than asking the interpreting therapist to take your place.

20. *Organize activities within each session so that they are clearly delineated.* Each of the many segments within a session should have a clear beginning, middle, and an end. Songs and rhymes that accompany a playful action can help provide this experience. For example, the game Row, Row, Row Your Boat has a clear structure. Activities that are not accompanied by songs can be organized by saying, "We will do three rounds of thumb wrestling," or "Two more turns and we're done."

21. *Make sure that each Theraplay session contains some challenge to the child's negative inner working models.* You must entice the child to accept a different view of herself and the world. You should present the child with challenges that encourage her to grow and move forward rather than simply remain as she is. The optimism implied by your expectation that the child can reach, stretch, and grow is ego enhancing.

To the degree that apparent "comfort" means continuing in unhealthy patterns, you should *not* be concerned with making the child "comfortable." Repetitive actions, for example, may seem to make an autistic child comfortable, but because such withdrawal into his own world prevents the child from growing, you should find ways to draw him out.

22. *Conduct your sessions without regard to whether the child likes you.* Convey to the child that there is something about him that is likable, regardless of whether or not he views you in the same way.
23. *Make your presence felt throughout the duration of a child's distress or angry outburst.* Help the child gain mastery over a temper tantrum by staying in physical contact, or close by, and by verbalizing your confidence that with your help the child will be able to regain control.
24. *When at a loss for ideas, incorporate the child's body movements into your repertoire.* Just as parents do with their young infants, you can use the child's slightest movement as a foundation on which to build a Theraplay activity. An inadvertent wiggle of a toe can suggest a "wiggle toes" game. A child's wild jumping up and down can be the signal to play a more organized jumping game with a rhythmic song to help structure it.

Notes

1. Klaus et al. (1970, p. 191) describe typical post-delivery behavior of mothers toward their newborns as follows: There is "an orderly and predictable" progression in inspection and contact "starting with fingertip touch on the infant's extremities . . . to massaging, encompassing, and palm contact on the trunk."
2. See DeGangi (2000) for a discussion of sensory integration issues. See also Ayers (1979).
3. See the following source for an excellent discussion of the ethical issues involved in maintaining safety and avoiding coercion. "ATTACh White Paper on Coercion in Treatment." Sept. 2008. Available from www.ATTACh.
4. If you work with large children or adolescents, do not attempt to hold them by yourself. You should also get training in procedures for providing safe containment.

5. Cohen and Beebe (2002) use the research of Field (1981) to help parents understand why infants look away. Research shows that five seconds before an infant looks away, his heart rate has begun to rise. About five seconds after he looks away, the heart rate returns to baseline. Then once the infant regulates himself, he will resume looking at the partner, provided that the mother has tolerated the baby's move away and patiently waited for his return. If a mother is anxious and desperately needs her baby to look at her, she may interfere with the infant's cycle of reregulating his arousal, and instead begin to "chase."

CHAPTER SIX

Working with Parents

Throughout this book we emphasize the essential role that parents play in Theraplay treatment. In this chapter we describe the many aspects of our work with parents that lead to their being able to play their part in developing the secure, attuned, joyful relationship that is the goal of treatment. The ultimate goal is for the relationship to settle into a self-perpetuating, healthy pattern so that parents can maintain it at home. If two therapists work as a team, the interpreting therapist will have the primary responsibility; if you work alone, you will be responsible for working both with the child and with the parents. In Chapter Four we discussed how to coordinate these two roles as well as how to handle both on your own.

In this chapter, we describe the following:

- How to prepare parents for their active role in treatment.

An earlier version of parts of this chapter appeared in "Training Parents of Failure-to-Attach Children" by Booth and Koller, *Handbook of Parent Training: Training Parents as Co-Therapists for Children's Behavior Problems* (Briesmeister and Schaefer, eds.), New York: Wiley, 1998. Reprinted with permission of the publisher.

- How to help them achieve a more positive, empathic understanding of their child's needs.
- How to guide them through a sequence of steps leading to competence in carrying on the healthy pattern that is established in treatment.
- How to meet parents' needs so that they can respond to their child's needs and implement what they have learned.
- In the final sections we describe how to work with high-risk, vulnerable parents who for many reasons need added support and resources.
- We conclude with a case study in which Theraplay is used successfully to help a vulnerable parent.

Working with parents is a multifaceted aspect of Theraplay treatment. As you guide parents through the steps leading to a healthy relationship, you must always be sensitive to their needs. You will need to discuss developmental and attachment issues while helping parents understand the meaning and antecedents of their child's behavior. You may also need to help parents with general parenting issues, including selecting appropriate schools or summer camps, dealing with in-laws, and finding suitable physicians or nutritionists. In other words, in addition to having psychological sensitivity, thorough child-development training, personal wisdom, maturity, and sound judgment, you must also have a good deal of familiarity with the current world of child rearing.

Although we describe each aspect of the work with parents separately, many of the steps overlap and the work is spread out over all the contacts you will have with parents. Some of the work is done in special sessions without the child—for example, during the intake and feedback sessions and during regularly scheduled parent sessions. The rest of the work takes place while the parents are observing and participating in sessions with their child.

PREPARING PARENTS FOR THEIR ACTIVE INVOLVEMENT IN THERAPLAY

Careful assessment and preparation of parents is essential to the success of Theraplay treatment. This section describes in depth the intake interview, the MIM observation and analysis, and the

feedback session, which are all important elements in helping you to understand the parents and helping the parents to reflect on their child's experiences.

As you learn more about the parents you can decide whether they need more preparation before starting treatment. If the parents are ready, you must explain the nature of Theraplay and get a commitment for treatment to begin. A very useful final step before starting the work with the child is to have the parents experience Theraplay for themselves. This personal experience clearly demonstrates the nature of Theraplay treatment and helps parents be more mindful of their own feelings and needs as well as those of the child.[1] If you do not have such a session at the beginning of treatment, you can have it at any time that seems appropriate during treatment.

Intake Interview

The intake interview is an opportunity for you to begin the process of forming an alliance with the parents in which they can feel safe. As you gather details about the child you can begin the process of helping parents understand more about what lies behind their child's behavior. You will also learn as much as possible about the parents and begin to assess their capacity to form a healthy relationship with their child.

FORMING AN ALLIANCE AND CREATING SAFETY. Throughout the whole assessment process, you must work actively to form an alliance with the parents so that they feel safe and can become active members of the treatment team. All parents who seek treatment for their child are struggling with feelings of distress and disappointment, and have various levels of difficulty understanding their child's needs. Because parents are essential to the healthy development of their child, you must establish a supportive, empathic relationship with them: it must be one that clearly acknowledges their crucial role in the family, respects their genuine concern for their child, and takes their goals for the child and their family into account. You must create a safe setting in which parents can talk about their feelings and concerns without feeling criticized. If parents are to respond to their child's needs and achieve the happy relationship with their child that they dream of, they must feel understood and supported. In fact, you must respond to the parents in the same empathic, caring manner

in which you respond to their child. Hughes (2007, p. 122) puts it this way, "The therapist needs to establish that she will serve as an attachment figure for the parents and that the parents and therapist will, together, serve as attachment figures for the children."[2]

LEARNING ABOUT THE CHILD'S NEEDS AND BEHAVIOR. The first step in the intake process, as we described in Chapter Four, is to have the parents complete two standardized behavior checklists. We are currently using the Child Behavior Checklist (CBCL) (Achenbach, 1991) and the Parenting Stress Index (PSI) (Abidin, 1995). These two measures can be repeated at the final meeting in order to assess the outcome of treatment.

Right from the beginning as you inquire about the child, you should make clear the importance of understanding what lies beneath the child's behaviors. As you listen to the parents' concerns about their child and discover their assumptions about motives, you can begin to set the stage for empathy by expressing curiosity about the meaning of the child's behavior and speculating about how his early experience might have led to his current behavior. Hughes provides an excellent list of questions that you might ask, some of which are listed here:

- What makes him seek attention that way?
- What do you think makes it so hard for him if he does not get what he wants?
- Why is making a mistake so difficult for him? Is it for you?
- Were/are there times when he does not argue, but rather accepts your decision?
- What do you think is the reason why he does that sometimes and not others?
- Do you think there may be other motives that might explain these behaviors? (Hughes, 2007, p. 127)

To help parents understand the meaning of their child's behavior you can introduce them to the idea of inner working models, the roadmaps that children develop based on their interaction with caregivers. They need to have a clear understanding of the ongoing powerful effect that early experiences have on their child's sense of

herself and of what she can expect from others. You can point out to adoptive parents, for example, that their child's difficult behavior may stem from a negative view of herself that developed when she was very little. As they describe some difficult behavior, you can ask, "How do you think she was feeling about herself at that moment?" "What does his hoarding of food tell us about the picture of the world that he developed when he was little and often had to go to bed hungry?"

ASSESSING THE PARENTS' CAPACITY TO FORM A HEALTHY RELATIONSHIP WITH THEIR CHILD. As part of your preparation for starting treatment, you need to assess the parents' capacity to form a healthy relationship with their child.

If you have experience using the Adult Attachment Interview (George, Kaplan, and Main, 1985) and the Working Model of the Child Interview (Zeanah and Benoit, 1995), you can use them to gain valuable information about the parents' attitudes toward attachment as well as their attitudes toward their child. Parents who were well parented themselves or who have achieved a secure state of mind that prepares them to understand and respond to their child's needs will require less preparation. Parents whose own parents were insecure or disorganized will have more difficulty. However, even the most secure parent may struggle when faced with an adopted or foster child or a child with developmental problems who will not let her get close and who sends confusing signals about his needs.

In an attachment-based treatment such as Theraplay, it is essential to learn as much as possible about the parents' own childhood experiences and their current states of mind regarding attachment. In Chapter Four we discussed questions to ask during the Intake Interview. The more you understand about the parents' experience, the more empathy you will have for them.[3] Equally important, the more that parents are able to reflect on their own childhood experiences and how these experiences affect their current feelings and responses to their child, the more empathy they can have for their child. A helpful question is, "What was it like for you when you were your child's age?" or "How similar or different was your experience from your child's?" Parents need to understand how important it is to come to terms with their own experience if they are to respond to the needs of their child. Because of the interactive nature of relationships,

the parents' and the child's difficulties will interact in ways that are sure to set off the parents' own "attachment triggers."

After you have learned as much as possible about the parents' concerns and their personal history, you should arrange the next step in the assessment process: the MIM. Parents should understand that this will provide an opportunity to learn more about how the child responds to various kinds of activities and how their relationship works. The MIM will also allow you to assess each parent's capacity to form a healthy relationship with the child.

MIM Analysis

As you analyze the MIM you will be looking for interactions that demonstrate the parents' strengths. You will also be noting moments when you sense that the parent's fears and uncertainty have intruded on their efforts to understand and respond in a healthy manner to their child. In addition, you will be looking at how the child signals his needs and how easy it is for the parents to read and respond to them. What you learn will guide you in planning treatment that meets both the parents' and the child's needs and ultimately leads to the parents' being able to respond to their child's true needs.

Because of the nature of the interactive dance between parent and child, there is often a close relationship between the child's struggles and those of the parent. A biological child who is brought for treatment will have a picture of himself and of what he can expect that grew out of years of interaction with his parents. The child's behavior is an accommodation to the parent's strengths and anxieties. As we saw with Adam in Chapter Four, his difficulty being soothed and comforted as a baby interacted with his mother's ambivalence about taking charge and having her child be dependent on her: this created a dance that was unsatisfying to both. Adam seemed to be asking for more closeness, but because his mother responded to his clingy and demanding behavior with annoyance, Adam felt rejected.

The child who is in foster care or has been adopted brings an inner working model of what to expect from others based on her experience of earlier inadequate caregiving. Many of these children appear to deny any need for nurture and comfort. The child's message seems clear: "I don't need you. I can take care of myself. I don't expect you to love and delight in me." But the underlying need is actually very different. If the child's new caregiver is dismissive of attachment

needs, the child will miss out on what he really needs, and the two will not be able to settle into a comfortable, secure relationship. If, however, the caregiver has a clear insight into the child's underlying needs and is comfortable meeting them, the child will be able to accept this healthier relationship and build a true sense of security.[4]

As you analyze the MIM you can note both the parents' and the child's comfort with each of the four dimensions as well as the areas that are difficult for them. Understanding the areas of the parents' strengths and any sources of difficulty is the first step to helping them change.

STRUCTURE. In this dimension you are looking for the parents' ability to organize the interaction in ways that provide regulation and convey a sense of security and safety to the child. Many parents who are poorly regulated themselves or who have unresolved mourning or trauma find it difficult to set limits and to be confident leaders. Some parents give too much power to their children out of a belief that children need to make their own decisions and should learn early on how to organize themselves. Others hesitate to set limits because they fear the child's anger if they don't go along with his every wish. Some parents may have experienced such harsh discipline as a child that they lean over backward to avoid passing on such treatment to their child.

ENGAGEMENT. In this dimension you are looking at the parents' ability to connect with and delight in their child, while at the same time being aware of the need to attune to and regulate his excitement. This includes their ability to play together in a physically interactive manner. Is the parent so achievement oriented that he is only interested in teaching? Is the parent so preoccupied that she can't keep the child's needs in mind enough to regulate the interaction?

NURTURE. In this dimension you are looking at the parent's ability to anticipate and respond to the child's need for the comfort, soothing, and support that form the basis of a secure relationship. For example, does the parent sense the child's discomfort in this strange situation and is she able to reduce his anxiety? Sometimes it is clear that the parent is ready to be more nurturing but the child resists it. Can she get past the child's rejection of her offers of appropriate support and nurture? What feelings get in the way of the parent's being able to let

his child depend on him, and to nurture and calm him? Sometimes parents find it difficult to be nurturing with an older child. "That's babyish. He's too old for that." Some parents have developed a dismissive attitude toward attachment, believing that the only way to avoid pain is to avoid being close.

CHALLENGE. In this dimension you are looking to see whether the parent has appropriate expectations for his child, whether he can provide the scaffolding and support that make it possible for his child to succeed, and whether he can take pleasure in his child's success. If the task turns out to be too difficult for the child, can the parent modify it in ways that help the child accomplish it? If a parent has inappropriate expectations, you need to explore what it is that makes it difficult to attune to this part of the child's development. Is the parent so young and inexperienced that she doesn't know what to expect of a child at different ages? Perhaps his own parents expected him to grow up too fast. Some parents are unable to support their child's exploration and moves toward independence because of a fear of being abandoned themselves. Others may be uncomfortable with their child's dependency needs and thus push their child to be more outgoing and achieving. Adopted children, who may not be ready for age-appropriate challenges, are often pushed by their parents for academic achievement as part of an effort to help the child "catch up."

The Feedback Session

During the feedback session, you can help the parents become more aware of their own needs and experiences while continuing to build empathy and understanding for the child's experiences. Having assessed the parents' and child's comfort with the four dimensions of interaction, you should choose a few specific points to emphasize in your feedback. Choose aspects of the interaction that you want to support and enhance. Find moments in the child's behavior that you want the parent to understand better as well as moments in the parent's response about which you need to learn more. Make sure to include the message of hope that you want to convey.

Having organized your ideas about the focus of the feedback, you should choose two or three videotaped segments for each parent that have significance for their relationship with their child. The feedback session is above all an opportunity to deepen your therapeutic

relationship with the parents as you indicate your understanding of their feelings and your appreciation for how much they care about their child and how hard they are working to make the relationship go well. All of the explorations of the parents' and child's experience must be done carefully and tactfully to avoid any sense of blame.[5]

In the following section we illustrate the feedback process using a transcript from a single case. Sam, age four and a half, was brought by his father, a single parent, for treatment because of his angry, defiant behavior and frequent temper tantrums. When his father leaves him in the care of his baby-sitter, his behavior often gets out of control: "He yells at her, is mean to her, and refuses to do what she asks him to do. Sometimes she has to call me to come home and settle him down." During Sam's first three years he suffered many disruptions in care. He has been back living with his father for a year. With unusual insight, his father said, "I think that Sam is like me, his fear comes out as anger." The father thinks that his son might interpret his past absences from Sam's life as abandonment and that this might be affecting their relationship and the boy's behavior.

As we analyzed the MIM in preparation for our feedback session, we saw that there were many strengths in the relationship that could be built upon. Sam is a bright, engaging boy who seems genuinely happy to be with his father. The father is attentive and caring and very proud of his son's spirit and intelligence. The two enjoyed active, rough-and-tumble play together although occasionally Sam got too excited and became rude and defiant.

Our goal in the feedback was to help the father understand the importance of his role in providing clear structure and in developing a secure relationship that would anchor Sam and lead to greater self-regulation.

THERAPLAY IN PRACTICE

Beginning the Feedback Session

The feedback session began with a brief discussion of the father's reflections on the session.

DAD: It was kind of fun. You know we play a lot but this was different.

INTERPRETING THERAPIST (IT): How was it different?

DAD: We play a little rougher . . . cars and tackle football.

IT: We were all impressed by how involved you are and how patient.

DAD: I don't always have patience. I have to be honest.

IT: No one is. And he's not all that easy to be patient with. He gets so excited that he's all over the place.

DAD: Yes. If he gets excited it's harder to get him to do things or to keep him in one place. He wants to do this, whether or not I want him to do it. . . . I try to calm him down. . . . But I think I was the same way.

IT: That may give you some insight into how to help him be calmer. He's lively, active, smart, but he needs an anchor, he needs to be settled down a bit. I think you're his main anchor, aren't you?

DAD: Yeah.

POINTING OUT STRENGTHS. During the MIM feedback you can point out the parents' strengths and successes—many of which they don't even recognize. This gives the parent confidence and the ability to hear about the areas that are difficult.

THERAPLAY IN PRACTICE

Highlighting a Positive Interaction

After the brief general discussion we turned to a moment in which the father had successfully taken charge of the interaction.

MIM Scene

The scene we showed Dad was from the end of the first activity: Have two animals play together. The play went on for more than five minutes with Sam becoming more and more active, diving his two puppet animals down over the sofa pillows with much energy and loud sound effects. The following is close to the end of the action.

SAM: Cannonball! (both dive their animals off the back of the sofa) Put 'em on your fingers.

DAD: On my fingers? (does so)

SAM: Beat ya! Beat ya! Cannonball! (all four animals dive down wildly) Let's do all of them. (diving sounds) Beat yers.

DAD: (looks at Sam) [*Sensing that the play had gone on long enough?*] Wanna play with something else?

SAM: Uh-huh! (emphatic) [*Relieved that Dad has taken charge?*]

DAD: Huh, you do?

SAM: (quickly gets up, approaches envelopes) Put 'em back.

DAD: Put 'em back?

SAM: (begins to rummage through envelopes looking for next activity)

DAD: Hold on, hold on we gotta see what we have to do first.

Feedback

The interpreting therapist says, "Both of you seem to be having a good time. Let's look first of all at how you manage to get him involved with you. What you did was ask a lot of questions; you were trying to draw him out I think. Let's watch it for a bit."

DAD: Yeah, he usually tells me what to do right off the bat. He comes up with the idea.

IT: So he usually leads the play—is that something that you intend?

DAD: Yeah, I play along with him. I let him use his imagination. He tells me what to do. I let him tell me what to do when we're playing because that's his game.

IT: That makes sense. (watching the tape for a few moments) Now he's moved way off the sofa and you follow him, but then you want him to come back, so you use your words but he doesn't respond. Then you do something very helpful. You move closer. He needs to feel your presence, so that was good to move in. Now, here is the important moment. His play is beginning to feel scattered and at loose ends. You, then, very clearly say, "Wanna do something else?" he says "*Uh-huh!*" It sounds as if he was relieved when you

said that. It felt like you were just right. You knew that it was time to end the activity. How did you know that?

DAD: It just seemed like he was being bored with it.

IT: That's exactly what I was feeling as I watched it. It had gone on long enough and he welcomed your taking charge. It's very helpful to him that you sense when it's time to stop. You know, if we think about what his early years might have been like, he's bound to have missed out on some of the caretaking that would make him feel calm, that would have organized his experience. So for a while, it's going to be up to you to help with that. So this is just a lovely moment when you sensed what he needed and said, "Let's stop." I want to confirm that that's a really good thing. As we work together, we're going to be looking more and more at what does calm him, because kids do need that. And the only way we learn to be calm ourselves is when we get help with that as a baby.

HELPING PARENTS UNDERSTAND THE MEANING OF THE CHILD'S BEHAVIOR. In order to deepen the parents' empathy for the child, you can show them a segment of the tape in which you think they may have missed what the child was feeling. The child may have miscued and the parent, therefore, did not understand the true meaning of the child's behavior. Watching it again they may be able to understand the child's underlying feelings.

THERAPLAY IN PRACTICE

Sam's Sad Drawing

Dad reads the instructions: Make a drawing and have child make one just like it. Dad's efforts to get Sam to copy his drawing seem to be interpreted by Sam as criticism. He first becomes sad and ends up being resistant and finally angry.

MIM Scene

Sam and his Dad are sitting at the table.

DAD: (reads directions and pulls out pencils and paper; draws a smiley face)

SAM: (takes pen and makes a circle using his left hand)

DAD: You drawing what Daddy drew?

SAM: A potato head.

DAD: A potato head? I drew . . . Is that a potato head?

SAM: No. (quiet voice, head down)

DAD: Can you draw a smiley face?

SAM: No.

DAD: Come on, draw what Daddy drew!

SAM: Pumpkin.

DAD: A pumpkin face? I drew a smiley face you drew a pumpkin face.

SAM: Sad one. (head drooping, voice low) *[Dad didn't hear "sad"?]*

DAD: You drawing hair on it?

SAM: Sad one. (softer voice, sad look)

DAD: Can I draw something else?

SAM: (shakes his head)

DAD: No?

SAM: Almost done.

DAD: Wanna draw a house? Daddy draws a house, you draw a house? (hopeful, upbeat tone) *[Hopeful that a house will engage him and he will actually comply with the task?]*

SAM: (shakes his head and continues, completely absorbed in drawing)

Sam continues for a long time drawing a house. Dad makes suggestions: a door, a window, can you draw with your right hand? Sam rejects most suggestions.

DAD: You're not going to do that? Ready to play something else?

SAM: Uh-huh. Can I keep the picture?

DAD: Yeah we can keep it. Put it right over there. Put your name on it.

SAM: Not done. (starts drawing again; this goes on for some time) *[Dad becomes a bit impatient.]*

DAD: Are you done?

SAM: (throws pencil, grabs paper) *My* paper. (defiant look)

DAD: Okay, you can keep it!

SAM: (challenging look at Dad as Sam crumples the papers)

DAD: (face and voice convey total surprise) I thought you were going to keep them.

SAM: (throws crumpled papers across room) We're done drawing.

Feedback

The interpreting therapist says, "We're interested in what happened during the drawing activity that made it end up with his crumpling the paper and throwing it. You drew a smiley face? What's your view of what happened?"

DAD: He started to do it. He usually draws smiley faces on his own, so I knew he could do it.

IT: So that was a good choice; you knew you weren't making it too hard for him. And then you said, "Is that what Daddy drew?" So was he already not doing quite what you had done?

DAD: Yeah, he had started wanting to draw his own picture. He wasn't drawing the picture. That's what I think. *[Begins to think of another possibility?]* Maybe in his eyes he was drawing the picture but in my eyes he wasn't . . . Before he wasn't good at drawing. I showed him how to draw a smiley face, then he drew it pretty good.

IT: The reason I'm spending time on this is that when you questioned whether he was copying yours, he began to resist more. "I'm doing a potato head, a pumpkin head," and then he said, "This is a sad one." Did you hear that?

DAD: No.

IT: Well, let's see if we can hear that. (watch tape together) So what do you make of that?

DAD: I don't know. He draws happy faces and then sometimes he draws sad faces, it didn't seem any different.

IT: It starts with his seeming to be interested in copying your drawing. Then when you let him know that it wasn't quite what you expected, things kind of went downhill. So we were just wondering if there was a possibility—and we can't know for sure at this point—that he felt bad about not doing it just the way you wanted him to do it. Is that possible?

DAD: Yeah.

IT: What I felt about this whole sequence leading up to his crumpling it and throwing it, almost as if it started out okay and it ended up not feeling good.

DAD: Yeah, he does that a lot too; if he messes up, he wants to erase it. If he's got an eraser, he'll try to erase it. Or he'll crumple it and throw it away and start over . . . cause it wasn't good enough for him. I never said it wasn't good enough, but I guess I was kind of saying that there!

IT: I don't think you meant to be critical, just wanting him to look closely and follow your pattern. But it looks as if Sam is very sensitive to the possibility that he isn't doing it just right, just right to please you. I wonder whether the "sad face" doesn't reflect how he was feeling. But very quickly he digs in his heels and becomes a bit rebellious, "I'm doing a pumpkin face!" You must be wondering, "What's happened here? We started out okay, now why is he so stubborn?" But he's really feeling bad about his drawing and so he crumples it and throws it across the room. We'll watch to see if that might be a pattern—feeling unsuccessful and then getting angry or messing things up.

POINTING OUT THE CHILD'S NEED FOR CONNECTION. The "Leave the Room" task is particularly useful in helping parents understand how important they are to their child's sense of safety and to his ability to contain or regulate himself during their absence.

THERAPLAY IN PRACTICE

Sam Alone

Sam's response to being left alone was a dramatic example of how he becomes dysregulated when he is on his own.

MIM Scene

Sam is standing beside the couch.

DAD: Okay. (reads) Parent leaves the room for one minute. (Pauses a minute, looks at Sam) Stay here and play . . . or whatever.

SAM: (hopping like a bunny with his arms raised toward Dad) A rabbit.

DAD: (leaves room quickly without looking back)

SAM: (goes to envelopes, pulls out food. Hesitates a moment and then puts back. Sits on couch, makes a rude raspberry sound. Stands, leans hands on coffee table, and jumps feet off floor repeatedly. Stands on couch and jumps up and down, runs from one end of couch to the other, jumps from couch to chair. Runs toward camera, runs to couch and falls on it making noises, tosses throw pillows to ground, arranges them in a line, jumps on them saying "Boing," jumps out of room toward where Dad went, examiner follows, all come back)

DAD: Get in there. (calmly)

SAM: (falls on floor)

DAD: Gonna take a nap? (steps over child)

SAM: (coughs loudly)

DAD: (sits on couch and looks at next card) *[No effort to reconnect to child.]*

SAM: (looks at Dad)

Feedback

IT: Now I want to show you how things went when you left the room. We use this task as a way of looking at how the child manages when he's all by himself. The child's response to one minute of separation gives us an idea of what it means to him to be left alone. You've told us that he seems to experience your going out for an hour or so as an abandonment?

DAD: Yeah.

IT: So we're very interested in what he does here. What do you think he did?

DAD: He misses me, I know. He gets hyper. I don't know. He starts acting up.

IT: (watching the tape, which starts at the point where Dad reads card) I want you to think about how he might be feeling.

The first thing he did when you left is get the food. But he didn't let himself give in to that impulse. So what could he do then? Babies suck their thumbs or have ways of comforting themselves. It looks as if bouncing around is one way he can fill the emptiness when he's all alone.

IT: (watching the scene) Now, how do you think he was feeling? Can you get into his feelings?

DAD: He wanted to know what Daddy was doing? He's very curious what I'm doing all the time—if I'm in the bathroom, have the door closed, take a shower.

IT: So what does it mean to him, why does he need to find out what you're doing?

DAD: I don't understand that sometimes. He wants to know what I'm doing and do what I'm doing, pretends to shave.

IT: He wants to be like you? Also it's almost as if it doesn't feel good if he isn't right with you.

DAD: Yeah.

IT: That's a very good thing for him. The task he has to do, and you have to do with him, is to form a really good connection now that you're back together. He needs to be convinced that he's really safe, that you aren't going to abandon him. We have to think of the way a toddler never wants his parent to leave. If he were not eager to be with you I'd be concerned.

DAD: (nods)

IT: But it's a pain in the neck right now?

DAD: Sometimes.

IT: It's a very good sign, because what I see happening here is not "I gotta go see what Dad's doing." It's more like, "I'm falling apart without him." Does that make sense to you. Am I exaggerating?

DAD: No, I understand.

IT: So, we need to keep this in mind. It's part of why he misbehaves when you're gone. Instead of thinking that we have to teach him to behave, we need to think, "What can we do to help him so he doesn't feel that he's falling apart?" You've taken on a big, important task here, to be the safest,

most reassuring person for him to turn to. That doesn't mean you can't go out and do what you have to do. But we have to help him so that he doesn't feel so lost and worried about what's going to happen. There must be times when he's all alone that he'll suddenly feel in his body the way he felt as an infant; abandoned, hungry, no one to soothe and calm him. Now that he's older (points to screen) instead of crying he's jumping around. But like an infant, his first thought was to get to the food.

DAD: (laughs) He eats all the time.

IT: Okay. Well, that's another way he's comforting himself. So, we'll be talking about how you can be the person who feeds him emotionally instead of his feeling "I just gotta get it all by myself." That's another thing about children with his early experience. They figure "no one is going to do it for me so I have to do it myself." He does some of that, but what's so encouraging with Sam is that he's not just saying "I'll do it myself," he's coming to you. We need to fill him up with the sense that he can hold on to you even when you are not right there. We need to find something that reminds him of you and that calms him so that he can keep you in his mind when you have to leave. That is what we will be working on as we begin our sessions.

EXPLORING WHAT LIES BEHIND THE PARENTS' BEHAVIOR. During feedback, you can also explore what went through the parent's mind at crucial moments during the interaction. In order to do this, you should choose moments in the MIM video that seem to reflect some hesitance or a strong feeling on the parent's part that interfered with his ability to keep his child's needs in mind.

THERAPLAY IN PRACTICE

Father's Response to Leave the Room Task

We sensed some discomfort in the Dad's response to this task: he left quickly, ignoring Sam's signal that he wanted to stay

connected (hopping toward him with arms outstretched) and offering no guidance about what Sam could do during his absence ("you can play . . . or whatever"). Something must have been stirred up for him that made him lose sight of his son's need for help in handling the separation. We asked Dad to tell us what thoughts went through his head as he read the card telling him to "Leave the room for one minute." As he looked at the interaction, Dad said, "I guess I was afraid that he would make a fuss. I thought, 'The quicker I get out of here the better.' I didn't want him to be so upset that he couldn't settle down for the rest of the activities. Now that I look at what went on, I can see that he really needed me to respond to his bunny hop before I left." Watching how Sam handled his absence gave him insight into how he might be more helpful to him around separations. "I guess it would help if I told him what he could do." We then asked him to look at what happened when he returned. Again Dad ignored the message of Sam's lying on the floor and coughing. Dad said, "I guess I worry that he won't grow up if I give in to his little games of pretending to be a baby and needing my help." We were able to talk with the father about how his own experiences as a child might have affected his response to Sam. He began to see how his worry about Sam's anxious, crying response might get in the way of responding in a way that would help Sam grow up step by step.

Deciding Whether Parents Need More Preparation

By the end of the feedback session you should decide whether the parents need more preparation before you start treatment. As we stated in Chapter One, you should not begin working with a family if they are unable to keep the child safe; this would include parents who are still abusing drugs, neglecting or abusing their child, or so depressed that they cannot attend to the child's needs. The preparation we have described above assumes that the parents do not fall into those categories. Even after all this careful preparation you may still find that parents are not ready to begin Theraplay with their child. Some parents are so needy that they are unable to feel empathy

for their child's struggles. Others are still so caught up in unresolved or dismissive attitudes toward attachment that they will need more opportunity to come to terms with their own issues before they can be open to meeting their child's needs. And finally, some parents are so hurt, angry, and even traumatized by the day-to-day conflict with their difficult child, that they are not ready to participate in Theraplay sessions with their child.

If the parents need their own individual preparation before you begin Theraplay treatment, you have the option of working with them yourself or referring them to another therapist. While they are attending to their own needs, you should, if possible, arrange individual treatment for the child. This might be a modified version of Theraplay, with the goal of helping the child feel safe and increasing his self-esteem. It could also be another modality that supports the child until his parents are better prepared to join in Theraplay sessions.

In the final section of this chapter we give more details about how to work with high-risk, vulnerable parents. The following section describes how to proceed with Theraplay when parents are stable enough to join their child in treatment.

Presenting the Treatment Model

Before they commit to treatment, parents should have some understanding of the nature of Theraplay: the basic assumptions, the use of touch and physical closeness in regulating affect, and the treatment's hands-on playfulness. They must also understand how central their role will be. You should consider preparing a written description of the model based on the material in the earlier chapters of this book. It would be ideal to show parents a brief videotaped example of Theraplay.

Agreeing to Engage in Treatment

At the end of the feedback session, you should come to an agreement with the parents about whether to engage in treatment and, if so, what the goals should be. These would include the goal of reducing the troubling behaviors that led to the parents' bringing their child for treatment, but will be enhanced by the insights gained from your observations of the MIM and understanding of the underlying

reasons for the problems. For example, the father's initial goals of having Sam reduce his temper tantrums and be less defiant and oppositional with his baby-sitter shifted to goals based on a greater understanding of the underlying reasons for Sam's behavior. We agreed that we wanted Sam to feel secure in his relationship with his dad so that he would be able to regulate his feelings when his father was away. We wanted him to be able to seek comfort from his dad and be able to talk about his feelings with him. Our goals for the father were that he take a more active role in engaging his son in satisfying, playful activities, provide more structure and guidance to their interaction, and find ways to help him feel more secure and calm. Because Sam rejected many forms of nurture, we wanted to help the father provide the calming, nurturing activities that would build a sense of security for Sam so that he would be less distressed by separations.

Be sure that your working alliance is well established and parents are clear about their role as participants in the sessions. Hughes (2007, p. 152) describes such an alliance thus: "The therapist is the 'expert' regarding issues of attachment and therapy, whereas the parents are the 'experts' with regard to their unique family and the individuals in it." Make it clear that you will handle any difficulties that arise in sessions and that the parents do not need to take charge. As Hughes suggests, however, you should also agree on a way of signaling each other if either of you feel that things are not going right. Parents need to be able to let you know if they are uncomfortable with what you are doing with their child and you need to be able to let them know if you think they should be responding to their child in a different manner. For example, a father who gets caught up in the playful aspect of Theraplay may begin to tickle or stimulate a child at the very moment when you recognize that she needs help to calm down. You need to have a comfortable relationship that allows you to say, "Dad, Jane was getting pretty excited. She needs you to help her settle down right now. Just put your arm around her for a moment."

Parents should also be clear about the basic plan for treatment. This should include discussing when you will meet and when you will have sessions without the child, confirming the arrangements for observing the first few sessions, and planning when they will join the sessions. They need to have a clear understanding about the fees and how payment will be handled. It is a good idea to have parents sign a form that describes the nature of Theraplay treatment, including

the use of touch, your policy for handling out-of-control behavior, and the expectation that parents play an active role in sessions. You should also have them sign a document that acknowledges their understanding of the rules for confidentiality, and your legal obligation to report any evidence of neglect or abuse of the child. Finally, you should have them sign a form giving permission to videotape sessions.

Experiencing Theraplay

Giving parents a Theraplay experience for themselves is a powerful way to help them gain understanding of what Theraplay is all about and what they can expect to happen during sessions. In addition, it gives them insight into their own feelings and responses, gives them an opportunity to get some of their own needs met, and helps them understand and empathize with their child's experience. It is ideal to have this session as the final step in preparing parents for their participation in treatment, but it can also be introduced later during treatment as needed.

A word of caution: Theraplay sessions can stir up intense feelings on the part of the parent that have the potential of creating boundary issues. If you plan to have parents experience a Theraplay session you need to be very comfortable with the Theraplay model in working with children and their parents, and you need to have had experience working therapeutically with adults. You should develop a plan that is clearly defined and that provides opportunities for the parent to process the work either with you or with an experienced colleague. You will do well to have a co-therapist and to videotape your session so that you can view it with your colleague after the session.

THERAPLAY IN PRACTICE

A Parent Experiences Theraplay

Sonia sought help for her seven-year-old nephew, Michael, who had been sexually molested by his mother's boyfriend. When this was discovered, Michael was removed from his mother's care and placed with Sonia. As treatment for the

sexual abuse issues progressed, Sonia began to trust the therapy process and asked the therapist, who was trained in Theraplay as well as in working with children who have suffered abuse, to help her develop a better bond with her nephew. Because Sonia had never been a parent before and her own early experience had been troubled, the therapist decided to give Sonia an experience of Theraplay for herself before beginning Theraplay sessions with Sonia and her nephew.

Sonia is from an alcoholic home and had become the lost and responsible child within the family system. During the intake interview, it became clear that she had difficulty feeling safe and developing trust within her own adult relationships and that she was very task oriented and performance based in providing and receiving approval from others. She had never experienced safe and meaningful touch and had had few opportunities for just plain fun. In planning the session the therapist decided to include the Theraplay activities that would introduce her to these experiences: Caring for Hurts, Pop Cheeks, Stack of Hands, Pop the Bubble, Beep and Honk, Face Painting, Feeding, and singing a special song.

After a brief moment of uncertainty, Sonia yielded willingly to the experience of having the therapist find and put lotion on her small scratches and bruises. She had seen the therapist take care of Michael's hurts during his sessions with her and, therefore, she was able to relax and enjoy this close, nurturing touch. With a tone of surprise, she said, "It feels really good, really comfortable to me." She then asked several questions about what this type of touch and interaction would mean to a child her nephew's age. The therapist briefly talked about the importance of touch for children of all ages. Sonia was especially interested to learn that even if a child had not received adequate nurture and touch as a baby, something could be done to help him experience this at a later age.

She became more animated as she and the therapist played lively games of Pop Cheeks and Stack of Hands. "These would be fun little games for Michael. I'll bet he would want to do them all the time." When asked how *she* felt doing them, she said with a contented smile, "Connected, like it's just me and

you and the world." The therapist added that the reason for doing these activities was to have a way to connect with a child without the child having to perform. Because Sonia's hope in seeking help for herself and Michael was that she might develop a better bond with him, this was an important point for her.

Sonia laughed and enjoyed the funny sounds that the therapist made as she touched Sonia's nose, her ear, or her chin in the Beep and Honk game. The therapist asked if she ever got to have fun like this when she was a child. "Oh no, life was always too serious for such nonsense. There was always a lot going on." Then she became thoughtful and said, "I think being serious helped me keep my own little space together. It helped make me feel safe. Everything was so chaotic in our house. I never got to be silly like this. This is really fun."

Sonia enjoyed the rest of the activities. "It's just playing and being. I don't have to do anything." When the therapist offered Sonia some crackers, her first impulse was to take them in her hand to feed herself, but she quickly reminded herself, "Oh, I know the rule. In here you like to feed me." She had learned this rule as she watched Michael's earlier sessions. As she was being fed, Sonia said, "I think my parents always thought I was fine and that everything was okay, because I was so serious, always doing just what I should do. They never had to worry about me."

This led to a discussion about what it was like for her to be the lost child in an alcoholic home. How she had to avoid attention in order to feel safe. "Now I'm not comfortable getting attention from others, not even on birthdays." As a result of being the center of attention that finally felt safe, Sonia was able to look at her own experience and gain some understanding of her own personal responses.

The real surprise came just at the end of the session. Looking directly into Sonia's eyes, the therapist sang the Twinkle song: "What a special girl you are." Sonia responded with big child-like smiles and said shyly, "I feel like crying." In response to the therapist's reassurance, "It's okay," Sonia relaxed and tears rolled softly down her cheeks as she

wondered out loud, "Why is this happening to me?" "I think you never felt safe enough just to be who you were meant to be—no expectations, no performance, no perfect little girl." Together Sonia and her therapist savored this moment of genuine connection and shared good feeling.

Later the therapist commented that the experience of participating in a Theraplay session could help Sonia learn what it feels like to a child when he gets this kind of attention and care. "Now that you know how good it feels, you will be able to give it to Michael." "Thank you," Sonia said as she held the therapist's hand in a warm clasp. "I have really enjoyed my time with you."

HELPING PARENTS GAIN A MORE POSITIVE, EMPATHIC UNDERSTANDING OF THEIR CHILD

Once treatment begins, you continue the process of helping parents become more sensitive to their child's experience. As we have noted, our typical pattern is to have parents observe for the first four or five sessions in order to facilitate this process. In Chapter Five we discussed situations where, because of the child's needs, parents should be included in sessions from the beginning.

Understanding the Reasons for Having Parents Observe

As you interact with the child alone, you can discover the most effective ways to engage her in a positive relationship before you face the more complex task of orchestrating the interaction between the child and her parents. In the presence of a self-confident, engaging adult, the child can experience and accept the new approach, begin to see herself and the world in a more positive light, move through the resistance phase, and be prepared to respond positively when her parents come into the sessions. Parents find it easier to practice the new approach if the child is comfortable and responsive. Some parents are so worn out and wary of interacting with their child that they need to get some distance from the child before becoming

actively involved in sessions. A period of observation, leading to greater empathy for their child, can be very valuable. With the help of the interpreting therapist, they are able to see their child in a new light and develop more understanding of her struggle.

You need to be sensitive to the effect on parents of observing a competent Theraplay therapist successfully interacting with their child. Parents may feel jealous of the relationship developing with the therapist; they could also feel put down or disempowered by the therapist's success. Parents will be especially troubled if their child typically presents a cheerful, friendly face to strangers but is distant and difficult at home. Parents of such a child have frequently heard, "She's so sweet. I don't understand why you find her so difficult." The implication is that it must be the parents' fault. You should be careful that the child's initial outgoing response to her Theraplay therapist is not interpreted by her parents as yet another confirmation that they are inadequate.

In order to prevent this from happening, it is important to explain the pattern at the very beginning. "Many children are cheerfully accepting when they first meet a new person. We know that it can be hard for you to watch your child be cooperative and charming when she is seldom that way at home. We also know that very soon we will face the same challenges you do. We spend these first few sessions with the child while you watch so that we can find the best way to help your child. This will give you a chance to see how we deal with the problems as they arise. You are the most important person in your child's life and we will bring you into sessions and start the work of changing your relationship as soon as we see that she is ready."

The role of the interpreting therapist is to help parents focus on what is going on in the session. If a parent finds it difficult to focus on the session because she has such a great need to talk about her own problems or the difficulties she faces at home, you should schedule more frequent sessions without the child in order to respond to her need for support and guidance. When you and the parents join the child in the session, the parents' time with you is cut in half. This makes it especially important that you have regular sessions with the parents in which you can provide support and guidance, answer questions, share observations, and discuss progress.

As you work with the parents in your role as interpreting therapist, you will continue the process of creating empathy for the child. The following is a list of the various steps in the process:

- Focusing the parents' observations on the Theraplay therapist's empathic approach to their child
- Guiding parents' observations toward more empathy for their child
- Helping parents understand behavior that takes place outside of sessions
- Helping parents manage difficult behavior
- Keeping parents' expectations in line with their child's needs

Focusing Observations on the Theraplay Therapist's Empathic Approach to Their Child

An important reason to have parents observe sessions is that they can see a model for an attuned, empathic approach to their child. When things go well, they see new possibilities for how they might interact with their child. When the Theraplay therapist faces the same difficult behaviors that they face at home, they are reassured that they are not alone in their struggle. As the child becomes more responsive, parents gain hope that they too can learn how to respond to their child's needs. Thus at the same time that we help the child to become more accepting of such interactions and to feel better about herself, we are demonstrating to the parents a more empathic and positive way of relating to their child.

As they watch the Theraplay therapist and notice the way the child is valued and respected, parents often begin to see their child as more appealing and more lovable. Seeing the Theraplay therapist's delight in their child often makes it possible for parents to recapture, or experience for the first time, the delight so typical of parents with a responsive baby. One mother, watching her teenage daughter in her first Theraplay session, poured out her disappointment and frustration. "I hate how she looks. She is so dirty and messy. I think she deliberately dresses like that to annoy me." The mother watched the therapist polish her daughter's fingernails, arrange her hair in interesting new styles, place a soap-bubble crown on her head, and engage her in lively thumb- and arm-wrestling contests. During the fourth session, the mother said thoughtfully, "What has happened? She is so beautiful. I never noticed that before."

A father watched a therapist count freckles, find and take care of hurts, and rub lotion on the hands and feet of his six-year-old son.

He suddenly said, "Oh, I see how much he needs this. I wish I had done it a lot more. I think I'll do it tonight before he goes to bed."

Another parent, noting the way her depressed daughter brightened up in the presence of her lively, energetic therapist, said, "Oh, she really responds when someone is more energetic. It's not my style, but I'm going to try to be more like that." Because many parents who seek Theraplay treatment for their child are stuck in ineffective and sometimes even destructive behavior patterns with their child, it is enormously useful for them to see a very different approach, with a more positive outcome.

Guiding Parents' Observations Toward More Empathy for Their Child

As they watch, parents have the opportunity, free of the stress and preoccupation of everyday living, to become more aware of their child's feelings and needs. Such empathic intuiting of their child's feelings is a common experience for new parents with a healthy baby, but this ability to connect has often been lost by the time a family comes for help. In many cases, unfortunately, it was never achieved, either because the child's signals were hard to read or because the parents were too preoccupied with their own needs to read them.

To increase parents' empathy for their child's experience and feelings, you might ask, "How do you think she's feeling right now?" or "Notice how he smiles and relaxes when his therapist does that." Some parents recognize that the child is enjoying an activity, but dismiss it as "just manipulating. He'll lap it up all right. He's happy when you're paying attention to him, but I can't be with him all the time." Some parents see the child as "selfish" or as perhaps not even deserving of all this special attention. "But remember," you can say, "does a little baby have to earn the special attention that makes him feel so good? We want to fill your child with good feelings that he can hold on to when he doesn't have you right with him." This would be an opportunity to explore with the parent what it is in her own experience that makes it hard to respond empathically to her child.

Another parent, when asked how she thought her child was feeling about having lotion rubbed on her hands said, perhaps confusing her own feelings with her child's, "She hates it. She can't stand to be touched or have lotion put on her." The therapist responded, "Yes

that is what she is saying with her words: 'That's for babies.' But look closely. Is she really resisting? Would she cuddle in like that if she were totally rejecting of the closeness? I wonder what that would be like for you? What do you remember about being taken care of when you were little?"

Parents who are uncomfortable with their child's younger needs or have very high expectations may ask, "Why are you babying him? He is seven years old. He needs to learn that he can't be a baby all the time." This is an opportunity to explore with these parents their own issues around growing up as well as helping them understand their child's needs. You can explain that every instance of babyish, resistant, or angry behavior on the part of their child offers an opportunity to respond to his underlying needs—for nurture, calm structure, or for nonpunitive acceptance of angry feelings. By using these opportunities they can begin to create the kinds of interactions that develop trust and lead to an awareness of the caring, soothing presence of adults. "She will learn that you are there for her and she can count on you."

As parents watch their child experiencing a new kind of relationship in the Theraplay session, you might ask, "How do you think it makes him feel about himself and his view of the world?" and comment, "We want him to feel special and well cared for" or "We want him to learn that he doesn't have to be in charge in order to get his needs met. The more he believes that, the more he will be able to relax."

With the parents of a foster child who was neglected and abused, you might speculate about how he views himself and the world, based on those early years of abandonment and neglect. "He could only believe that he was unworthy and unlovable, expecting adults to be unresponsive and neglectful. His insistence that everything be under his control is the only logical outcome (other than despair and giving up) of such a view of himself and of the world."

Parents need to understand that it is possible to change the child's view of herself and expectations of others, but that it will take many repetitions of the kinds of experiences that an infant has in a stable, responsive family in order to begin to feel secure, to trust, and to develop a strong, positive self-concept. As they watch the Theraplay therapist working with their child, they begin to see how to do this themselves.

Understanding Behavior That Takes Place Outside of Sessions

Parents often want help with how to handle a problem they have faced with their child during the week. The adoptive mother of a six-year-old girl complained that it is always a struggle getting her daughter ready to go to school. "Judy always creates a scene. Her clothes are too tight, her socks have lumps in them, and she can't bear to wear the gym shoes she has to have today. Nothing is right and nothing I do helps. It always ends with both of us angry. Then she goes off to school and both of us feel bad."

The interpreting therapist says, "Let's think about what might be going on with Judy at times like that. How do you think she is feeling about herself at that moment? How does she feel about leaving you? What do separations mean to her: abandonment, loneliness, pain? Her complaints keep you with her and delay the separation. And finally they create angry feelings that make it easier for her to leave you. Those angry feelings don't help in the long run, though, so we need to find a way to help her get off to school feeling better about herself and more connected to you." Together they make a plan for Judy's mother to dress her daughter in a playful, nurturing way that will help Judy feel more secure and enable her to go off to school happily.

Sometimes it is possible to give parents a more empathic understanding of their child's past behavior. For example, John's parents reported that when he first came to live with them, he would often stand silently next to something he wanted rather than ask for it. In an effort to help him become more "grown up," his parents had refused to respond to John's helpless silence and had insisted that he use words to let them know what he wanted. John had never experienced the empathic, attuned responsiveness that is so important in the early life of an infant. No one had been around to "read his mind." What he needed most from his new adoptive parents was that they be able to intuit his needs. This was a hard lesson for his achievement-oriented parents to keep in mind.

Later when John came home exhausted from a soccer game, he fell apart when they asked him to do his homework and his chores. His parents, forgetting for the moment their new understanding of his needs, scolded him for exploding into a temper tantrum rather than using his words to tell them how tired he was.

The conversation with their interpreting therapist went like this: "Think what a toddler would be able to do. He couldn't tell you. It would be up to you to figure it out, and if you weren't able to, he would have a tantrum." "But John is not a toddler, he's six years old!" "Yes, but when he's exhausted, he doesn't have the self-control that a six-year-old might have. At those moments he is like a toddler. And besides, this is a wonderful opportunity for you to do the kinds of empathic caretaking that will add one more brick to the structure of his new self-esteem and to his ability to trust that you really care and will take care of him."

Helping Parents Manage Difficult Behavior[6]

The advice you give to parents about how to handle their child's difficult behavior at home should be based on the Theraplay principles of having parents meet the child's needs for clear, safe structure, consistent follow-through, sensitive affect regulation, and empathic understanding of the meaning of the child's behavior. Many problems become easier to handle or disappear altogether when the child feels understood, calmed, nurtured, and valued.

Many parents who come for Theraplay treatment have already tried reducing or eliminating children's misbehaviors by giving them consequences such as taking away privileges or eliminating the use of a favorite toy. They have also tried supporting good behavior using sticker charts and other rewards. These methods often fail because the parent does not recognize the child's underlying negative belief about himself or does not understand the reason for the child's misbehavior. Behavioral approaches that depend on a child's wanting parental approval often do not work until a child's attachment issues are addressed.

Our approach supports the development of secure attachments. The first step is to provide a clear sense of safety. In order to do this, parents need to be firm about stopping hurtful or dangerous behavior. We coach parents to stop such behavior immediately, speak firmly in order to convey the seriousness of what happened and, depending on the child's age, talk about how the other person might have felt. In addition we help them approach their child with an open, accepting attitude. We recommend that they use the attitude that Hughes (2007) designates by the acronym, PACE, which stands for playfulness, acceptance, curiosity, and empathy. Being playful

can often diffuse a difficult moment; the core parental attitude of acceptance, curiosity, and empathy guides parents to "look under the behavior" at what might have prompted the child to behave in such a way. Thus, when a child behaves inappropriately, parents need to accept (though not approve of) the child's behavior, show curiosity (not disapproval) about why she behaved that way (that is, try to figure out what the child was feeling), and provide empathy for the child's motivations. Such an approach avoids triggering in the child an overwhelming sense of shame, which is emotionally destructive to the self and to relationships.

Instead of using time-outs, we suggest the use of time-ins (Weininger, 2002). As an alternative to sending an angry child to his room alone, parents sit close to the child and quietly verbalize what the child might be feeling. By sharing their own emotional control with an upset child, parents teach emotional self-control and problem-solving skills. The child learns that the parent is not afraid of her own emotions and that she knows how to handle them. This can be very comforting and reassuring for an angry, upset child. The child, in turn, also learns how to master his own emotions through this attuned, emotionally regulating experience.

The following is an example of a troubling episode that one parent discussed with her interpreting therapist. "On Tuesday Robert (five years old) was hurrying to get ready to go out to play with his friends, he discovered that his favorite sweat pants were in the wash. He just fell apart, crying and screaming. I showed him all the other choices he had, jeans, shorts, but it did no good. He just fussed even more. He can be so inflexible and irrational! Then I lost my patience and shouted at him, 'If you don't hurry up we'll all miss out on playtime.' At this point he was so angry that he threw a shoe at me. I really lost it then, 'You've ruined it for all of us and you're grounded from your TV for the rest of the day!' "

The interpreting therapist responded, "Let's see if we can understand what might have been going on with Robert. He was looking forward to wearing his favorite pants, the ones that have no zippers or seams so they don't itch or tickle him. He was in a hurry and excited about going out to play. Not finding his pants would have made him even more agitated. Then he couldn't listen to your sensible suggestions for other things he might wear. I can certainly understand how frustrating that must have been for you. Finally when you suggested

that he was to blame for spoiling everyone else's fun time, he just couldn't control himself and he threw his shoe at you.

"Let's see if we can figure out how to help Robert when he has such strong feelings. When he's agitated like that, he really can't focus on your good ideas for solutions to the problem. Maybe it would help if you let him know you understand how he feels. You might say, 'Gosh, I *know* how much you like those sweats. I'm sorry they're in the laundry.' He might suggest that he wear them dirty, but you can stand your ground even while you let him know that you understand how hard this is for him, 'I know you are disappointed, but they need to be washed before you wear them again.' At that point it might be possible to shift his focus and help calm him down by engaging him in some simple Theraplay activity such as playing a hand-clapping game. If he's too upset for that, you may need just to sit quietly near him and let him know that you understand how he feels. When he seems a bit calmer, you could offer him another pair of pants. If he kicks those away you can set them down next to him calmly and tell him that he can try them on when he feels better. To show that you understand his exasperation, you could say with an emotion that matches the intensity of his emotion, 'Oh my! Nothing's okay right now, is it? I wish you could wear those sweats, too, but I can't let you. They are just too dirty. I know this is hard and you don't like it one bit. But I still have to say no. You may think I'm just being a mean Mom, but sometimes Moms have to say no. I'm going to let you think about that for a little while.' Then you can back off a bit, but stay close enough to be a calm presence and to be able to check on how he's doing. If it is too late to go to the playground when he is finally settled down, you can say, 'I'm sorry Robbie, we can't go to the playground now because it's too close to dinner. Come help me make the salad.' "

For children who hit, bite, or throw, the emphasis should be on de-escalating the child in whatever way works best for him. Once he is calmer and feels better, he should be encouraged to make it up to the hurt party by doing something helpful for her. For example, if a boy threw a toy and hurt his sister, he could rub lotion on her arm. It is important to remember, however, that we cannot dictate feelings. The boy who threw the toy may still feel angry at his sister. It is crucial that parents not try to tell their child to smile, talk nicely, or even to say, "Sorry," when they can see the child is still having

strong negative feelings. Once the feelings have settled down, you can help the child do something that repairs the relationship and shows respect for the aggrieved child.

The approach of being aware of the child's developmental needs combined with an empathic tone can often circumvent behavior problems. Playfulness and distraction can also help, as can staying close while the child is struggling and inviting him back into connection with the parent or any victim (interactive repair) as soon as the child is ready. Finally, firm limits with empathy are definitely necessary even if the child becomes angrier. Consequences that are not connected to the "misbehavior" should be avoided.

Keeping Parents' Expectations in Line with the Child's Needs

Parents need to have realistic expectations that are congruent with their child's needs at each stage of development. For example, it became clear as we watched Hassan's father give his five-year-old son a physics lesson that he had very high intellectual expectations. Being unable to meet these expectations had contributed to Hassan's low self-esteem and his unwillingness to talk in school. Treatment focused first on helping his father understand why it was so important to him for his son to achieve at a high level. Once he could separate his own needs from those of his son, he could begin to match his expectations to Hassan's very appropriate five-year-old interests and capacity for understanding.

Some parents seem reluctant to let their child grow up and therefore give their child little opportunity for practicing new skills or exploring the world. They cling to the child, and often give the message that separations are dangerous. As we watched four-year-old Tommy and his mother negotiate the Leave the Room task during their MIM we could see how hard it was for the mother to leave him. Turning to Tommy with an anxious look on her face, she said, "The card says I have to leave the room for one minute. Will you be okay? You won't be frightened? I'll be right outside the door and I'll come right back." Tommy, his face mirroring his mother's anxious look, began to whimper and cling to her. "Don't go. Don't go. I'm scared." After a brief moment in which she tried to cajole him into staying, "It's just for a minute. You'll be all right," she sighed and said, "All right, I'll stay here." With Tommy's mother, we

explored what it was that made it so hard for her to separate from her child. Once she understood her own feelings, she was able to help Tommy become more comfortable with separations and to support his age-appropriate exploration and independence.

When a child is developing normally and the parents are not preoccupied with their own emotional agenda, it is relatively easy for parents to keep their expectations at an appropriate level. At times, however, an intrusion into a healthy family relationship can shake the child's self-confidence and reduce his ability to meet the usual expectations. This could be the birth of a new baby, a special challenge at school, or the death of a grandparent. Suddenly the bright, competent child may become anxious, whiny, and unhappy. For example, for his first six years, Jonathan was very comfortable in the highly verbal, intellectual atmosphere of his family. Their philosophical approach from the beginning was to encourage him to think for himself, speak up about his needs, and explore independently. At the same time they had clearly established that he could come to them for comfort and support when needed. Their approach had worked very well to produce a happy, self-confident boy. However, following the birth of a new baby, which coincided with increasing demands at school, his behavior deteriorated. It took only a few sessions for the parents to understand that they needed to lower their expectations for achievement and independence (challenge) and increase their understanding and acceptance of his need for comfort, cuddling, and relaxation (nurture).

LEADING PARENTS TOWARD COMPETENCE IN THE THERAPLAY APPROACH

Although empathy and understanding are essential to successful parenting and are the focus in our discussions with the parents, we do not depend on discussion alone to effect change. Parents also need practice in order to implement their new insights. This is the aspect of Theraplay that distinguishes it from most other attachment-based treatments.

We prepare parents to carry on the new approach at home by taking them through the following steps:

- Focusing parents' observations on the adult caregiver role
- Guiding practice during sessions

- Giving homework
- Role playing the parent role
- Having parents take charge of sessions

Focusing Parents' Observations on the Adult Caregiver Role

As you guide parents to a more empathic understanding of their child's behavior, you will also help them understand the Theraplay therapist's role. Learning from observing the therapist as he interacts with their child is the first step in preparing parents to take the lead in sessions and, ultimately, to take the lead in renewing their relationship with their child. You can point out the fine points of the Theraplay therapist's responses to the child, explain the importance of certain activities or interactions, and advise the parents about how they can transfer what they see to what they do with their child at home.

POINTING OUT HOW THE THERAPIST ORGANIZES THE INTERACTION. The following is an example from the very beginning of three-year-old Tracy's Theraplay sessions. Her parents had wanted help to handle Tracy's constant efforts to take charge of every interaction and her desperate meltdowns when things didn't go her way. Because it was so typical, her parents were not surprised that she tried to take charge of the very first Theraplay session. When the therapist, Roger, began a hand-clapping game, Tracy suggested another clapping pattern. When he made a lotion handprint, she wanted to do her other hand first. They were very interested to see how Roger might handle this and still remain in charge. Instead of entering into a discussion about the relative merits of each method, he simply said, "You have good ideas, but we will do this first." When Tracy began to pout and complain, he said, "I know it's not easy to let me decide, but I've got some games that I know you will like." Recognizing that her need to feel secure in the new situation, Roger showed her the list of activities he had planned and then he moved ahead with confidence. The parents needed help to understand the therapist's approach, which was so different from their own pattern of extended arguments followed by angry withdrawal. "Watch how Roger stays with her and continues to try to engage her," the interpreting therapist said. When

Tracy suddenly stopped her angry protest and began to enjoy herself, the interpreting therapist pointed out, "She has finally realized that she can have fun without having to be in charge of it."

POINTING OUT HOW THE THERAPIST REGULATES THE INTERACTION. We return now to an example from Sam's first Theraplay session. He is the four-and-a-half-year-old boy whose MIM feedback we have discussed earlier. Regulation was a very important issue for Sam, so his therapist, Margaret, planned the first session carefully to help him feel secure and to keep him calm. Because he found it difficult to handle separation, his father and the interpreting therapist sat to one side in the room where the session occurred. Margaret played a game of Row, Row, Row Your Boat, alternating fast and slow as she made sure that Sam was able to handle the excitement. Later when he became too excited during a game of blowing bubbles, he slipped away. Margaret calmly followed him to the corner of the room and sat beside him stroking his back until he was settled. Then she quietly suggested that he get all soft and floppy so that his body was very relaxed. At that point she invited his father to come and see if Sam could wiggle just one part of his body while remaining soft in all the other parts. This intrigued Sam and he was able to wiggle his tongue and his tummy with only a little movement in his fingers and toes.

Later, as they watched a video of the session, the interpreting therapist pointed out the many things Sam's therapist had done to keep Sam calm while still making the activities fun and interesting. "See how she plans the activities so that they are fun for him, while she watches carefully how excited he is. That's what he needs you to do."

HANDLING PARENTS' RESISTANCE. Even after careful preparation, parents may still be uncertain about, or be outright resistant to, accepting an approach that is so different from what they experienced as a child or what they have been taught about parenting. The following is a sample of the many questions that parents may have as they watch the Theraplay sessions with suggestions for how to respond.

- "*How can playing help?*" This question requires a careful explanation of the basic assumptions of Theraplay: that playfulness, empathy, and responsiveness are important to their child's self-esteem and security. You must also help the parents understand the subtleties underlying the playfulness. "We plan

very carefully so that the play helps the child learn how to self-regulate, how to engage in active give-and-take with another person, and how to feel really good about herself. She learns that it feels good to know that grown-ups can take the lead and make her feel safe."

- *"Aren't you rewarding bad behavior when you turn his effort to kick you into a game? Shouldn't you give him a consequence for refusing to do what you want him to do? I believe that if you let a child get away with something like that, he will just keep doing it. He needs to be punished."* You can point out that the therapist set very clear limits and did not let him kick her. She stopped the hurtful behavior, but instead of making him feel ashamed, she surprised him by turning the action into something that made him feel good about himself. Another response might be to ask the parents whether consequences and punishments have worked. Most likely they are not working well or the parents would not be asking for help. Then you should explain that Theraplay has a very different way of thinking about misbehavior. "We are trying to build a closer relationship with your child. Punishments create distance. When the child feels better about himself and about his relationship with you, he won't need to have those behaviors.
- *"Why don't you let him choose what he wants to play?" "Why aren't you answering his questions? Isn't it disrespectful to ignore what he says?"* You can explain why it is important that the child feel he is in the presence of someone who is able to organize the interaction, help him feel calm, and keep him safe. We always answer appropriate questions, but when the child keeps asking questions, it is a sign of anxiety, and we want to respond to the anxiety rather than to the question. We want him to be able to relax and enjoy the interaction without the burden of having to take charge.
- *Some parents watching the Theraplay therapist will say, "I can't do that. I don't know how to play."* You will need to explore the parent's feelings about play and express your sadness that she has missed out on something so very important. You can reassure her that you will be right there guiding her efforts. Giving her an opportunity to experience Theraplay for herself will be also very helpful.

- *Occasionally a parent is so discouraged or so angry and hurt by her child's rejection that she says, "I just can't go into that room and pretend that I'm feeling okay."* You can say, "I'm glad you told me that. You are right. It's not good to pretend that you are just fine when you're not. Today you can just watch. Then let's get together to talk about how things are going and what we can do to make things better for you."

Guiding Practice During Sessions

After observing four or five sessions, parents enter the Theraplay room and join in the fun under your guidance. This step requires careful preparation.

PREPARING FOR JOINING THE SESSION. Parents must understand that their entrance into the sessions may stimulate some resistance or a return to earlier patterns on the part of their child. If parents are not prepared ahead of time, they may think that they have done something wrong or be reinforced in their fears that their child doesn't like them. If they know that such responses are very common, they are able to understand and accept them better.

To help the child with his parents' entry into a session, whether it is the very first time or in any of the following sessions, you should plan activities that turn their entry into a game. For example, as we saw with Adam in Chapter Four, the therapist and child may hide under pillows or a blanket and call to the parents to find them. Be sure to hide with the child, so that you can help contain his excitement as he waits to be found. Cuddled together under the blanket, the two of you can call to the parents to "come and find us."

In preparation for this step, you should coach the parents to talk about the wonderful girl they are hoping to find and to respond with joy when they find her. If the child is young and restless, tell them, "Don't take too long finding her. She really can't wait." Once the child has been found, make sure that at least one parent and the child make a strong connection so that they can contain the excitement of the surprise greeting. The parent can give the child a hug and hold her hand until she is settled for the next activity. With good preparation, the reunion between child and parents goes smoothly and leads easily to the activities that follow.

In addition to preparing parents for their entry into the session, you should also coach them on how to handle the activities you have planned. This kind of preparation should take place in a separate planning session with the parents and can include role playing the activities so that they are very clear what their role is. For example, you can say, "When we play 'Mother, May I,' you take charge, Mom, and make sure that you help Melissa do the actions just the way you ask her to. Dad, you and I will be part of the team with Melissa. Sometimes I'm going to pretend to do it wrong and, Mom, I want you to make me do it just right too. I want her to see that a person can make a mistake and it isn't the end of the world."

GUIDING THE ACTION. Once the parents are in the room, the Theraplay therapist takes the lead in giving clear directions to them about their role in each of the activities you have planned: "Mom, you sit here, and Dad, you sit on Juan's other side. We're going to help him get all soft and floppy. Mom, lift his arm and wiggle it a bit to see whether it's relaxed. Good. Dad, how about his other hand? Now that he's all soft and floppy, Dad, you tell him to wiggle just one part of his body—maybe his tummy." Parents benefit from the presence of a confident, supportive therapist who can guide them as they try out the new approach.

Occasionally a parent is too rough in his play with his child. You can say, "That was a bit hard. Let's try it very gently. We don't want any hurts here." If a parent continues to be rough with his child, you should meet with him in a separate session in order to discuss the issues underlying his rough approach and to practice the activities in a safe and gentle way.

A parent who speaks negatively about his child or reprimands him for what he considers bad behavior during the session needs your help to gain a better understanding of the Theraplay approach. You should meet with him before the next session and remind him that it works best if he lets you take charge of the session. Make sure that you explore his feelings about the way you are handling the child's behavior. Also make sure that he understands and accepts the basic philosophy of Theraplay. Remind him of your agreement that he can signal you if he is uncomfortable about what is going on in the session and that you will signal him if he forgets and does something that you think is not helpful to his child.

FOCUSING ON PARENT'S NEEDS. By the time you bring the parents into the room, you will have a good idea what dimension of interaction is hardest for the parents to manage. Depending on their particular unresolved issues—as you now understand them—you should plan sessions to give parents an opportunity to practice the skills they need and to become more comfortable with the interaction.

Structure. If a mother is unable to assert her authority with her child, plan activities that give her practice leading the interaction. For example, the mother of a fourteen-year-old adopted girl is asked to lead her daughter in a mirroring activity. This sets up a situation in which the mother must lead the action and provide clear directions with few words. The girl is to follow every movement her mother makes. In order to make the game more intriguing, the girl balances on a stack of pillows as she concentrates on her mother's movements. The mother had the experience of taking charge of a pleasurable moment of joint attention and focus that brought them closer together.

Engagement. As you will remember, Sam's father took very little initiative in organizing the interaction and used many questions to engage his son. Sam seemed happy to enter into rough-and-tumble games with his father, but the resulting interaction was often chaotic and unfocused. In Theraplay sessions, Margaret helped the father initiate more direct efforts to engage Sam in games that allowed more clear give-and-take and calm interaction. She showed the father how to initiate a Stack of Hands game and she coached him to go slower or faster in order to make it more fun and to provide some experience of regulation. When Sam began to get too excited, she showed Dad how to help him slow down by holding each hand gently and signaling with his fingers when it was time for him to move it.

Nurture. If a Mother has been unable to respond to her son's need for comfort and protection, you can have her take care of every tiny hurt she can find on the boy's arms and legs. You can also help parents become more aware of keeping their child safe by taking precautions to prevent accidents. For example, "Mom, that time he jumped too fast. He could bump himself. Help him do it again carefully, so he'll be really safe this time."

Challenge. If a father is uneasy about his son's passive resistance, you can engage the two of them in a tug-of-war, with father and son on one side and you on the other. They must work together with energy to pull you to their side.

Giving Homework[7]

As powerful as the sessions themselves can be for making a child feel good about herself and for setting the relationship on a better footing, it is essential that the parents carry on the same approach at home. The father who said at the very first session that he would try some of the nurturing activities that night with his son was clearly ready. Other parents may need to wait until they feel more confident or their child is better prepared to respond. But all parents need to put the ideas into practice on their own at some time. As soon as you see that parents are comfortable interacting with their child in the new, more empathic and structured way, you can ask them to try some of the activities that you think will be successful at home. Your suggestions for homework must take into account the family lifestyle and schedules.

For some parents, homework may have to be as basic as asking them to get up in the morning in order to make breakfast, rather than sleeping in. Getting this kind of structure in place is necessary before suggesting specific games and activities. If there is a question whether the child will respond to the parent's initiative, suggest activities that do not require an active response on the part of the child. They can be typical parenting activities, such as having the child sit on the father's lap while he reads a story, or bathing the child and wrapping him in a big comforting towel and gently massaging him.

Some parents find that a regularly scheduled time for Theraplay works best. Others find it easier to incorporate Theraplay activities and attitudes into all of their daily routines rather than schedule a regular time. The wake-up call can be turned into a wonderful five-minute checkup session (pretending the child is a lump in the bed that needs to be gently smoothed out; or waking up sleepy fingers and toes with loving kisses). The bedtime routine can be enhanced by ten minutes of quiet feeding, rocking, and singing.

Many parents feel so overwhelmed by how much time it takes to get their child through the daily routines that they wonder how they could possibly spend another fifteen minutes each day playing with their child. You can suggest that they make a game out of bed

making or putting toys away that turns these simple routines into shared, joyful experiences rather than chores. "You'll be surprised at how much time you will save."

When making a homework assignment, it is important that you help parents plan carefully so that the experience goes well. You might ask, "When is the best time to schedule such activities? Can you arrange it while your other children are at school or taking a nap or busy with something else? Where will you do it? What activities would you like to try first?" At the next session, ask how the homework went. If there were problems, you can help the parents modify their approach so that it will work better next time. If parents come in week after week without having made use of Theraplay activities at home, you need to explore what it is that is making it so hard for them.

Prepare parents for the fact that children are not always as responsive at home as they are with their Theraplay therapist. To make sure that the activities can be done without undue resistance or out-of-control excitement, you can practice their chosen activities in the session to make sure that the child is comfortable and that the parent can manage them well.

The following is a list of good homework activities (See Appendix B for descriptions of the activities):

- Playing Beep and Honk
- Making a Special Handshake
- Singing the "Twinkle" song
- Counting Fingers and Toes
- Blanket Swing (both parents are required for this activity)
- Playing Slippery, Slippery, Slip
- Doing a Weather Report on the child's back
- Playing Cotton Ball Hockey
- Finding the child under a blanket
- Measuring body parts with Fruit by the Foot and feeding the pieces to the child

More important than the activity is the parent's attitude of active engagement: acknowledging feelings; responding to needs; being accepting, positive, and playful. Parents of children with histories of

trauma and loss will need special help to create a secure, regulated, yet playful atmosphere at home. They must learn to recognize both the signs of escalating excitement and the behaviors that are evidence of distress. They must be prepared to introduce a calming ritual that the child will accept when he begins to escalate. As part of your preparation for making the homework experience successful, you can help the family create a list of comforting rituals that are genuinely soothing to their child (see Gray, 2002, p. 261). Once you have made this list you can practice the activities in sessions with the child.

Playing the Parent Role

In preparation for parents to take a more active role in sessions, you and your co-therapist should meet with them (without the child) to plan and role-play the activities that will take place during the next session. During the role play, one parent can play out the anticipated response of the child while the other parent practices taking the lead. If there is only one parent, you can take the role of the child. Parents must learn, for example, how to move slowly and calmly for the easily excited child, or how to move confidently from one activity to another for the child who has trouble with transitions. Though not all parents need to practice ahead of time, it is a powerful tool that we strongly recommend. Parents who have not experienced good parenting themselves find it especially helpful. Toward the end of treatment, such role playing can be geared to the parents' taking full charge of the upcoming session with the child.

THERAPLAY IN PRACTICE

Practicing the Parent Role

The following is an account of a role-playing session with a single mother, Carmen, who had just regained custody of her three-year-old daughter. During the year and a half since she was removed from her care because of domestic violence, her little girl, Selena, had been in several foster homes and was finding it difficult to settle down with her mother. Child Protective Services (CPS) referred her for a series of eight

sessions with the goal of fostering the relationship between the two and helping Carmen understand and respond appropriately to Selena's needs.

The MIM revealed that while Carmen obviously cared about her daughter, her way of showing it was through teaching. For example, instead of using the feeding task ("Feed each other") as a way of getting close, she asked Selena to name the colors of the candy pieces and to count them. When asked why teaching was so important to her, she said, "Selena needs to know a lot if she is going to get along in the world. She's already had to be in so many foster homes." We felt that she and Selena would benefit from the opportunity to shift the focus of their interactions to more attuned and nurturing activities.

Carmen was initially a bit resistant to the idea that she needed more help to relate to your daughter. "I know how to take care of her. I took care of her all the time when she was a baby. I raised all my brothers and sisters. I don't need this." But as she watched the Theraplay therapist taking good care of Selena and having fun with her, she became excited. "I could do that. My mother never played with us kids like that, but I can see that Selena really likes it." Carmen then entered into the sessions and very quickly learned the new approach.

In preparation for Carmen to take charge of the final session, we scheduled a planning and role-playing session. Although she had interacted with her child under the guidance of the Theraplay therapist for several sessions, she needed practice to be able to take charge and move smoothly from one activity to another. Carmen chose activities for her role-playing session that she had enjoyed doing with Selena during earlier sessions: Newspaper Punch, Lotion Handprints, Row, Row, Row Your Boat, Feeding, and singing the "Twinkle" song.

The interpreting therapist played the role of Selena while Carmen took the parent role. Though Carmen had a clear idea of what she wanted to do, she needed help to keep focused on her child and to move quickly enough to stay in charge. As she practiced how she would check out her daughter's strong muscles before having her punch the newspaper, her eyes

wandered to the other side of the room. The interpreting therapist said, "Could you look at her when you do that? You have such lovely warm eyes, if you look right at Selena, she will see how much you love her." When she moved slowly to introduce the next activity, the interpreting therapist, playing Selena, slipped away. Carmen said, "Oh, I see that I have to move faster or I'll lose her." And thus the practice session went on, smoothing out the rough edges of her approach, preparing her to be responsive and to take charge when face-to-face with her little girl.

Having Parents Take Charge of Sessions

The final step in helping parents feel comfortable in using the Theraplay approach with their children comes when they take charge of a session on their own. This is the culmination of all the experience parents have had as they participated in earlier sessions. When the session is over, you can show the videotape to the parents so that they can evaluate their own performance. They are often very pleased with what they see.

Following the preparatory role playing, Carmen took charge of the final session with Selena, while the Theraplay and interpreting therapists sat to one side as a cheering section. At the end of our eight sessions, Carmen was much better prepared to parent her child, but would still need a great deal of support. We recommended that her CPS worker continue to monitor the family closely, that the current very good foster mother continue to provide child care while Carmen worked, and that Selena and her daughter come in for monthly check-ups for three months and then once every three months for a year.

MEETING PARENTS' UNMET NEEDS

As we have made abundantly clear, an essential part of Theraplay treatment involves meeting the parents' needs and making them feel well supported and well understood. Just as the Theraplay therapist makes a child feel good about himself by being appreciative and empathically responsive, so the interpreting therapist responds to the parents.

Providing Support

All parents need support, understanding, and empathy for the problems they face in raising their children. Parents of children with attachment problems or with constitutionally based developmental problems such as autism, however, need stronger and more consistent support because their children give so little back in response to their parents' efforts. Before parents can attend to the needs of their children, they need to feel supported, to have early unmet needs acknowledged and responded to, and to feel good about themselves. Many parents have not been parented in a positive, empathic manner themselves. It is, therefore, essential to meet their needs. Although empathy and acceptance can go a long way toward relieving an overburdened parent, parents often need more than that. When this is the case, you should help them find appropriate supports in the community. For example, parents of a child with autism may need information about parent support groups and respite care. Parents of adopted children may welcome the opportunity to share their experiences and problems with others through adoptive parent organizations. You need to know what your community resources are and guide parents to them.

Using Group Theraplay to Meet Parent's Needs

Another way of meeting parents' needs for good parenting is through Theraplay Parent Groups. In Chapter Twelve we describe Group Theraplay and give examples of including parents in groups with their children.

THERAPLAY IN PRACTICE

Group Theraplay for Parents

Group Theraplay was offered as one component in a program for public housing residents geared toward improving parenting skills, providing knowledge of child development, and increasing the range of choices available to parents for interacting with their children (Leslie and Mignon, 1995). The plan was to have a total of twelve sessions: the first ten were to be for "Moms only," the last two would include one or more

children of each mother. Three facilitators led the sessions. The goal was to increase participants' ability to accept and practice healthy self-nourishing behaviors and to have a better idea of how good nurturing feels. Each session began with Checkups and ended with sharing a treat; in between were a series of playful active and quiet games.

To reduce any resistance that might occur, the first session was planned to be fast and fun. Activities such as Paper-Patty-Cake (the challenge is to keep a piece of paper between your hands as you clap), Peanut Butter and Jelly, Stack of Hands, "Miss Mary Mack," and Pop the Bubble were not only challenging, but provided the type of silly fun that these mothers had never felt was permissible. Feeding a partner a Popsicle or giving her five licks from a Tootsie Pop allowed group members to be nurtured in a fun, nonthreatening manner. These women were so uncomfortable touching each other that they could not do so unless it was required as part of a game. Passing a lotion squeeze and having your neighbor guess where you touched her with a feather were acceptable. Massaging shoulders all around the circle was more difficult. In addition, the women tended to do the group activities very quickly and did not request a repeat, regardless of their evident enjoyment. The group members were given a voice in how games were played: thumbs-up for games to be repeated, thumbs-down for duds. The childish Theraplay good-bye song was rejected outright and replaced with a rap song created by one of the participants.

Although the plan had been to include children during the last two sessions, when the time came to decide about including their children, the mothers resoundingly voted "No!" The experience filled such an important need that they were not ready to share it even with their children. They needed to have something just for themselves.

Dealing with Parents' Individual Issues and Marital Conflicts

Sometimes parents need help in resolving their own individual issues or marital conflicts, including conflicts over parenting styles that

interfere with the successful parenting of their children. If these are minor conflicts, you may be able to help resolve them during your individual parent sessions. But sometimes parents' issues and conflicts are so serious that they need to be addressed more intensely than is possible in conjunction with the Theraplay sessions. In this case, you should refer them for individual or marital work separate from the Theraplay sessions. Such work can take place concurrently with the Theraplay sessions. Occasionally it has been necessary to stop Theraplay treatment until parents have resolved these other issues.

WORKING WITH VULNERABLE, HIGH-RISK PARENTS[8]

The approaches suggested in this chapter have assumed a level of mental health, cooperation, and openness that you will not always find in parents. Some parents, although they have brought their child for treatment, are quite unprepared to participate effectively in it. Such parents will need longer preparation before they can embark on joint treatment with their child. In this section, we discuss some of the reasons that parents might find it difficult to participate, the ways these difficulties manifest themselves, and how to prepare them for Theraplay.

Understanding the Parents' Difficulties

Parents may be unprepared for Theraplay because of lack of motivation, lack of insight, or their own personal issues. If a child's teacher or the school social worker has suggested that they get help for their child, the parent may not wholly agree and therefore come reluctantly. Parents who have been unable to keep their child safe may have been mandated by Child Protective Services to get treatment either to help them keep the child safe at home or to prepare for having the child returned to them. These parents are likely to resent coming to treatment. Other parents may recognize that their child has a problem but they expect you to fix it. If you suggest that the parents should also be involved in treatment, they are uncomfortable because they think this implies that you blame them for the problem. Some parents, while less defensive than this, may have very little insight into either their child's or their own issues. Adoptive parents who have successfully raised their own biological children may find

it difficult to understand why personal issues of their own might be stirred up in the face of challenging behavior from an adopted child who has suffered early relational trauma. If parents have themselves been poorly parented, they may have many issues they need to work through before they can achieve the kind of security that is required for good parenting. And finally, personality disorders in a parent may lead them to become dysregulated and angry under stress, thereby making the treatment difficult.

Understanding What Lies Behind the Parent's Reluctance

In order to help ill-prepared or reluctant parents, you must understand as much as possible about what lies behind their reluctance or outright resistance. The following is a sample of the kinds of issues that may lie behind the parent's rejection of what you have to offer:

- They live in a culture that sees therapy as a sign of weakness or as something that is only for "crazy people."
- They grew up in a harsh, unresponsive environment and therefore have no emotional energy for play or for nurturing. When presented with the Theraplay model of playful, responsive, nurturing care, they find it hard to accept. "I don't want to play with my child. He needs to be prepared for the real world."
- They identify with and therefore defend their own parents' harsh parenting. They may say, "That's the way my parents did it and I turned out okay" or "I needed to learn that lesson to survive."
- They are uncomfortable with the idea of responding in an accepting, empathic manner to their child's needs because they fear such a response would undermine their authority. They want their child to know that they "mean business. If I play with my child he never wants to stop."
- Having never experienced empathy themselves, they lack empathy and are often unaware of their child's needs. They may concentrate on meeting their own needs while remaining unaware of the child's needs or projecting their own wants and needs onto the child. They are surprised when the child acts out as a result.

- They have their own history of neglect and trauma. In order to protect themselves they have built up emotional armor against hurt. This is often manifested by anger and toughness. They have great difficulty trusting others.

These underlying parental issues may manifest themselves in a variety of ways. The parent may fear the child and his emotional responses. The parent may be resentful or angry at the child. Or the parent may be jealous of the child, or in competition with her. While trying to make things better for their child, they may begin to feel that the child is ungrateful. "How can my child behave this way? He has it so much better than I did."

Preparing Vulnerable Parents for Theraplay

If treatment is to be successful with a vulnerable parent, you must recognize that there is a hurt child inside, a child who is unprepared to respond to her own child's needs. You must find ways to meet the vulnerable parent's basic needs: to feel safe, to feel accepted, and to feel understood. The following are guidelines for this work.

- Establishing a trusting relationship with vulnerable parents may be a challenge, but it is essential to the work you hope to do with them and their child. The key is to understand and respond empathically to their own anxieties and needs.
- You must accept and acknowledge their distrust of you. "I understand that you do not think you need to be here. It must be very upsetting that after all your efforts to prepare yourself for bringing your child back home, people still think you need help. I'm asking you to be part of your child's treatment because you are the most important person in her life and you know her best. I need your help."
- You must learn about and accept the parent's definition of the problem. Let them know that you understand that they want the best for their child.
- Go more slowly in exploring their history. Avoid being confrontational or judgmental when exploring their parenting behaviors and beliefs.

- Gradually get to know their own trauma history. Have them talk about their lives. "What was it like as a child? What would happen when you felt bad? What were the important things your parents wanted you to learn? How did they teach it to you?" Express empathy for their experience.
- Don't take their bluster personally. They may seem to be pushing you away, but they are only protecting their fragile self-esteem.
- When all else fails and you cannot reconcile your two points of view, let parents know that you appreciate how strong their feelings are about the issue. "I have strong feelings too. Maybe we can't work this out but let's see if we can. Maybe I can learn something from you and you can learn something from me."
- With parents who stress the seriousness of life or who value obedience and control, you should emphasize structure more than playfulness at first. It will not work well to use the lighthearted, humorous approach that is so useful for breaking the ice with many families.
- Set lower goals. Even small changes can have an important effect on the child.

Deciding When to Begin Theraplay Sessions

At some point you will be ready to bring the parents and child together for Theraplay sessions. Your decision to do so depends on your judgment that the parents are able to remain calm, to be consistent, and to use the Theraplay approach safely at home.

PREPARING FOR REUNIFICATION. Theraplay-guided visitations have proven helpful in supporting parents' attempts to meet the requirements for reunification. Rather than leaving parents on their own to reconnect with their child after long absences, you can use Theraplay activities to guide parent visits. This is an opportunity to create meaningful interactions and has the additional value of increasing parents' understanding and appreciation of their child's needs. There is also the possibility that the sessions will meet some of the parent's own needs as well. See Chapter Ten for an example of using Theraplay during supervised visits between a biological mother who is working toward reunification with her children.

If you are deciding whether to use Theraplay with a family that is in the process of reunification, you must consider the risk of disappointment to the child if the parent is unable, in the long run, to improve enough to regain custody. If the parent is to have unsupervised visits, you must also be sure that the parent is stable enough to make use of the Theraplay activities at home in a safe and appropriate manner. It is important, therefore, to do a good assessment of the parents' potential to reflect on and change their behaviors before bringing parents together with their child in Theraplay treatment. The MIM can be an important part of this assessment.

Working with Families Where Domestic Violence Has Occurred[9]

If you are working with families whose children have been removed from the home because of domestic violence or physical abuse, a great deal of preparation is necessary before you bring the parents and child together using Theraplay. In order to gain parental cooperation during this process, you can emphasize that doing this preliminary work will help them feel calmer and more confident and will help them be better able to create a safe environment for play and for connection with their child.

The first step is to assess the extent and degree of violence and the interpersonal skills that each parent needs to work on. Typically these are skills for managing anger, managing stress, and resolving conflicts (communication and problem-solving skills). In order to maintain a level of safety throughout the Theraplay treatment, parents must be able to manage their own emotions and remain calm before they can handle their child's behavior. If the violence has occurred between the spouses, the abused parent has to become strong enough to reassure the child that she will no longer tolerate violence and can protect the child.

After assessing the needs you must help the parents develop the necessary skills. Depending on the situation these skills can be learned in a group or individual setting. Couple or family sessions are not effective for this part of the work.

Parents also need basic parent training, particularly around the issue of the impact of violence and abuse on children and how they themselves have been affected by violence. In order to do this, it is

helpful to teach them about the three basic needs and three basic fears that all children have, including themselves as children.

The three basic needs are

- To feel safe
- To feel accepted
- To learn to calm oneself

The three basic fears are

- Of being abandoned
- Of being overpowered or overwhelmed
- Of failing

If these needs have been unmet in childhood or are not addressed in treatment, they will continue to affect them as adults and to interfere with their ability to respond to their children.

This training sets a foundation for the parent to understand themselves better and to have empathy for their child. Parents are more motivated to do the work of Theraplay when they begin to understand that they are still affected by unresolved childhood needs and fears and that there are things they can do to help themselves and their children feel and do better.

The following is an example of the use of Theraplay with a vulnerable young mother and her infant in a residential treatment center for substance abusing mothers.

THERAPLAY IN PRACTICE

Theraplay with a Substance-Abusing Mother and Her Four-Month-Old Infant[10]

Helen and her mother, thirty-two-year-old Emma, had been living in a residential care setting for substance abusing mothers and their infants from late pregnancy on. There are five families in the setting, all of them placed there through Child Protective Services. Typically families remain in care

throughout the first year after the child is born. The focus is on strengthening the mothers' ability to take care of their babies (being able to provide the basic nurture), interacting with the babies (attending to the developmental and psychological needs) as well as handling their addiction (treating the substance abuse). Theraplay intervention began when Helen was four months old and the aim was to improve the overall emotional connection between Helen and her mother, Emma.

Emma is a very typical mother in this setting. She has been using opioid drugs for a number of years. She has a college education and has been working part-time. She suffered violence in her relationship with Emma's father. Helen is her first baby. In the beginning of her pregnancy Emma sought help and started buprenorphine-replacement therapy which continued after birth. When Helen was born, she suffered from neonatal abstinence syndrome and required morphine medication.

During the first months the caretakers in the residential setting described the relationships between Emma and Helen as very passive. Emma took good basic care of Helen, who was a sweet, smiling, but motorically tense baby. However, there was little social exchange between them: Emma's eyes seemed empty when she looked at Helen, she didn't smile or talk to Helen. She often placed Helen on the floor and started to read or do other things. When asked to pick Helen up, she placed Helen facing away from her in her lap.

The Infant MIM Observation

Emma read the instructions out loud to Helen in a very quiet voice. She placed Helen on a pillow before her without looking at her. The interaction was empty; Emma looked and sounded very sad. When asked to tell the child about the time when she was a newborn, Emma froze for quite a while and said nothing. For most of the time Helen was rather stiff and often turned her head away when her mother approached.

Based on the initial interviews and self-reports of her own attachment experiences, Emma's inner world seemed barren. She had very few images available. She couldn't describe Helen

or herself in relation to Helen very well. She said that she thinks Helen is a sweet baby, but she couldn't give any personalized memory of Helen as a newborn.

The goals of Theraplay treatment were to give Helen a basic sense of connectedness and shared joy with her mother, both of which seemed almost totally lacking, and to help Emma become more open and responsive to her baby.

Session 1: "Placing Helen in a Lap"

The Theraplay therapist put her arm around Emma's shoulders, while Emma carried her baby; together they entered the Theraplay room singing a song. The therapist helped Emma sit in a large beanbag chair where she could hold Helen on her lap. Helen reacted with an open smile to the therapist's welcoming song. In contrast, Emma smiled vaguely. She seemed unable to keep Helen sitting safely and comfortably in her lap. In order to put lotion on Emma's hands, the therapist took the baby onto her own lap. When she tried to put the baby back into Emma's lap, Helen resisted and arched her back. So the therapist kept Helen in her lap, but this seemed to lead to the mother's leaning back and drifting away. In the end, Helen wasn't sitting comfortably in anyone's lap.

Sessions Two to Five: "Helen Gets Involved"

The therapist helped Emma find a comfortable way to hold Helen. As she began to relax a bit, Emma started to sing along with the greeting song, and—most important—Helen started to relax and lean toward her mother. The therapist played a peek-a-boo game in which she covered Emma and Helen together with a chiffon scarf and then lifted the scarf to find them. Next she turned Helen slightly in her mother's lap so that she could see her mother's face and had the mother lift the scarf and peek out at Helen. Helen was intrigued and for the first time seemed eager to look into her mother's eyes.

Discussions with Mother: "You Have a Nice Smile"

Because Emma had so little capacity to reflect on her baby's or her own experience, time was set aside to talk with her after

every third session. In the beginning Emma was very tense. A key moment occurred while, for the first time, she watched a videotape of herself with her baby in a Theraplay session. Helen was lying on a pillow near her mother, babbling to herself. Emma had, as usual, placed her there without much checking or orienting. The therapist paused a frame from the second session and said: "Look, you have such a nice smile when you look at Helen here. I think that Helen really feels your warmth and enjoys it!" Emma looked very surprised and said, "Do I? Really?" Her face was animated, she colored a bit, and after a moment, she spontaneously changed Helen's position so that she could see her face better and she smiled at her.

Sessions Five to Eight: "I Am Here"

Helen was eagerly anticipating the session. She looked keenly into the therapist's eyes. When the therapist sang, she responded with lively vocalizing. She responded happily when the therapist counted her toes and fingers and played peek-a-boo with a scarf. Her whole body relaxed as the therapist "danced" with her: playfully moving her arms up and down and making her feet kick. Emma smiled faintly as she watched her baby's pleasure and her body moved in rhythm with the dancing. When it was her turn to have lotion on her hands, Emma relaxed, and seemed to enjoy it. In spite of the sense of shared pleasure, however, Helen still avoided eye contact when seated facing her mother.

Session Nine: "I Am Here and *You* Are There"

Beginning in this session the therapist began to transfer the positive interaction that had developed between her and the baby to the mother and Helen. After the usual welcoming song and rubbing lotion on Helen's arms and legs, the therapist brought out the bubbles—an activity that Helen enjoyed. After blowing a few bubbles, which Helen greeted with excited vocalizations, the therapist took Helen in her lap and gave the bubbles to Mom. With some hesitation, Emma started to blow slowly and Helen's face got rather still. But then Emma burst

into a lovely smile and said very firmly, "This one is for my darling Helen's little hand!" She blew a group of bubbles and laughed. Helen looked directly into her mother's eyes and started to giggle. This moment of eye contact and joint laughter lasted a long time. The session ended with the most relaxed feeding thus far in the sessions.

End and Follow-Up

Theraplay lasted for eighteen sessions, plus twice-monthly follow-up sessions, until Emma and Helen left the residential setting when Helen was nine months old. Their relaxed and more connected interaction was seen in the residential setting very soon after Theraplay began; it was especially evident after the ninth session. The future seems more optimistic for Emma and Helen now. They are in regular outpatient contact with their Theraplay therapist and the residential team. Emma is still in replacement therapy but is in the process of quitting the program. In the follow-up interview Emma's descriptions of Helen are much more vivid and coherent than they were at the initial interview.

Conclusions

The outcome of Theraplay with this high-risk infant and mother was positive. Because the Theraplay was conducted within the context of an intensive, twenty-four-hour residential treatment setting, where Emma and Helen received multiprofessional support in everyday life throughout the first nine months, it is not clear how much of the change can be attributed to Theraplay itself. Nevertheless, all the residential workers were surprised to see how the emotional interaction between Helen and Emma began to change only after Theraplay began. We had many thoughts about why that might be. First, Theraplay works directly with the most basic elements of good interaction. It helps the therapist to focus on emotional connection, not just on giving instructions to the mother about what to feed or how to dress her baby. It does this focusing in a noninterpretative, playful, positive, and growth-promoting way. This approach seemed important

with this traumatized mother who had up to this point passively avoided instructions to be more active with her baby. This issue was further highlighted in the parental discussions. Efforts to ask Emma directly to reflect on her baby's feelings or intentions had not worked. Sharing and verbalizing the joint positive moments in Theraplay seemed to increase her ability to think about herself more positively.

Notes

1. Our colleagues in Finland now include a parent session as the first step in Theraplay treatment in order to consolidate the therapeutic alliance. For an excellent discussion of the value of these sessions as well as a detailed account of one such session, see Laakso, M. "Parent Session in Theraplay: A Way to Consolidate Therapeutic Alliance and Joint Focus." In E. Munns (ed.), *Applications of Family and Group Theraplay.* Maryland: Jason Aronson, 2009.
2. See Hughes (2007) for a very good discussion of how to prepare parents for the teamwork involved in DDP.
3. See Hughes's (2007, pp. 150–151) Parenting Profile for Developing Attachment. It is a checklist in which parents indicate their perception of self and partner on a number of issues. It is a good source of information about the parents' views, as well as a way to alert parents to the importance of understanding their own needs and the needs of their child. See also Siegel and Hartzell, (2003, pp. 133–134) for a list of Questions for Parental Self-Reflection that are useful in guiding parents to understand more about themselves.
4. For a full discussion of this point, see Dozier, M. "Attachment-Based Treatment for Vulnerable Children," *Attachment and Human Development,* 2003, *5*(3), 253–257.
5. Beebe (2003, p. 45) cautions about the need for sensitively supporting parents when reviewing tapes of their interaction with their babies. "The success of the video method depends on the therapist's sensitive capacity to 'hold' the mother: to follow her lead and be her advocate; to sense the moment to suggest the video and how long to watch it; to maintain a collaborative rather than a didactic stance; and to *stay with* the parent as the video is shown, alert to any signs of parental distress, particularly shame or

feeling criticized, using these empathically to deepen our understanding of the parent's experience of the infant, and of her own inner world."

6. The section on handling difficult behavior is contributed by Dafna Lender.
7. The section on homework is based on a Theraplay handout prepared by Phyllis Rubin.
8. The section on working with vulnerable parents is based on a Theraplay handout prepared by Phyllis Rubin.
9. The following section on working with families where domestic violence is an issue is based on personal communication with Donna Gates.
10. This case is part of a Finnish Theraplay program designed to study the effectiveness of Theraplay (Mäkelä, Salo, and Lassenius-Panula, 2006). In this study there is a standard protocol for pre- and postmeasurement and also for supervision throughout Theraplay. A set of standardized evaluations were used: The infant Marschak Interaction Method (MIM); The Parent Development Interview (PDI), a semistructured interview focusing on maternal representations of the baby and themselves as a mother (Slade, Belsky, Aber, and Phelps, 1999); the Edinburgh Postnatal Depression Scale (EPDS), a measure of maternal depression (Cox, Holden, and Sagovsky, 1987); socioeconomic status and attachment questionnaires. The same set of measurements was repeated three months after the end of treatment and will be done again one year later. The Theraplay process was closely supervised (four times) in a study supervision group that meets monthly for a follow-up and supervision of all ongoing Theraplay processes.

PART THREE

Specific Applications of Theraplay

In Part Three we look at how Theraplay can be adapted to meet the needs of particular groups of children. Chapters Seven and Eight are devoted to how we work with children whose relationship problems have a constitutional or neurological base. Chapter Seven describes how Theraplay can be adapted for children with regulatory disorders. Chapter Eight describes how we work with children with autism.

The common issue in these two chapters is that the child's neurologically based challenge makes it hard for his parents to meet his needs. Anything in the child that interferes with his ability to respond readily to his parents' efforts to engage him or to comfort and soothe him can interfere with the development of a secure attachment relationship. Although we do not expect to change the basic neurological problem, Theraplay can help the child tolerate stimuli and cope with new experiences. It can also help parents understand their child's needs and provide appropriately attuned responses. By doing so, it can overcome some of the barriers to healthy interaction, thus making it possible for these children and

their parents to develop warm, joyful, interactive relationships that can open up the child to further learning and healthy experiences.

In Chapters Nine and Ten, we turn to groups of children whose problems stem not from within their own physical nature but from some failure on the part of the caretaking environment to provide what they need. Chapter Nine addresses how Theraplay can be adapted to meet the needs of children who have suffered complex trauma. Chapter Ten considers how Theraplay can be helpful with children who have been separated from their birth parents and placed in foster care or adoptive homes. Theraplay must find ways to help these children learn to trust and form a secure attachment to new parents following the loss of their original parents and the varying degrees of trauma that such a loss entails.

Most of our examples of Theraplay treatment up to this point have been of children from toddlers through school age. In Chapter Eleven we look at how Theraplay can be adapted to working with adolescents. Finally, Chapter Twelve discusses the application of Theraplay principles to groups of all ages.

CHAPTER SEVEN

Theraplay for Children with Regulation Disorders

Annie Kiermaier

To understand how regulation disorders can affect children, let's first take a look at two three-year-olds.

Jose is a bright, active boy who seems to sail through his day. He sleeps ten hours a night, waking up cheerfully in the morning. Jose can easily dress and feed himself breakfast before his father drops him off at child care on his way to work. Jose participates enthusiastically in the child-care program. He enjoys drawing astronauts, putting puzzles together, and listening to stories. During outside play, he likes to throw and catch a large ball with his friends and rides eagerly on a tricycle. When his father picks him up, he tells about his fun day. After supper, his father reads a story to Jose before he falls asleep at 8:00. Jose's father reflects on how reasonable his son has always been.

Katia is also a bright, verbal child. She still occasionally wakes up at night, crying and calling out for reassurance from her mother. She often wakes up irritably in the morning, fussing and demanding that her mother help her get dressed. She screams and refuses to wear certain clothes such as turtleneck shirts or pants with a snug waistband. She can't stand the texture of her plastic raincoat against

her skin and refuses to wear it. When her mother puts her into the car seat to take her to child care, Katia screams and kicks the back of the seat in front of her. She cries and clings to her mother when it's time for her mother to leave the child-care center for work. Once settled into child care, Katia enjoys pretend play with her friends and listening to stories during circle time. But she is easily overwhelmed when the room is loud and chaotic, withdrawing to suck her thumb and watch cautiously from the sidelines. When music is played loudly, she bursts into tears. She becomes easily frustrated when trying to put puzzle pieces together, sometimes throwing them on the floor. She draws with an "immature" grasp, scribbling and making simple shapes and colors with an occasional attempt at a face with two small circles for eyes and a line for a mouth. During outside play, she never throws or catches a ball with other children. She runs clumsily and never even tries the tricycles. She falls asleep in the car on the way home from child care and often has a lengthy meltdown tantrum at home. After supper, Katia snuggles lovingly with her mother during story time, then often has another tantrum at bedtime, screaming that she doesn't want to be left alone. Her mother is exhausted and worried about Katia. She blames herself because she has to work full-time and leave Katia in child care. She wonders if there is something wrong with her attachment relationship with Katia, and has heard that Theraplay might be helpful.

There are striking differences between Jose and Katia even though both pregnancies and births were healthy and normal. As a newborn, Jose quickly developed a predictable routine of sleeping and waking about every three hours to breast-feed. After nursing, his mother could easily lay him back in his crib and he would fall asleep. Katia, on the other hand, was a fussy, irritable newborn who slept for only brief periods and nursed frequently, every hour or two, day and night. She was most content when her mother held and rocked her gently in the rocking chair, but the moment her mother tried to lay Katia down in the crib, she startled and began to cry.

Katia got off to a much more difficult start in life than Jose. Both children are physically healthy and live in stable, loving homes. So how can we understand the differences? And more important, how can Theraplay help Katia and her mother?

THE INTERPLAY AMONG THE DEVELOPMENT OF THE BRAIN, ATTACHMENT, AND REGULATION

There are a variety of perspectives from which we can view Katia's problems. We can look at some of the exciting brain research done in the last decade that has deepened our understanding of how the brain develops. We can look at the development of attachment relationships during the first years of life. And we can look at how human beings develop the capacity to regulate their responses to sensory and emotional stimuli. It is actually in the intersection of these three perspectives that we will best understand Katia and learn how Theraplay can help her.

As we read in Chapter Two, science and medicine are learning more and more about the awakening and growth of human beings in the first years of life. From the twenty-fifth week of gestation in utero until after a child's first birthday, the brain is undergoing exponential growth and development, most particularly in the right hemisphere. At the same time, the baby is developing an attachment bond of emotional communication with a primary caregiver, which significantly affects the development of self-regulation. These two happen in synchrony with one another; the attachment relationship is the foundation of the infant's ability to self-regulate, and the ability to self-regulate strengthens the attachment relationship. The infant begins life by being externally regulated by the mother and is dependent on the mother's capacity to attune to his emotions and regulate his experience (Siegel, 2001). The development of the attachment relationship and the ability to self-regulate are so closely entwined that Allan Schore (2000, 2001a, 2005) defines attachment as the "dyadic regulation of emotion." As the child grows and develops, he internalizes those experiences and gradually becomes increasingly able to regulate responses to both emotional and sensory stimuli themselves. The key points to understand are

- Infants come into the world with their own unique genetic, physiological, and neurological makeup.
- During the first year, the infant's brain is experiencing dramatic, exponential growth, especially in the right hemisphere, which is

involved in affective expression and the ability to self-soothe and regulate.

- The infant's most important achievements during the first year are the development of a strong attachment relationship with a primary caregiver and the ability to self-regulate emotional and sensory stimuli.
- The ability to self-regulate is formed and shaped by the attachment relationship of infant and caregiver.

SOCIAL-EMOTIONAL DEVELOPMENT OF YOUNG CHILDREN

The infant's earliest experiences are the foundation of healthy social-emotional development, but they are only the beginning. Stanley Greenspan has created a useful framework for understanding the sequence of social-emotional development that follows this early period. In the DC:0–3R (*Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, rev. ed.,* Zero to Three, 2005)[1] the sequence is described as Capacities for Emotional and Social Functioning (see Table 7.1). Each level describes a distinct developmental stage in the progression of social-emotional growth from birth to forty-eight months of age.

Most young children move readily from one level to the next, building on their acquired experiences. But children with regulation

Level	Emotional and Social Functioning Capacities	Developmental Level
1	Attention and regulation	Observable beginning between birth and 3 months
2	Forming relationships; mutual engagement	Observable beginning between 3 and 6 months
3	Intentional two-way communication	Observable beginning between 4 and 10 months
4	Complex gestures and problem solving	Observable beginning between 10 and 18 months
5	Use of symbols to express thoughts and feelings	Observable beginning between 18 and 30 months
6	Connecting symbols logically; abstract thinking	Observable beginning between 30 and 48 months

Table 7.1. Capacities for Emotional and Social Functioning

disorders, for reasons either intrinsic to themselves or because of adverse experiences, do not move so easily through the developmental progression. They are held up or delayed because they are struggling to regulate their responses to emotional and sensory stimuli that adversely affect their attachment relationships and their overall development. Treatment for these children involves strengthening the one-to-three month skills of shared attention and regulation. The intimate, mutually engaging, reciprocal interactions of Theraplay re-create the dynamics of the parent-infant relationship in the first months and therefore help the child develop the capacity to self-regulate within the context of the relationship with the parent.

REGULATING AND PROCESSING SENSORY STIMULI

Difficulties with regulating and processing sensory stimuli were first studied and described by Jean Ayres (1971, 2005). In the 1960s and 1970s, she and other occupational therapists identified a variety of "sensory integration dysfunctions." Ayers first defined "tactile defensiveness" as an over-responsiveness to the sensations of touch, especially light or unexpected touch and soon began to categorize over- and underresponsiveness in other sensory systems including tactile, auditory, visual, vestibular, and proprioceptive. The interrelationship between sensory sensitivities and emotional and behavioral responses has been the focus of the work of Stanley Greenspan and occupational therapist Georgia DeGangi (DeGangi, 2000; DeGangi et al., 2000; Greenspan and Wieder, 2006b). They and others describe the continuum of regulatory-sensory processing variations seen in children and even in teens and adults.

Occupational therapists place their primary focus on the concept of sensory processing disorders, whereas mental health and developmental professionals look at the interface between sensory processing disorders and behavior and so frame difficulties as regulatory disorders. Other terms which include the concept of sensory processing are also used: Regulation Disorders of Sensory Processing (in the DC:0–3R) or Regulatory-Sensory Processing Disorders (in the ICDL-DMIC). Regardless of the descriptors, these are all ways of understanding the same important point: that children's development can become derailed and their behavior become dysregulated when they have difficulty processing sensory stimuli. Although

most of the research and treatment of regulation disorders has been with young children (age five and younger), older children and even teens and adults can struggle with regulating their responses to sensory input and can benefit from treatment.

UNDERSTANDING REGULATION DISORDERS

All children have their own unique patterns of regulatory-sensory processing with a wide spectrum of responses. A regulation disorder should be considered, however, when a child's sensory and motor responses challenge or prevent the typical development of emotional, social, language, motor, or cognitive skills. Regulation disorders, as described in the DC:0–3R, have clearly identifiable constitutional-maturational patterns.[2]

According to the DC:0–3R, the term *Regulation Disorders of Sensory Processing* "refers to a child's difficulties in regulating emotions and behaviors as well as motor abilities in response to sensory stimulation that lead to impairment in development and functioning. The patterns of behaviors that are characteristic of this disorder are manifest (1) across settings and (2) within multiple relationships. . . . Sensory stimuli include touch, sight, sound, taste, smell, sensation of movement in space, and awareness of the position of one's body in space" (2005, p. 28). The DC:0–3R lists three types of regulation disorders:

- Hypersensitive
- Hyposensitive or Underresponsive
- Sensory Stimulation-Seeking/Impulsive

Each of these types of regulation disorders includes three features:

- Sensory processing difficulties
- Motor difficulties
- A specific behavioral pattern

Hypersensitive

Hypersensitive children have *sensory processing difficulties* because they are easily overwhelmed by sensory stimuli that are part of everyday life: light touch, loud noises, bright lights, unfamiliar smells and

tastes, rough textures, or movement in space. They experience significant stress trying to manage the intense responses to various stimuli. There are two subtypes of hypersensitive children, fearful/cautious and negative/defiant. Both respond in a hypersensitive way to sensory stimuli but have different *motor* and *behavioral* patterns.

FEARFUL/CAUTIOUS. The fearful/cautious child responds with crying, "freezing," distractibility, aggression, angry outbursts, tantrums, excessive startle reactions, motoric agitation, attempts to escape the stimulus, and reduced tolerance for variety in food textures, tastes, and smells. *Motor patterns* in the fearful/cautious child may include difficulties with postural control and tone, difficulty in fine motor coordination, difficulty with motor planning, less exploration than expected, and limited sensory-motor play. *Behavioral patterns* of the fearful/cautious child include excessive cautiousness, inhibition, and fearfulness leading to a restricted range of exploration, limited assertiveness, difficulty handling change, clinginess in new situations, as well as shyness, distractibility, impulsivity, irritability, tearfulness, and a limited ability to self-soothe. The fearful/cautious child has difficulty recovering from frustration or disappointment. He tends to approach new experiences or sensations slowly or avoid them altogether.

NEGATIVE/DEFIANT. There is a second group of children who are also hypersensitive, but who respond very differently. They are negative/defiant children whose *sensory processing patterns* and *motor patterns* are similar to the fearful/cautious child, but who have very different behavioral responses. *Behavioral patterns* include negativistic behaviors including infants who are chronically fussy and toddlers or preschoolers who have reflexive negative responses or frequent angry tantrums. These children are controlling and defiant, often trying to do the opposite of what is requested of them. They prefer repetition and are upset by change. They are compulsive and perfectionistic and will avoid or delay engagement in new experiences or sensations.

Hyposensitive/Underresponsive

The *sensory processing difficulties* of this group of children are the opposite of those of hypersensitive children. Underresponsive

children require high-intensity sensory input before they are able to respond. They are generally quiet and watchful, often seeming unresponsive to their environment and unreceptive to overtures from others. Caregivers may need to be very persistent to engage a hyposensitive child; it is difficult for such a child to reach a threshold of arousal that will motivate him to act and interact with others. These children have *sensory reactivity patterns* that are underreactive to sounds, movement, smell, taste, touch, and proprioception. Their *motor patterns* include limited exploration, restricted play repertoire, lethargy, poor motor planning, and clumsiness. They will search for specific sensory input and try to repeat it over and over, such as swinging or jumping up and down. *Behavioral patterns* of these underresponsive children include an apathetic appearance, fatigability, withdrawal from stimuli, inattentiveness, and an apparent lack of interest in exploring or interacting with their world. These children may appear delayed or depressed, seeming to "tune out" conversations and showing only a limited range of ideas or imagination.

Sensory Stimulation Seeking

The *sensory processing difficulties* of the children in this third category require high-intensity, frequent, or long duration sensory input. Their craving for high-intensity sensory stimuli may lead to destructive or high-risk behaviors. *Motor patterns* include a high need for motor discharge, diffuse impulsivity, and accident proneness without clumsiness. *Behaviorally* they have very high activity levels. They are constantly seeking contact with people and objects and stimulation through deep pressure. They appear reckless and disorganized because they are always seeking sensory stimulation. They are excitable, intrusive, and may be aggressive, daring, reckless, and preoccupied with aggressive themes in pretend play. These children's urgent need for physical contact with people or objects leads to destruction of property, intrusion into others' physical space, or hitting without apparent provocation. Others may mistake this child's behaviors for deliberate aggression and could in turn become deliberately aggressive to the child.

ASSESSING REGULATION DISORDERS

How can Theraplay help children who have these regulation disorders of sensory processing? The first step is to determine during the assessment process whether the child has regulatory challenges that may be adversely affecting her well-being, including relationships with caregivers. You may begin to find clues that a child has a regulation disorder during the parent interview or during observation of the Marschak Interaction Method. If a child has a regulation disorder, it is important that it be accurately assessed so that effective strategies can be incorporated into the child's treatment plan.

The Theraplay therapist may choose to refer the child for an evaluation by an occupational therapist who has expertise in diagnosing and treating sensory processing disorders. However, because regulation disorders can be viewed from both a sensory and a behavioral point of view, it is equally valid for clinicians with mental health expertise to diagnose regulation disorders using the DC:0–3R for children five years and younger, combined with one or more of the diagnostic tools that can help assess regulatory difficulties.[3]

Researchers have found that about five percent of children have difficulties with regulatory functions, so you might consider screening all newly referred children. Most of the tools and treatment approaches focus on children eight and younger. If you suspect that an older child or teen is struggling with regulatory problems, a consultation or referral to an occupational therapist may be in order.

Mild to moderate challenges with regulation might not be picked up during assessment, but may become increasingly apparent during the early phases of Theraplay treatment. Either way, once the clinician understands that the child is struggling with a regulation disorder, Theraplay should be geared to intervene effectively. It may be difficult to discern whether a child's primary problem is a regulation disorder, or is related to another problem such as a struggle within the parent-child relationship, or if both are happening at the same time. Regardless, if you suspect that a regulation disorder may be adversely influencing a child's behavior, it would be helpful to incorporate a regulatory perspective into Theraplay treatment.

For the child with a regulation disorder, Theraplay might be the primary intervention, or might be offered in conjunction with occupational therapy, depending on the child and also on the skill sets of the Theraplay clinician and the availability of an occupational therapist with expertise in Sensory Processing Disorder.

UNDERSTANDING THE CHILD'S RESPONSES TO SPECIFIC SENSORY STIMULI

We turn now from a consideration of the three basic types of regulation disorders to look more closely at children's responses to specific sensory stimuli. Following each description is a list of Theraplay activities that can be useful in developing regulation in that sensory modality.

Carol Kranowitz provides a useful framework which we follow here (1998, 2003). Using the occupational therapy framework of sensory processing disorders, she describes how children respond using their tactile sense, vestibular sense, proprioceptive sense, and visual and auditory senses. Each of these sensory systems can contribute to the problems children with a regulation disorder face as they try to regulate their responses to touch, balance, movement, sight, and sound. Children's responses to sensory stimulation can be either *hypersensitive, hyposensitive,* or a combination of both. Some children, in addition, will show inconsistent responses that change over time, such as becoming increasingly hypersensitive as the day wears on, or inconsistent responses in different environments, such as home versus school.

Tactile Sense

Kranowitz describes two components of the tactile sense: the *protective/defensive system* and the *discriminative system.* The protective/defensive system alerts children to potentially harmful stimuli; it helps them survive. The *discriminative system* tells the child that they are touching something and can provide considerable detail, such as where the body is being touched, whether the touch is light or deep, and information about size, shape, temperature, density, and texture of the object. Tactile dysfunction is the result of inefficient processing in the brain of sensations perceived through the skin, causing difficulties with touching and being touched by

other people and objects. People can be *hypersensitive* to touch, *hyposensitive*, or have *poor tactile discrimination.*

Kranowitz finds that the tactile sense also gives children information about tactile perception, body awareness, motor planning, visual perception as well as helping the child feel emotionally secure and develop appropriate social skills. Children with tactile dysfunction have difficulty learning through touch. Tactile perception doesn't develop appropriately because the child can't practice without experiencing extreme responses. *Hypersensitive* children may withdraw from normal social interactions such as physical affection (hugs and kisses) and struggle to experience pleasure and joy in relationships because touch is aversive. *Hyposensitive* children may be underresponsive, experience little pleasure, and give little positive feedback to caregivers. The development of empathy can be very difficult. The *hypersensitive* child is preoccupied with her own pain or discomfort, whereas the *hyposensitive* child doesn't understand others' feelings and so can't relate well. Children who do not innately enjoy being near other people have difficulty learning how to play with others. They struggle to develop meaningful human relationships. Children with tactile dysfunction appear to reject others, either by fight or flight, and so end up being rejected in turn. They may try to rigidly control their interactions with others. Forming warm attachment relationships with others is challenging.

HYPERSENSITIVE. Children who are hypersensitive react negatively and with great emotion to unexpected touch, especially to light touch or even just the anticipation of being touched. They tend to react with fight or flight. With fight, the child reacts with strong resistance and even aggression; with flight, the child actively withdraws from contact or passively avoids objects and people that cause distress. These children especially avoid light touch such as a gentle kiss. Tickling can be a painful experience for the hypersensitive child. But ironically, these hypersensitive children may crave deep touch like a big bear hug that provides firm touch and deep pressure; the pressure helps suppress sensitivity to light touch. Some hypersensitive children seem to need a great deal of touch and will repeatedly touch things that provide soothing and comforting tactile experiences, such as the silky lining of a blanket. These children sometimes hold objects, such as a small toy, to defend themselves from unexpected touch on their hands. As you work with a child that is hypersensitive to touch, you

will need to monitor the child's responses and carefully introduce the "just right" amount of touch, including hugs. When playing Funny Ways to Cross the Room, for example, you and the parent will receive the hypersensitive child with a warm, firm hug.

HYPOSENSITIVE. Children who are hyposensitive underreact to tactile sensations and need extra stimulation. In order to get this they may constantly touch objects and people. They don't seem to notice or react to nurturing touch and may also not notice painful touch. They may not show much reaction to touch at all unless it is very intense. These children need more intense and frequent stimulation to reach a threshold of stimulation to which they can respond. When you work with such a child you should choose activities that provide high levels of stimulation to the hyposensitive child, such as Row, Row, Row, Your Boat or bouncing a young child on your knee to "Trot, Trot to Boston." You may need to repeat the activity with great energy until the child begins to react positively, such as with smiles and laughter.

POOR TACTILE DISCRIMINATION. Children who have poor tactile discrimination will have difficulty using the tactile sense for increasingly complex purposes, such as learning at school. Because the brain doesn't give the child accurate information about how things feel, the child needs to handle objects repeatedly to determine anew their weight, texture, and shape. Buttoning a coat, for example, is a very challenging experience for the child with poor tactile discrimination.

THERAPLAY ACTIVITIES TO DEVELOP TACTILE REGULATION. The following Theraplay activities provide tactile stimulation that can be adapted for children who are hypersensitive, hyposensitive, or who have poor tactile discrimination—providing the "just right" amount of stimulation for each child to learn to regulate his responses.

- *Using lotion, powder, and other messy materials (Nurture):* Encourage the child to touch and handle the lotion as well as to allow you to rub it on him. Use firm, deep pressure when massaging. Use a variety of textures on the child's skin when massaging, such as a brush, pot scrubber, washcloth, sponge, as well as smoother textures. Create messy and "touchy" play with shaving cream, Jell-O, or yogurt.
- *Fanning (Nurture):* Gently fan the child with a fan, pillow, or newspaper.

- *Cotton Ball Touch and other touch activities (Nurture):* With his eyes closed, the child identifies where you have touched him. Add more challenge by asking the child to discriminate between a touch with a cotton ball or a feather. Draw a shape, letter, or design on the child's back or hand; ask the child to identify it. Ask the child to close his eyes and identify parent's or therapist's body parts with his hands: for example, nose, hair, finger, or ear.
- *Paint Prints (Nurture):* Use finger paint or shaving cream to "paint" the child's hand or foot, then press onto paper to make a print. Afterwards, gently wash, dry, and powder the foot. Indulge in the tactile experience, letting the child enjoy the messiness!
- *Manicure (Nurture):* Another great tactile experience!
- *Feeding (Nurture):* Offer foods with a variety of textures.
- *Blanket Swing and more (Nurture):* Before or after a blanket swing, use the blanket to provide deep pressure by rolling the child up in the blanket and making him into a hot dog. Add condiments such as ketchup and relish by providing firm pressure. Pretend the child is the middle of a hamburger, using sofa cushions or pillows as the buns and applying firm, gentle pressure.
- *Special Kisses (Nurture)*: Elephant, butterfly, Eskimo kisses will increase child's ability to tolerate light touch.
- *Peek-a-Boo (Engagement):* Move beyond peeking from behind your hands to tossing a scarf or blanket over the child and gently pulling it off as you say "peek!" Let the child reciprocate to "find" the adults. Then put everybody under the blanket together, making the blanket into a tent.
- *Hand-clapping games (Engagement):* Play simple Patty-Cake with younger children, more complex games with older children, such as Sailor Went to Sea.
- *Progressive Pass Around (Engagement):* Each takes a turn adding a touch as the activity goes round the circle. This provides opportunities to experience different kinds of touch and then recall them in sequence.
- *Pop the Bubble (Structure):* In addition to popping bubbles, have the child blow bubbles to strengthen her oral motor skills.

Vestibular Sense

The vestibular system tells a person where the body is in space, giving the brain information about balance and movement from the neck, eyes, and body. In addition it contributes to the development of muscle tone that allows the body to move smoothly and efficiently. The vestibular system tells the brain if the body is moving or standing still, in which direction the body is moving and how fast. The core of the vestibular system is the inner ear, which registers every movement made by the body. Kranowitz (1998, p. 101) defines vestibular dysfunction as the inefficient processing in the brain of sensations perceived through the inner ear. A child with vestibular dysfunction has difficulty "integrating information about movement, gravity, balance, and space. She may be oversensitive to movement, or undersensitive, or both. . . . The child may not develop the postural responses necessary to keep upright. She may never have learned to crawl and creep. She may be late learning to walk. She may sprawl on the floor, slump when she sits, and lean her head on her hands when she is at the table. As she grows, she may be awkward, uncoordinated, and clumsy."

Children with vestibular difficulties may have visual problems as well, such as difficulty focusing when either the child or an object is moving. There may also be difficulties with processing language. Movement, which is naturally calming for most children, can be dysregulating for the child with vestibular dysfunction. Difficulty moving in an organized way adversely affects the child's behavior, attention, and expression of emotions. An inefficient vestibular system may cause the child to be *hypersensitive* to movement, including intolerance for rapid movement or gravitational insecurity. Or a child may be *hyposensitive* to movement, craving and desiring movement. Especially when the head or eyes move, the brain is flooded with sensory stimuli it can't incorporate or organize. The Theraplay therapist carefully adjusts vestibular activities such as swinging the child in a blanket to address any vestibular hyper- or hyposensitivity.

HYPERSENSITIVE. Children who are hypersensitive may avoid riding bicycles, sliding, and swinging. Car rides make them feel sick. Rotary movement, such as swinging on a tire swing, causes dizziness and nausea or stomachache. These children become easily fatigued and have poor motor coordination and motor planning. Vestibular

dysfunction causes gravitational insecurity resulting in abnormal distress and anxiety in reaction to even the possibility of falling. The brain overreacts to changes in gravity, even to such a simple activity as standing up. Movement for these children is difficult and often elicits a fight or flight response. Fight can manifest as negative, defiant behavior, as resistance to being picked up or rocked, and as anger and stubbornness. When a flight response is elicited, the child shows avoidance of movement and extreme caution. Activities such as Ring-Around-a-Rosy are very scary for these children. In response to all these difficulties, the children can become inflexible and very controlling, which causes social and emotional problems.

HYPOSENSITIVE. The brain of the hyposensitive child doesn't create enough movement messages. These children require a high level of movement before they can respond. They crave lots of activity and may seek to resist gravity in unpredictable ways. These are the children who like to swing upside down or hang over the edge of furniture. They may seek intense movement sensations by crashing into people and objects or by climbing high onto objects then jumping off. These children crave linear movement such as rocking and swinging and seek out rotational movement such as spinning or vigorously shaking the head. The vestibular system affects gravitational security, movement and balance, muscle tone, bilateral coordination, auditory-language processing, visual-spatial processing, motor planning, and emotional security. All of these systems are adversely affected when the child is hyposensitive to vestibular stimuli.

THERAPLAY ACTIVITIES TO DEVELOP VESTIBULAR REGULATION. The Theraplay therapist carefully adjusts vestibular activities to address any vestibular hyper- or hyposensitivity.

- *Blanket Swing (Nurture):* Vary the rhythm and pace, for example, going faster and slower.
- *Ring-Around-a-Rosy (Structure):* Move faster to increase spinning.
- *Motor Boat (Structure):* Also offers opportunity for structured spinning.
- *Push-Me-Over, Land-on-My-Knees (Engagement):* Provides many opportunities for vestibular stimulation, especially when the child is pulled onto adult's knees and bounced.

- *Push-Me-Over, Pull-Me-Up (Engagement):* Can be repeated so that it becomes predictable and safe.
- *Row, Row, Row Your Boat (Engagement):* Can be done fast, slow, and in between.
- *Piggy-Back/Horsey-Back Ride (Engagement):* Can be gentle, or "rough" and jerky.
- *This Is the Way the Baby Rides (Engagement):* Provides lots of vestibular stimulation. A variation is the nursery rhyme: "Trot, trot to Boston, Trot, trot to Lynn, Trot, trot to Boston, All fall in!" Let the child gently "fall" off adult's lap at the end.
- *Balancing activities (Challenge):* Start with child balancing pillows on his tummy while lying on floor, then have the child balance objects on his head and walk across the room.
- *Balance on Pillows, Jump Off (Challenge):* After balancing on a stack of pillows, arrange the pillows in a line on the floor and have the child jump from pillow to pillow or in between the pillows.
- *Tunnels (Challenge):* Child crawls through a play tunnel or tunnel made from pillows, blankets, or adults' legs.

Proprioceptive Sense

Kranowitz (1998, pp. 132–133) defines proprioception as "sensory information telling us about our own movement or body position [which helps] integrate touch and movement sensations.... Receptors for the proprioceptive sense are in the muscles, joints, ligaments, tendons, and connective tissue. The stimuli for these receptors are movement and gravity." These receptors send messages to the brain about how the muscles are stretching or contracting and how joints are bending and straightening. Proprioception tells the brain if the feet are on the floor or the hand is holding a cup. It increases body awareness, contributes to motor control and motor planning, and helps with the ability to move body parts efficiently and economically. A well-functioning proprioceptive system helps a person walk smoothly, run quickly, climb stairs, sit, stand, stretch, and lie down easily. The person feels emotionally secure because he can trust his body. Proprioceptive dysfunction causes the inefficient processing of sensory stimuli through the muscles, tendons,

joints, ligaments, and connective tissues and often is associated with problems with the tactile and vestibular systems. It causes a poor sense of body awareness, which makes motor planning challenging. These children are clumsy and easily frustrated. They have difficulty manipulating objects, often exerting too much or too little pressure, spilling or dropping objects. They compensate by using vision to watch what the body is doing. Getting out of bed and getting dressed are difficult unless the child is watching every move he makes. Since new movements are unsettling and produce fear, children with proprioceptive dysfunction are often emotionally insecure. Proprioception affects body awareness, motor planning, motor control, grading of movement, postural stability, and emotional security.

THERAPLAY ACTIVITIES TO DEVELOP PROPRIOCEPTIVE REGULATION.

- *Tug-of-War (Challenge):* Provides great opportunity for joint compression and putting pressure on the child's arms and legs.
- *Partner Pull-Up (Challenge):* Opportunity for coordination and using large muscles.
- *Pillow Push (Challenge):* Child can use arms and even legs to push hard.
- *Wheelbarrow (Challenge):* Another great opportunity for large muscle "work."
- *Wiggle in and Out (Challenge):* Put your arms around the child and ask him to wiggle out. Create mild to moderate resistance in a playful way.
- *Thumb, arm, or leg wrestling (Challenge):* Narrate the "match," describing the child's activities to give them feedback about where their body is in space.
- *Crawling Race (Challenge):* Lots of movement.
- *Balance on Pillows, Jump Off (Challenge):* Do lots of jumping to provide proprioceptive input to the legs.
- *Newspaper Punch, Basket Toss (Challenge):* Increases coordination and control with lots of structure.
- *Special Handshake (Engagement):* Child has to think and then remember various hand movements.

- *Free-Throw (Engagement):* Great chance for throwing. Start with lightweight items like cotton balls or newspaper balls. If it's safe, increase to heavier objects like beanbags.
- *Lotioning or Powdering (Nurture):* Use firm, deep pressure.
- *Slippery, Slippery, Slip (Nurture):* Provides lots of proprioceptive input, especially to joints.

Visual and Auditory Senses

Children may be over- or undersensitive to both sights and sounds. A hypersensitive child may quickly become overexcited when there is too much visual stimulation. Bright lights or a visually overstimulating classroom may cause a hypersensitive child to cover her eyes, reduce eye contact, or be inattentive and distractible. A hyposensitive child may need to touch as well as look at objects, craving additional sensory input. The child may miss important visual cues such as other people's facial expressions and gestures.

Children who are hypersensitive to sound may cover their ears to loud sounds or certain pitches. They may be hypervigilant to sounds, alerting to the distant sound of a washing machine, for example. They may be easily distracted by seemingly minor noises. If a child is hyposensitive, she may have difficulty following verbal directions or even listening to normal voices. The hyposensitive child may seek out high volume of music, TV, and movies and compensate by speaking in a loud voice.

Theraplay to address visual and auditory sensitivities focuses on carefully assessing for hyper- or hyposensitivities and then modulating Theraplay activities accordingly. Using a brightly colored ball with a hyposensitive child or gently whispering with a hypersensitive child are ways to adapt the environment to the child. You may also need to adapt other aspects of the environment, such as closing a window to shut out loud noises, as well as advising parents and teachers on environmental adaptations during the rest of the week.

HOW THERAPLAY CAN HELP CHILDREN BECOME BETTER REGULATED

Returning to what we've learned about early brain development, attachment, and self-regulation, we look now at how Theraplay can help children who are struggling with regulation disorders. You will

recall that the ability to self-regulate is formed and shaped by the attachment relationship of infant and caregiver. So the focus of Theraplay is to use the attachment relationship to help the child regulate responses to sensory stimuli and therefore develop the capacities of attention and regulation of Level One of the Emotional and Social Functioning Capacities in Table 7.1. Regardless of whether the child is dysregulated because of his own innate makeup or whether he became dysregulated because of adverse early childhood experiences (such as exposure to severe stress, trauma, or inadequate attachment experiences), the approach during Theraplay will be the same: to use the attuned, intimate, playful, interactions of Theraplay to help the child become better regulated and to give the parents hands-on tools to help their child as well. Theraplay sessions are designed to

1. Help the child respond positively to sensory stimuli
2. Help the child develop emotional responses congruent with her sensory experiences
3. Keep the child engaged in positive, reciprocal interactions during moments of dysregulation
4. Offer experiences during moments of dysregulation that repair the attachment relationship and help the child become better regulated
5. Strengthen the parents' ability to understand and be empathetic toward their dysregulated child

Riding the "Regulatory Rollercoaster" During Theraplay Sessions

Theraplay sessions are organized so that they provide a "rollercoaster" of stimulating activities alternating with calming activities in order to help the child practice regulation with the support of the therapist and her parents. We alternate brief activities that *challenge* the child's ability to self-regulate, then quickly move to calming, soothing, *nurturing* activities that help the child return to homeostasis. The cycle is repeated over and over, all the while maintaining close *engagement* and clear *structure.* Adult guidance and structure help the child trust that the adults will keep him from becoming dysregulated or out of control. Repeating the "Regulatory Rollercoaster"

throughout sessions provides reparative, experiential learning for the child and parent that helps the dyad simultaneously develop a stronger attachment relationship and better self-regulation.

Using the Theraplay Dimensions

Each of the Theraplay dimensions provides specific help in working with the child with Regulatory problems.

STRUCTURE. The dimension of structure helps the child learn that the therapist and his parents can help him stay regulated and calm. Knowing the limits and boundaries of acceptable behavior is essential for the dysregulated child to feel safe and secure. Predictability is especially important for both the hyper- and hyposensitive child. Knowing what is coming next and having time to prepare for transitions is an essential aspect of structure for the dysregulated child. Consistent, safe, secure structure from adults will lead to the child's increasing ability to regulate his own responses to stressful stimuli. Slowing down, waiting, and attending carefully are especially helpful to both the hypersensitive and sensory-seeking child. When you carefully trace around hands, have the child wait for your signal to punch a piece of newspaper, or follow your directions during Red Light, Green Light, you are providing the clear, predictable structure that helps the dysregulated child feel safe and in control of himself.

ENGAGEMENT. The primary goal for the dysregulated child is to be able to tolerate sustained positive engagement for longer and longer periods of time and with increasingly close interactions. Children with regulation disorders often cope by withdrawing from interactions using negative responses, such as crying, fleeing, or hitting, that disrupt interactions with caregivers. Engaging activities help the child sustain a positive connection by focusing on the child and providing exciting, surprising interactive experiences. When you start the session with a checkup of body parts, freckles, and boo-boos, you help the dysregulated child focus and attend. When you invite the child to play Blow Me Over, she may respond with smiles and laughter. If the child disengages from play, you can quickly bring her back in enticing, engaging ways. You can engage the child who avoids eye contact with a gentle game of Peek-a-Boo. You can reengage the child who tries to hit you by making a Stack of Hands.

NURTURE. The attachment relationship that the infant and the mother develop during the earliest months of a child's life is essential to survival and forms the basis of the later capacity for self-regulation. The qualities of that nurturing relationship are not optional; they are essential for human development. Mirroring those early experiences, the Theraplay therapist and the parents provide consistent, predictable, warm, soothing experiences that reassure the dysregulated child that adults will always offer comfort and stability. The child's emotional needs will always be met. When you take care of hurts, sing quiet lullabies such as the "Twinkle" song, and put lotion on hands and feet, the child gets the message that she is cherished and that she can always count on adults to help soothe and calm her.

CHALLENGE. The greatest challenge for a child with a regulation disorder is when she becomes dysregulated either by too much or too little sensory stimulation. Theraplay's challenging activities, therefore, focus on gradually increasing the child's ability to tolerate sensory and emotional experiences that are just a bit outside her "comfort zone." Challenge for a hyposensitive child, for example, might be for her to sustain a game of Peek-a-Boo for several minutes. Challenge for a hypersensitive child, however, might involve being able to tolerate and even enjoy identifying the body part the adult is touching with a feather. As the child's tolerance for sensory-focused activities increases, you can increase the intensity and duration of activities in order to provide more and more challenging experiences. For a child who is hypersensitive to sound, you would start with gentle whispers, then gradually add louder and louder sounds, always carefully monitoring that the child is not becoming overwhelmed. Songs and rhymes are wonderful ways to introduce exciting sounds to children who become easily overwhelmed by sound.

CASE EXAMPLES

Using the framework of the DC:0–3R, the sensory integration concepts from occupational therapists, and the four Theraplay dimensions, we will look now at how Theraplay can help children with different types of regulation disorders become better regulated. Even if a child is too old to be diagnosed using the DC:0–3R, the concepts of hypersensitive, hyposensitive, and sensory-seeking/impulsive can still be applied to understand the child's problems with regulation and to create an effective treatment plan.

THERAPLAY IN PRACTICE

Helping a Hypersensitive, Fearful/Cautious Child

We now return to three-year-old Katia, whom we met at the beginning of this chapter. During the assessment process, her Theraplay therapist determined that Katia is a hypersensitive, fearful/cautious child. She demonstrated *overreactivity to sensory stimuli,* especially to certain textures and touches, to loud noises, and to sudden changes in movement. She had difficulty self-soothing and had to depend on her mother for comfort and reassurance. Katia demonstrated *fearful and anxious behavior patterns.* She was clingy and had difficulty separating from her mother. At child care she often withdrew and watched shyly from the sidelines, showing a limited range of exploration. She was especially fearful in new situations, such as when the family went to visit new friends or went shopping in new stores. She was frequently irritable and tearful. When she became overwhelmed she reacted with angry outbursts and frequent tantrums. She was easily frustrated and would often avoid new or challenging situations, saying to her mother or her teacher, "I can't. You do it for me." Hypersensitive *motor difficulties* included low muscle tone and difficulties with motor coordination and motor planning.

Treatment included weekly Theraplay sessions, followed by parent consultation to help Katia's mother understand that her daughter's behaviors were the result of hypersensitivities to sensory stimuli and to give her skills to help Katia regulate her responses. Katia was also referred for an occupational therapy evaluation with subsequent occupational therapy treatment. Theraplay sessions combined strong elements of nurture and structure, introducing stimuli that challenged Katia slowly and gradually, using elements that were predictable and repeated frequently. Her therapist, Terry, focused on close attunement with Katia. When she noticed even the slightest sign that Katia was becoming dysregulated, she would stop what she was doing and reflect to Katia how

she seemed to be feeling: "When I brushed your skin with the feather you pulled away. I bet that makes you feel tickly. I'm going to do it again, but this time I'm going to rub your skin with a cotton ball. Ready? Here we go!" Gradually Terry was able to introduce an increasing variety of tactile and auditory stimuli during sessions. She found that Katia enjoyed singing, so Terry would lead Katia and her mother in playful songs incorporating touch and movement that Katia could enjoy. Terry would respond with positive affect whenever Katia gave a positive response. During the first few sessions, Katia clung to her mother and sat in her lap, sometimes turning tearfully to face her mother. As Theraplay progressed, she was able to tolerate sitting in a beanbag chair and gradually developed a close relationship with Terry. Terry consulted with Katia's mother and her occupational therapist. Together they created a "sensory diet" and treatment plan. Katia's mother learned to introduce new sensory experiences gradually but confidently so that Katia was able to tolerate them better and better. Her occupational therapist focused on strengthening her motor planning and coordination so that after four months Katia was able to ride a tricycle. As Katia's confidence increased, she developed an "I can do it!" attitude that she showed both at home and at child care.

THERAPLAY IN PRACTICE

Helping a Hypersensitive, Negative/Defiant Child

Tyler is a charming four-and-a-half-year-old boy who attends Head Start and lives with his parents and two younger siblings. He was referred for an assessment because he was demonstrating negative behaviors including emotional outbursts and aggression toward others. Both his teacher and his mother describe a child who has "good" and "bad" moments, and whose behaviors are quite variable. At school,

Tyler's challenging behaviors tend to escalate as the day goes on and are much worse by the end of the week. In describing his behavior at home, Tyler's mother, Cindy, says that he is a "sweet" child who "loves structure." She believes that "the boundaries have to be enforced or he blows you off . . . he pushes. Tyler is very strong willed . . . hard-headed. He doesn't always like to take directions. He wants to decide. He is very active and gets very wound up. Getting him to calm down once he's wound up is hard." Both his mother and teacher report that Tyler demonstrates auditory hypersensitivity, he often says that things are too loud. He has been observed to place his hands over his ears and say, "It's too loud." His teacher also reports that Tyler has difficulty with bright lights and colors. At home, his mother observes that Tyler does well one-on-one, but such moments are infrequent as she is raising three young children.

During the MIM observation, Cindy did an excellent job of providing positive, clear structure to which Tyler responded very well. He was consistently engaged during the play observation. He understood the rules of a game, but "pushed" against those rules a number of times with angry outbursts. Cindy was positive, calm, and firm; all qualities to which Tyler responds well.

Tyler experiences sensory stimuli as aversive, especially loud noises and bright lights. Tyler's *sensory reactivity* patterns include increased distractibility, aggression, angry outbursts including tantrums, motoric agitation, and attempts to escape from the aversive stimulus. Tyler demonstrates almost all of the *behavioral patterns* seen in hypersensitive, negative/defiant children: negativistic behavior, controlling behavior, defiance, preference for repetition, difficulty adapting to changes in routines or plans, compulsiveness and perfectionism, and avoidance or slow engagement in new experiences or sensations.

Treatment for Tyler included home-based Theraplay with his mother, Group Theraplay at Head Start, as well as consultation with his teacher. The goal was to increase Tyler's

ability to tolerate auditory and visual stimuli in his environment with a reduction in his negative and defiant behaviors. Consultation with his Head Start teacher included strategizing ways to reduce Tyler's exposure to aversive stimuli at school. His teacher encouraged Tyler to sit beside her near the back corner of the room during breakfast so he was as far away from the other children as possible. His close proximity to his teacher helped him develop a supportive relationship with her so that he came to see her as his "secure base" in the classroom. It had the added advantage that she was able to calm and reassure Tyler and prevent him from hitting and kicking his peers during breakfast. Tyler's teacher and therapist worked together to modify the daily schedule, in order to intersperse periods of high activity with periods of calm; for example, having a quiet circle time with stories after noisy, active outdoor play. The teacher reduced bright lights in the room by turning off the overhead fluorescent lights and using daylight and several strings of white Christmas lights strung on the ceiling. She also created a "quiet corner" full of large, stuffed pillows where Tyler (and other children as needed) could "get away" by himself when he began to be overwhelmed.

Tyler participated in Small-Group Theraplay once a week with four other carefully chosen peers. Group Theraplay started with an introductory activity. Jessica, the therapist, carefully placed her hands on each child's shoulders or legs and said to the group, "Tell me in a quiet voice, who is this?" The children would whisper the child's name and say "Good morning!" After all the children were introduced, Jessica would ask the children to recite the Group Theraplay rules: "No hurts. Stick together. Have fun!" Each child would be checked for boo-boos, with small dabs of lotion rubbed gently around each boo-boo. If a child did not have a boo-boo, Jessica would smile and exclaim softly, "Hooray! No boo-boos!" Then she would lead a series of Group Theraplay activities. One of Tyler's favorites was the Theraplay version of Duck, Duck, Goose: when a child is tapped on the head to be

the "goose," he stands up and runs around the circle *toward* the other child. When the two children meet, they hug each other! Jessica very carefully modulated the group sessions, using a calm, quiet voice herself and encouraging all the children to use gentle voices as well. As Tyler's relationships with the other children in his Theraplay group strengthened, he was able to play with them with fewer and fewer aggressive episodes. The modifications in the Head Start daily routine and environment along with his improved relationships with his peers resulted in Tyler's behaviors becoming less and less angry and aggressive. From time to time, he still showed hypersensitivity to stimuli, occasionally putting his hands over his ears and saying, "That hurts my ears." But he did not have to resort to aggression. He had become a happy, active part of the Head Start class.

THERAPLAY IN PRACTICE

Helping a Hyposensitive/Underresponsive Child

Kadisha was a seventeen-month-old toddler whose relatives referred to her as "little Buddha" because she spent most of her time sitting and watching. She was not yet walking or saying words; many of her other developmental milestones had been achieved later than would be expected. She was overweight for her age, which slowed her ability to move around. Her pediatrician was concerned that she was not yet walking, but her parents were glad that she was an "easy" baby and not "getting into trouble." Her mother, Rachel, appeared mildly depressed; she spent much of her day watching television with the curtains drawn. Kadisha's father worked long hours on a construction crew and so was away from home most of her waking hours. Kadisha's public health nurse referred her to Theraplay therapist Bethany, who determined that Kadisha was a "slow to warm," hyposensitive/underresponsive

child. Theraplay goals were: (1) to help Kadisha respond appropriately to sensory stimuli, and (2) to help her mother learn how to interact and stimulate Kadisha in age-appropriate ways.

Theraplay with Kadisha and her mother, Rachel, focused on introducing sensory stimuli to excite and entice Kadisha into interactions. Bethany used peppermint-scented lotion when rubbing Kadisha's hands and feet. She brought Rachel into the play early on, so that she and Bethany could massage Kadisha's hands and feet at the same time. In order to increase the level of stimulation, Bethany used a multisensory approach. As she massaged Kadisha's feet she sang lively children's songs, such as "Old MacDonald Had a Farm." Bethany tossed a bright red blanket over Kadisha's head to play Peek-a-Boo, then said in an increasingly louder and more exciting tone, "Where's Bethany? Where's Bethany? Where's Bethany?" At the final exclamatory, "Here I am!" she pulled the blanket off Kadisha's head and smiled broadly at her. Engaged at last, Kadisha smiled and reached her hand toward Bethany's face. Bethany exclaimed, "Oh, you want more?" She repeated the game again, taking turns with Rachel. Bethany placed Kadisha on her lap facing her, bouncing her gently and then more vigorously to the nursery rhyme, "Trot, Trot to Boston." Next she handed Kadisha to Rachel and encouraged her to bounce Kadisha as well. Bethany continued to model for Rachel how to use playful, exaggerated facial expressions with wide eyes and an open mouth. She sat close to Kadisha and fed her goldfish crackers. Next she signaled for Kadisha to give her a cracker, beginning a delightful sequence of reciprocal interactions as they playfully placed crackers in each other's mouths. As a result of all the engaging stimulation, Kadisha became more and more animated. The session ended with a lively game of Beeping Noses between Kadisha and her mother. Each time Kadisha touched her mother's nose, Rachel would let out a loud "Beep!" and Kadisha would break into a broad smile with a lovely laugh.

As sessions progressed, Kadisha began to initiate more and more interaction with Rachel and Bethany. She signaled that

she wanted to play Peek-a-Boo by placing the red blanket on her own head, then on the adult's head. She climbed onto the adults' laps to be bounced and she pointed to the bottle of bubbles when she saw them. She began to vocalize, saying "ma" for "more" and "bubba" for "bubbles." After the sessions ended, Rachel said that she enjoys playing with her daughter more, that "she's more fun now . . . I like the way she laughs."

THERAPLAY IN PRACTICE

Helping an Impulsive, Sensory-Stimulation-Seeking Child

Three-year-old Wayne was referred for Theraplay by a child development agency because of his difficulty with transitions and with following his parents' directions. He frequently hit, kicked, and spat. The referral described his "hyperactive" behavior and difficulty calming himself when upset or excited.

Wayne's mental health assessment described him as a child who actively sought out high levels of sensory input, which often resulted in destructive or aggressive behaviors. He had a high need for motor discharge, was quite impulsive, and engaged in potentially dangerous behaviors such as jumping off the coffee table. Wayne desperately needed adults to structure his world for him and responded well to such efforts when they were available.

During the MIM he watched the assessor carefully and said that he was going to jump off the coffee table, as if he hoped she would tell him to stop. He responded well to his mother's efforts to structure his activities, was able to listen to and respond to directions, had strong imitation skills, and was very attentive to his mother when she was in close physical proximity and gave him clear, firm directives. However, the moment she backed away physically or emotionally, such as telling him he was being "naughty," Wayne rapidly became dysregulated, waving his arms in the air, and making hitting

motions. Wayne also disrupted the interactions using negative behaviors, such as sticking out his tongue at his mother. Wayne was a child who went from "zero to sixty" in a moment; he could attend and focus one moment and the next he was waving his arms and throwing objects. He was highly excitable, aggressive, intrusive, and daring. Much of his pretend play involved aggressive themes. His need for physical contact with people and objects led to the destruction of property, intrusion into others' physical space, and hitting without apparent provocation, which was often mistaken for angry aggression.

During the conversation between his mother and Annie, the therapist, following the MIM observation, Wayne interrupted the conversation by hitting Annie's arm. When Annie turned this into a "give me five" game, Wayne responded readily to the structure of the game and enjoyed the physically engaging activity. Interpreting his attempts to engage the therapist as aggression, his mother quickly intervened and told him he was being naughty. Wayne then began hitting a nearby glass aquarium. Wayne was desperately looking to adults to help him regulate his responses and give him a sense of structure that he was lacking.

The focus of the weekly Theraplay sessions was on providing lots of structure for both Wayne and his mother while giving Wayne the sensory "diet" that he needed with large helpings of tactile and proprioceptive input dished up with plenty of challenge. Annie began the sessions by saying to Wayne, "I know you're ready to play when you're sitting in the beanbag chair!" Wayne was so eager to play that he would run and leap into the chair. She would then "check in" with Wayne by pressing firmly on his arm and leg muscles while saying, "Man, you're getting stronger and stronger, aren't you? Show me how big your arm muscles are today." Wayne would flex his muscles while smiling proudly. Annie would apply deep pressure to his bicep muscles then continue to squeeze the rest of Wayne's arm and leg muscles. Keeping Wayne closely contained in the beanbag chair, Annie would then add more

tactile stimulation by massaging his feet and his hands with lotion, rubbing firmly toward his extremities. This activity would transition directly into a fun game of Slippery Slippery Slip that combined proprioceptive joint traction and compression, firm touch, and an element of joyful surprise when Annie would fall backwards and exclaim loudly, "Oh no! Now you can pull me back up!" After repeating the Slippery Slip game with lots of laughter and smiles, Annie would then lead a sequence of Row, Row, Row Your Boat with Wayne and Annie holding hands and rocking back and forth while repeating the song several times. At first Annie would say, "Now we're going to go really slooooow," while singing and moving very slowly. Next she would say, "Now we're going to go really FAST!" increasing the pace so Wayne and she were moving rapidly back and forth. Finally she would return to a normal pace. As sessions progressed, Annie would ask Wayne to choose if he wanted to go fast or slow. His first choice was always, "Fast." The changes in pace helped Wayne begin to regulate himself and respond to and enjoy both fast and slow movement. After this sequence of highly structured and increasingly active play, Annie would then lead Wayne down the "Regulation Rollercoaster" by offering a calming activity such as Soft and Floppy or gentle fanning while singing a quiet song. Sometimes his mother would read him a story while Wayne sat in her lap, an activity that they often enjoyed during the rest of their week as well. Then Annie would offer one or two more active games. Two of Wayne's favorites were Newspaper Punch, followed by Basket Toss and Red Light, Green Light. Annie would help Wayne pause and anticipate as she counted slowly, "One, two, three, punch!" After the newspaper had all been punched and torn, Annie, Wayne, and his mother would wad the newspaper pieces into tight balls. Annie would then make a hoop with her arms and Wayne would toss the balls when she gave the signal, "One, two, three, toss!"

During the early sessions, Wayne always needed to be holding an adult's hand, and still he had difficulty staying

engaged in Red Light, Green Light for more than a round or two. But as therapy progressed he was better and better able to stay focused and follow the directions when to start and stop. He was even able to play the game without holding an adult's hand. Once he had mastered the game, Annie let Wayne have a turn at calling out "Green light . . . red light!" while his mother and Annie followed his directions. Sessions almost always ended with Wayne sitting curled up in his mother's lap either listening to a story or being fed crackers. Then Annie and his mother would slowly rock Wayne in a blanket while gently singing the "Twinkle" song. When the song was finished, they would lower Wayne to the floor and Annie would scoop him up inside the blanket and hand him to his mother, exclaiming, "Look, Mom! Here's a wonderful present. I wonder what's inside?" His mother would carefully unwrap her "present" and discover a smiling Wayne.

Annie would often repeat activities so that they were predictable and Wayne could become confident of his ability to regulate himself during the play. She would also throw in one or two new activities as well to add surprise and excitement to the play. Wayne gradually became better and better regulated. His mother's understanding of Wayne's challenges increased dramatically. She shifted from telling Wayne that he was "naughty" and needed to sit in the "naughty chair" to having a variety of activities that she could use at a moment's notice that would meet Wayne's need for tactile and proprioceptive input while maintaining strong structure for Wayne. As a result their play became more joyful and fun for both of them.

When Annie arrived at their home for a session near the end of treatment, Wayne's mother met her at the door and exclaimed, "Oh Annie, come in and see what we're doing today! We're baking brownies!" She had arranged the ingredients on the kitchen counter, providing clear structure, while she told Wayne which ingredient to put in first, second, and third. Then she held the bowl while Wayne used his "muscles" to stir the brownie dough with a big grin on his

face. He carefully poured the batter into the pan that his mother held. While the brownies baked the two of them sat at the kitchen table and drew pictures together. Wayne was now able to use his mother's firm structure and playful engagement to regulate himself so that he could attend and focus during activities that they both enjoyed. His mother had learned many skills that she used to help Wayne calm and regulate himself throughout his day.

THERAPLAY IN PRACTICE

Helping a Child with ADHD

Many children who are diagnosed with ADHD have significant problems with regulating their responses to sensory stimuli. Because eight-year-old Brian can't seem to sit still, his father jokingly asks him "What's the matter? You got ants in your pants?" He wiggles and squirms at the kitchen table. He can only read a page of his homework before he stands up and tosses his foam basketball into its hoop. He's the star player on his soccer team and enjoys hiking and camping with his family. At school, however, he can't focus on his assignments. By the third grade, the expectations are increasing both at home and at school. He often becomes frustrated and even, at times, lashes out aggressively at his younger sister and his friends. His parents don't understand why he can't do things they see his peers doing. His father, especially, is increasingly frustrated and angry. A year ago, Brian was diagnosed with ADHD. He participates in "special education" at school and the guidance counselor recently referred his parents to Theraplay therapist Doug. Doug explained to Brian's parents that like the sensory seeking/impulsive diagnosis used with younger children, ADHD can also be understood as a disorder of regulation. He told them that the goal of Theraplay with Brian was for his parents to use their attachment relationship

with Brian to help him become better regulated. He talked with them about the "Regulatory Rollercoaster" during sessions, carefully interspersing active but structured play with quiet, calming activities.

The fifth session begins with Doug greeting Brian and his father at the door and challenging Brian to "See if you can walk to the beanbag chair in only five giant steps!" Brian grins up at Doug, then immediately lunges across the room in the requisite five steps. He turns and plops into the beanbag chair with Doug close behind him. Doug exclaims, "Way to go, buddy. Give me five!" Brian gives Doug a vigorous high five. Doug checks out Brian's muscles, firmly squeezing his arms and legs, then telling Brian to "squeeze my hands as hard as you can! Man, that's really strong. I wonder if you can push me over!" Doug kneels in front of Brian and shows him where to put his hands on Doug's shoulders. Doug then tells him, "When I count to three, you push on my shoulders as hard as you can. See if you can push me over. One, two, three!" Brian pushes hard on Doug's shoulders and Doug rocks back, falling onto the floor. "Wow, that was strong!" Doug reaches his hands toward Brian, "Now pull me back up, buddy!" Brian pulls on Doug's hands, bringing Doug back to a sitting position. Doug pulls a cotton ball out of his pocket and tells Brian to sit back in the beanbag and close his eyes. Once seated, he tells Brian, "I'm going to touch you with the cotton ball and you tell me where I touched you." He touches Brian on his hand; Brian exclaims, "My hand!" Doug invites Brian's father to touch Brian with a cotton ball, too. They take turns touching various body parts for several minutes before returning to more active play with "Mother, May I," which Doug has renamed, "Father, May I!" "Father says, hop four times" "Father, may I?" "Yes, you may!" Doug explains to Brian's father how to combine the Theraplay dimensions of structure and challenge to keep Brian engaged in play.

Over the coming weeks, Brian's father begins to understand his son's challenging behaviors in the framework of self-regulation and begins to develop a new repertoire of

Theraplay-based skills to help his son. Brian responds to his father's increasing ability to structure activities using a playful approach at home as well as during Theraplay. Near the end of their work together Doug reflects to Brian and his father, "You know what the best part of this is? I really love to see how much fun you two are having together these days!"

During the first few months, infants begin to develop two essential skills for life—the ability to participate in close attachment relationships, and the ability to self-regulate responses to sensory and emotional stimuli. These two skills are intricately connected and develop simultaneously. Unfortunately some children do not adequately develop the ability to self-regulate, either because of innate characteristics or because of inadequate or aversive experiences during those early months. Those children are likely to develop disorders of regulation, exhibiting behaviors that indicate that they are hypersensitive, hyposensitive, or sensory seeking/impulsive. Assessment and treatment approaches might include an occupational therapist with expertise in Sensory Processing Disorder. Theraplay provides a wonderful opportunity for parents to help their children become better regulated within the context of the close attachment relationship with their parents. The children reexperience their parents using structure, engagement, nurture, and challenge in ways that help them regulate their responses to sensory and emotional stimuli.

Notes

1. In the ICDL-DMIC (Interdisciplinary Council on Developmental and Learning Disorders Diagnostic Manual for Infancy and Early Childhood) they are called the Functional Emotional Developmental Capacities.
2. Difficulties regulating sensory processing are also known by a variety of terms including Sensory Processing Disorder, Regulation Disorder of Sensory Processing, or Regulatory-Sensory Processing Disorders.
3. An effective diagnostic tool is the TABS, the Temperament and Atypical Behavior Scale (Neisworth et al., 1999), a reliable and valid, norm-referenced, individually administered measure of dysfunctional behavior appropriately used with infants and young children between the

ages of eleven and seventy-one months. TABS provides quantitative data on the frequency or extent of atypical behavior in four subcategories: detached, hypersensitive-active, underregulated, and dysregulated as well as an overall Temperament and Regulatory Index. The tool can be completed by parents in about ten minutes and scored quickly by the clinician. *Pediatric Disorders of Regulation in Affect and Behavior* (2000) by Georgia DeGangi has three useful assessment tools to investigate a child's regulatory problems and development: the Infant-Toddler Symptom Checklist by Georgia DeGangi and Susan Poisson; the Functional Emotional Assessment Scale by Stanley Greenspan and Georgia DeGangi; and Sensorimotor History Questionnaire for Preschoolers by Georgia DeGangi and Lynn A. Balzer-Martin. Western Psychological Services has a variety of tools available to assess sensory integration dysfunction.

CHAPTER EIGHT

Theraplay for Children with Autism Spectrum Disorders

Sandra Lindaman
Phyllis B. Booth

As an example of our work with children with autism, we revisit Becky, described in Chapter Two. We have added comments about our treatment goals and follow-up comments by her mother.

Becky, a three-year-old recently diagnosed with autism, participated with her father and mother in an MIM. Becky had only fleeting interpersonal contact, had no language and, from time to time, displayed repetitive movements. On the task, "Play Patty-Cake with the child," her father, Ned, took her hands in his and rhythmically moved them to the words of the song. Becky looked at him during the first verse, but she flopped onto her back and her gaze drifted up to the ceiling lights. Ned followed her gaze and asked, "What are you looking at honey?" When he released Becky's hands, she moved away from him. He looked disappointed. "Not interested in Patty-Cake, huh?" he said. Later in an interview, he described Becky as a "phantom" in their home, someone who constantly was slipping away from interaction with her parents.

Over six months of weekly treatment her therapist, Sharon, found playful, physical, interactive ways to engage Becky and then prolong

that engagement through turn taking. Sitting across from Becky on the floor, she put Becky's feet on her chest and encouraged Becky to push her over on the count of three, and then pull Sharon up with her hands to see Sharon's smiling face. In this way the therapist set up a regulating rhythm and helped Becky experience the coordination of movement, sensation, and affect. She pressed the tip of Becky's nose and made a "beep" sound and encouraged Becky to reach out to touch her therapist's nose to hear the beep. Becky began to understand Sharon's intention and leaned forward when Sharon wiggled her index finger near her nose. Sharon caught a bubble on the wand and held it in front of Becky for her to pop with her finger. When Becky became a bit upset at the sensation of wetness on her finger, Sharon quickly acknowledged her discomfort and wiped it off. At first Becky did these activities in a rote manner without expression. Within a few sessions, Becky was smiling in response to her therapist's smiles and animated facial expressions. Her emotional communication grew dramatically. Becky began to fill in words in the phrase, "Ready, set, go!" and press Sharon's nose longer for a drawn-out "BEEEEEP." Becky began to imitate the actions of Peek-a-Boo and even tease her therapist by pausing in a series of peeks. She enjoyed the silliness of making loud and soft cheek-popping sounds. After twenty sessions, Becky made more consistent eye contact, requested games by initiating them, sang along to "The Wheels on the Bus," independently recalling words of the song. With the foundations of relating and communicating supported, Becky progressed to using language. After thirty sessions Becky was enrolled in a specialized preschool program and sessions ended. By this time her parents were confidently using the Theraplay techniques in their daily interaction with her at home. They now could coordinate their interactions with Becky to achieve a more satisfying relationship.

Ten years later, her mother viewed a videotape of a Theraplay session and reflected on that early period, writing:

> I had forgotten how earnestly her father and I always tried to interact with her and how odd and unresponsive to us she was. I remember just wanting her to look at me, wondering if she would ever call me, "Mommy," longing to really know her. . . . When we first brought Becky to The Theraplay Institute, she certainly seemed very much like a phantom—one who was physically present, but psychologically

> elsewhere . . . and slipping further and further away from us. I honestly felt like we were losing her.
>
> Ordinary babies and toddlers delight in interacting with other human beings. Becky not only had to be taught how to interact, she had to discover that it was a highly enjoyable thing to do. Theraplay did that for her. In addition, the "turn taking" involved in Theraplay laid a concrete foundation for Becky to be able to learn to engage in conversation.
>
> What is she like now? Her psychiatrist says she is one of the "highest functioning," yet truly autistic (not Asperger's Syndrome), people he has ever met. She has long conversations with me and tells me about her day. She introduces herself to people. She has friends and gets invited to parties. She reads and does math at about a second or third grade level. . . . She has a terrific sense of humor. She is adaptable to changes in her schedule. And, I know her. I truly know her like I never thought possible. She is the joy of my life and has taught me much more than I will ever teach her.

Autism is a disorder that negatively affects the processes that form the basis of the capacity to engage with others and participate in relationships. Because Theraplay treatment focuses on establishing the basic ability to engage, relate, and communicate, it is ideally suited to help the child with autism. We engage children in playful, positive social interaction in order to help them form relationships within their families and within social groups.

In the 1950s, Austin DesLauriers, a psychologist working in Chicago, developed a treatment for autism that supplied the early theory and format for what later became known as Theraplay. At a time when impoverished maternal care was assumed by many to be the cause of autism, DesLauriers theorized that autism was a neurological disorder that interfered with the child's ability to connect with others. Although he recognized the positive findings of behavioral therapists, such as Lovaas, for improving the skills of a child with autism, he believed that treatment must focus on increasing the child's social and emotional connection with others. His response was a therapy that minimized play with toys but maximized the gentle, persistent intrusion into the autistic child's private world to promote emotional engagement and social responsiveness. In the 1960s he made an effort to evaluate his new method using a multiple case study approach, the results of which were published in his book, *Your Child*

Is Asleep—Early Infantile Autism: Etiology, Treatment and Parental Influence (DesLauriers and Carlson, 1969). Ann Jernberg worked closely with DesLauriers on this and other projects, all focused on mother-child interaction. As we describe in the Introduction to this book, Jernberg incorporated elements from DesLauriers' relationship-based approach to provide treatment for children in the Head Start program. Soon after Theraplay was developed, The Theraplay Institute became actively involved in treatment of children with autism within a special program sponsored by the speech and language department at Elmhurst College in Illinois. As you will see in this chapter, Theraplay is being used internationally with children with autism.

Autism is now understood to be a neurodevelopmental disorder. Magnetic resonance imaging has made it possible to learn more about the brain function of children and adults with autism. In a summary of the new information about the neurobiology of autism, Diane Williams (2008, p. 11) says, "Autism is characterized by early brain overgrowth and alterations in gray and white matter. Functional imaging studies suggest that individuals with autism have reduced synchronization between key brain areas for different cognitive tasks. Processing connections within brain regions may be too strong. Understanding of these findings can lead to the design of interventions that accommodate the way the brains of children with autism function and may lead to the promotion of more flexible thinking and learning." In this chapter we make use of a variety of new findings about the neurobiology of autism to explain how we adapt Theraplay to meet the needs of the child with Autism Spectrum Disorder.

DEFINING AUTISM SPECTRUM DISORDERS

Autism spectrum disorders, also known as pervasive developmental disorders, are described in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (2000, p. 69) as "characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests and activities. The qualitative impairments that define these conditions are distinctly deviant relative to the individual's developmental level or mental age." These disorders range from a severe form called Autistic Disorder, through Pervasive Developmental

Disorder-Not Otherwise Specified (PDD-NOS), to a milder form, Asperger's Disorder. They also include two rare disorders, Rett's Disorder and Childhood Disintegrative Disorder. In this chapter we will follow current usage, which favors the term *Autism Spectrum Disorder* (ASD) to cover the whole range of differences, special abilities, and challenges.

UNDERSTANDING THE UNDERLYING PROBLEMS OF AUTISM

Recent research has given us insight into the neurological bases of autism. The behavioral and adaptive symptoms stemming from these neurological difficulties are the focus of Theraplay treatment. The following neurological problems, the resulting difficulties, and treatment goals are described in this chapter:

- A deficit in sensory-affect-motor connections

  Result: Child unable to get into regulation, rhythm, resonance, and synchrony with another

  Treatment goal: Establishing basic patterns of regulating and coordinating sensations, emotions, and movement

- A deficit in mirror neuron function

  Result: Child unable to read intentions of another

  Treatment goal: Reading and responding to nonverbal and verbal cues about other's intentions

- Difficulties in communicating, beginning with emotional signaling through complex strings of signals and language

  Result: Child unable to reliably communicate feelings, thoughts, and wants

  Treatment goal: Communicating feelings and thoughts to another

- May have additional processing deficits in the areas of motor planning, auditory and visual-spatial abilities, and sensory modulation

  Result: Child may not receive and process information in the typical manner and may be hypo- or hyperreactive to sensory information

Treatment goal: Establishing engagement with optimal sensory arousal

- These deficits affect the earliest, foundational aspects of interaction

  Result: Problems accumulate, leading to downstream effects; child unable to use symbols to express self or to use thinking and reasoning skills

  Treatment goal: Establishing basic patterns of attention, regulation, and relating that support higher-level functions

- The above challenges make it more difficult for parents to establish synchrony, consistency, and co-regulation in interactions with their child and therefore they are less rewarded in their efforts to connect

  Result: Caregivers' rhythm, timing, and consistency of interactions may be affected, resulting in additional social withdrawal on child's part

  Treatment goal: Guiding caregivers to get into synchrony with their child and to be able to use Theraplay principles of interaction independently

In the following section we expand on the research behind these neurological problems and their effects on relationship.

Deficit in Sensory-Affect-Motor Connections

Greenspan and Wieder (2006a, p. 397) propose a model in which a genetic predisposition, perhaps of several different types, interacts with later risk factors and challenges. This genetic predisposition leads to a biologically based processing deficit in the "ability to connect emotions or intent to motor planning and sequencing and to sensation and, later, to emerging symbols, making the inability to make this connection the core psychological deficit of autism."

The growing consensus that autism is a "disorder of connection" or coordination is supported by MRI studies of the brains of infants (younger siblings of children with autism, for example) later diagnosed as autistic (Williams, 2008). They demonstrate that there is reduced synchronization between various key brain regions.

This leads to an impaired ability to integrate information between various areas of the brain and accounts for the basic difficulty in co-regulation and connection. This underconnectivity makes it hard to process information quickly, to integrate difficult processing tasks, and to reorganize the processing networks flexibly.

Wilson-Gamble (2006, p. 4) expands the idea of a mental coordination deficit to describe the resulting difficulties.

> Examples of physical, psychological or relational *dis*-coordination include: the inability to do various things the child has to do at the same time, . . . the inability to organize body rhythms and temporal synchronicities to mutually co-regulate dyadic interactions (e.g., turn taking; shared emotions; shared meanings; understanding other's actions, intentions, goals; postural adjustment; joint focus). In addition, . . . autism interferes with the performance of the cingulate cortex of the brain, which plays an important role in coordinating quick attentional shifts, cognitive control, executive functions, emotional expression, evaluative processes, body movements, some autonomic functions, relaying information between areas of the brain, developing a "self-other" distinction, and allowing flexibility in neural transmissions.

A very recent finding that may help explain this relational discoordination is reported by Klin and others (2009). Two-year-olds with autism failed to attend to biological motion and instead attended to nonsocial actions. Typically developing infants, in contrast, prefer to attend to biological motion and to disregard nonsocial actions. The brain regions responsible for the perception of this motion are related to those involved in the basic social signals of facial expression and gaze direction and are thought to be related to the development of the ability to understand the intentions of others. The authors consider the possibility that the perception of biological motion may be altered in children with autism from a young age and contribute to the downstream consequences of impaired social development and social interaction.

A Deficit of Mirror Neuron Function

A further analysis of the failure of connection or coordination in the autistic child is provided by Fillipo Muratori's work on the role

of mirror neurons (2008). As we noted in Chapter Two, mirror neurons fire both when a goal-directed action is performed and when another person is observed performing the action. Muratori calls this an observation-execution system. When the system doesn't function properly, as is the case with infants with autism, they are less able to reproduce oral and facial movements. They cannot imitate an intentional action and they have difficulty anticipating the intentions of others' actions. Infants normally learn to anticipate by mentally coordinating others' intentions with their own intentions and by doing so, they generate a special quality of familiarity with other individuals. This capacity is lacking in many infants with autism.

Difficulties in Communicating

Innumerable difficulties arise from the basic disorder of coordination or connection. These include an inability to interact using emotional signals, gestures, and vocalizations as well as difficulty in maintaining interactions in order to engage in social problem solving and to create emotionally meaningful ideas.

Deficits in the Areas of Motor Planning, Auditory and Visual-Spatial Abilities, and Sensory Modulation

Although the basic difficulty with social relatedness and communication is common to the whole spectrum, each child may have a unique combination of other processing and regulatory difficulties, including motor planning, visual-spatial and auditory perception, and sensory modulation. Greenspan and Wieder (2006a) point out that these biologically based regulatory difficulties contribute to, but are not decisive in determining, the child's relationship and communication difficulties. In Chapter Seven we described various kinds of regulation disorders and how Theraplay can be used to treat them. Because children with autism may have some of these same regulation disorders, much of that discussion is applicable to our work with children with ASD.

Downstream Effects of Early Difficulties in Connecting, Regulating, and Relating

The core neurological deficit of synchronization, noted earlier, interferes with the development of connection, co-regulation, and relatedness and leads to a complex set of resulting downstream problems. As Greenspan and Wieder (2006a, pp. 396–397) point out, the following essential abilities of a fully functioning, mature individual become unavailable to the person with autism: empathy and seeing the world from another person's perspective (theory of mind); higher-level abstract thinking; joint attention, including social referencing and problem solving; emotional reciprocity; and functional language. Intervention at the earliest possible time, focusing on the development of the basic skills of connecting, regulating, and relating, has the best chance of providing a foundation on which these higher-level skills can develop.

Difficulty Establishing Synchrony and Consistency in Interactions

All of these difficulties interfere with the development of the smooth regulation and rhythmic coordination of typical parent-child interaction, leading to serious problems for the child's development as well as disappointment and erratic responses on the part of the parents. Wilson-Gamble (2006, p. 4), reporting on an international conference on Signs of Autism in Infants, says

> Home video studies show that when smooth mutual-regulation and rhythmic coordination of a typical parent/child interaction is missing, parents do not receive the reinforcement for the elements of their social interaction and their natural rhythm and synchronicity of interactions are affected. Unconsciously as they attempt to adapt to their child, the parents' interactions become irregular, insistent and/or physical resulting in them missing shared moments with their child. As a result of these natural parental adaptations, the parents inconsistently respond to the social initiations the child does make or do not encourage social interaction, which adds to the child's progressive social withdrawal.

UNDERSTANDING THE RELATIONSHIP BETWEEN THE PROBLEMS OF AUTISM AND THERAPLAY'S TREATMENT GOALS AND DIMENSIONS

The preceding analysis of the neurological bases of autism and of the resulting behavioral and relationship problems indicates the direction that treatment should take. Theraplay's relationship-based model is uniquely suited to the treatment of children with autism because it works directly at the level where the major difficulties lie. We now return to describe the treatment goals associated with each of the points above and the dimensions that best address each issue:

- *Establishing basic patterns of coordinating and co-regulating sensations, emotions, and movement.* In Theraplay we initiate carefully regulated interactions that are specifically designed to engage the child directly in a meaningful and reciprocal relationship, establishing basic coordinated patterns of give-and-take and the beginning of affective connection. The Theraplay dimension of structure helps the child become regulated and guides his participation in organized sequences of joint activity.
- *Reading and responding to nonverbal and verbal cues about intentions.* The Theraplay therapist carefully observes and responds to the child's cues and slightly exaggerates her own cues to make them noticeable and clear, so that the child can begin to understand the intentions of others. The Theraplay dimension of engagement creates multiple opportunities for the child to read cues and respond.
- *Communicating feelings and thoughts.* Also ideally suited to the needs of the child with autism is the fact that Theraplay does not depend on language; it concentrates instead on the precursors of language: give-and-take and completion of meaningful exchanges of interaction. Although we do not work directly on language development, it is not unusual for a child with autism to begin speaking in Theraplay sessions and to become more successful in communicating thoughts and feelings nonverbally and verbally to others. The Theraplay dimension of engagement can be the platform for building the child's ability to communicate

simple and gradually more complex messages about feelings and thoughts.

- *Establishing engagement with optimal sensory arousal.* We attend very closely to the child's level of arousal and carefully modulate our interactions; the therapist strives for the proper balance of sensory arousal and engagement. Because Theraplay is multisensory, it provides many opportunities to achieve optimal sensory arousal. The dimension of nurture contains activities that provide soothing sensory experiences; the playful active games of structure, engagement, and challenge address proprioceptive and vestibular needs.
- *Establishing the abilities to attend, regulate, and relate that support higher-level functions.* Because Theraplay's focus is on the early developing skills of attending, regulating, and relating, it builds the foundation for higher-level communication and thinking. The Theraplay dimensions of structure, engagement, and nurture provide the basic foundation to enhance the child's ability to relate; challenge can develop more complex skills at the proper time.
- *Helping caregivers to achieve the synchrony, rhythmic coordination, and joyful engagement with their child that will be rewarding to them all.* Improved parent-child relatedness is always the ultimate Theraplay treatment goal; we guide parents to understand and use all the Theraplay dimensions on their own in their daily life with their child.

The Importance of Early Intervention

The pervasiveness of the challenges to the early development of a baby with autism makes it clear that early assessment and intervention are crucial. This is particularly important because the period from twelve to twenty-four months, when many children with autism seem to withdraw, is normally the time for learning social skills such as reciprocal gesturing and the "rules" of complex social interactions. The hope is that, by identifying the difficulty early and basing treatment on an understanding of the basic relational and coordination difficulties faced by a child with autism, interventions can be designed to prevent the downstream cumulative effects of this brain-based

neurological problem. This is not to say, however, that treatment begun at a later age cannot be successful.

It is our experience that children treated with Theraplay, at whatever age the treatment is begun, become more aware and attentive, more socially interactive, and much warmer and more joyful. A great body of anecdotal evidence is available that supports Theraplay's effectiveness with this population; some of this evidence is detailed in the case examples in this chapter. In addition, a small number of research studies have been carried out that document the effectiveness of Theraplay in treating children with autism; these are described in Chapter Three. The preliminary results of a study of Group Theraplay for children with autism are described later in this chapter.

Assessing the Needs of the Child with Autism

Because each child with autism has his own unique profile, the success of treatment will depend on knowing the child's particular strengths and sensitivities. If the child has not had a formal diagnosis of ASD, we refer the child for a comprehensive evaluation at a center that specializes in the diagnosis of autism. We also make referrals for occupational therapy, speech-language therapy, educational placement, and special services as needed. In addition, we make use of the typical Theraplay assessment process, which consists of taking a detailed history from the parents, reviewing all past reports, and videotaping and evaluating the MIM. See Chapter Four for a detailed description of the Theraplay assessment process. Through this process we begin to understand the child's unique sensitivities, the types and degree of stimulation that will be tolerable to the child. Once we begin treatment, we learn even more about how the child responds to various activities and can fine-tune the repertoire of playful activities that will increase his tolerance for stimulation and encourage him to persevere in social interaction. Although children with autism may differ in the extent, degree, and severity to which they exhibit their difficulties in various areas, the treatment principles we describe here are applicable for all children.

SUPPORTING PARENTAL INVOLVEMENT

An important aspect of Theraplay's success with children with ASD lies in the area of parental involvement. As we have said, parents' efforts to engage their child often go unrewarded. Therefore, any

treatment that hopes to improve the relationship capacities of the child with ASD must include parents in order to help them find ways to interact in a rewarding manner.

In the past, there has been an assumption that the relationship difficulties of children with autism might interfere with their ability to develop attachments, but a series of studies in the 1980s challenged this assumption. Using the Ainsworth Strange Situation Protocol to determine attachment category, researchers found not only that they do form attachments, but also that nearly half of the children form secure attachments. Following up on these findings, Oppenheim and his colleagues (2008, p. 25) found that "maternal insightfulness" was a crucial factor in the development of a secure attachment in children with ASD: "Within the constraints imposed by their disability, secure attachments may help children with ASD maximize their developmental potential, similar to the role of secure attachments in typically developing children."

Oppenheim et al. (2008, p. 25) define insightfulness as "the capacity to think about the motives that underlie their child's behavior, to be open to new and unexpected behaviors of the child, to show acceptance of the child's challenging behaviors, and to see the child in a multidimensional way." Insightfulness, as they define it is thus very similar to the concept of reflective function, one of the core concepts of Theraplay that we describe in Chapter Two.

A secure attachment relationship is both the outcome of healthy parent-child interaction and the key to long-term mental health. Such a relationship is just as important in helping the child with autism achieve his developmental potential as it is with typically developing children. Our goal when working with parents is to help them become aware of their child's unique strengths, styles of learning, and special needs so that they will be better equipped to persevere in the relationship and facilitate overall interaction and development.

Parents of children with ASD, however, face two problems that make it more difficult to respond in the sensitive, reflective ways that make it possible to connect with their child:

- They must come to terms with their sense of loss at having a child who is not the responsive child that they had dreamed of.
- They must find ways to respond to a child who cannot respond readily to their overtures, who is often overwhelmed by stimuli

that would be comforting to most children, and who drifts away or resists their efforts to get close.

For these reasons, we must double our efforts to develop a sensitive, supportive relationship with parents in order to help them interact in a productive, fulfilling manner with their child. The case studies included in this chapter clearly illustrate the profound differences in sustainable progress that can be achieved based on parental awareness, understanding, involvement, and sense of competency.

Helping Parents Deal with Their Sense of Loss[1]

Many terms have been used to describe the process that parents must go through as they adjust to the reality of having a child who does not develop in the expected, typical manner. They have lost the child of their dreams and must come to terms with that loss. This coming to terms can be thought of as completing the grieving process, as achieving a "resolved state" (Oppenheim et al., 2007, 2008), as reorganizing their inner working model of themselves and their child, or as reorienting to the reality of the situation. Whatever the term used, the process is a necessary and important step for parents. We prefer the term *reorienting* because it sensitively and positively expresses the perceptual changes that parents must make in their understandings and expectations for their child. Until they have made some progress with this very difficult task, they will not be able to see the child for who he really is, separate from their own parenting needs.

In order to respond appropriately to parents' needs, it is important to assess where they are at that moment in the process of reorienting. Even though they have worried all along that their child is not developing in a typical manner, when they actually receive a diagnosis they are likely to feel an upsurge of distress. The literature in this field describes a sequence of emotional stages that parents go through on the road to accepting the diagnosis and the consequent reality for the child: shock, denial, blame, anger, guilt, acceptance, and action. However, in our experience, all of these stages may be experienced simultaneously or revisited at one time or another when specific life cycle events occur, such as birthdays, the first day of school, first communion, or bar mitzvah.[2] The parent's stage of reorientation

will determine how she interacts with her child at any one moment. Many factors affect parents' responses, including the specific nature and extent of the child's developmental difference; parental maturity and knowledge; the family attitude, culture, understanding, and support; and community attitude and support.

During this painful process of reorienting, it is essential that you listen to, attune to, and support parents in their struggle. At the same time, you should be aware of your own reaction to the parent's feelings that may stir up your personal experiences of loss. On the one hand, you may find that it is hard to respond to the parents' recurring bouts of grief and may find yourself pushing too soon to "cheer them up." On the other hand, when parents are in a period of denial, you may be tempted to try to get them to "face reality." Bearing the brunt of their anger may make you angry in return; it is important, therefore, not to take their anger personally. It is equally important neither to get swept up in their sadness nor to distance yourself so much that you can't be helpful. Even as you accept their sadness and their need to face the reality of what they fear may be the limitations of their child's future you must also convey a sense of hope—that it is always possible to build on the child's strengths.

At the same time that they are struggling to reorient to the reality of their situation, parents are faced with many new sources of stress. The diagnosis brings with it a busy schedule of therapy appointments that may tax parents who must also hold down a job, manage a home, and take care of their other children. Many parents feel guilt at the amount of time taken from their other children. Day care options for children with ASD are limited and often it is hard to find housing that is safe for such a child. Just when parents need help the most, members of the extended family may withdraw because they don't know how to cope with the needs of the child. In some cultures, having a child that is not developing in a typical way can be a source of shame leading to ostracism of the family. And finally, parents have a constant struggle to find funding for the many special treatments and school programs that their child needs. Given all the stressors that parents of children with ASD face, it is essential that you give them as much emotional support as possible. When we describe the guidelines for working with parents, we will return to this need to be emotionally supportive at all times.

Helping Parents Respond to Their Child's Signals and Special Needs

If parents are to provide the attuned, synchronous interaction that is the basis for social development, they must fully understand the child's ways of coping and responding, monitor their own reaction to their child who does not respond in a typical manner, and establish an interaction style that meets the ever-changing needs of their child with ASD. For these reasons we include parents directly in Theraplay in order to help them understand the nature of the child's difficulties that create barriers to social and emotional communication. We help parents learn how to accommodate to their child's unique sensory differences and special requirements as well as how to help their child regulate. We provide opportunities for them to have successful interactions with their child through guided, hands-on opportunities to read and respond to their child's signals. Theraplay provides parents with enjoyable, motivating ways to engage their child in positive interactions that benefit them and their child. Feeling successful and enjoying more satisfying interactions with their child can help them achieve a satisfying reorientation to their child's situation.

The following is a list of the benefits of including parents in sessions:

- All approaches to treatment stress the importance of increasing the amount of time that is spent engaging the child in meaningful interaction. When parents are part of the treatment, they can carry on the successful interactions with the child at home. This has the added benefit that the child can generalize from the treatment setting to the home.
- Because ASD involves difficulty in forming relationships, the obvious focus of treatment for the child should be on developing relationship skills. The best way to work on these is to do it the way a baby does, with the person who is most important to him.
- When parents are in sessions, the child benefits from the calming, reassuring presence of her familiar parent.
- Experiencing the playful, engaging interaction of Theraplay helps parents shift from a serious focus on remedial treatments to a lighter, more playful approach that engages the child and leads to more satisfying interactions.

Guidelines for Working with Parents of Children with ASD

The following guidelines for working with parents of children with ASD are adapted from Karyn Searcy et al. (2008).

FORMING A COLLABORATIVE RELATIONSHIP

- Make the process a truly collaborative one. Parents need to share in establishing the goals of treatment and in understanding how the interaction will lead to those goals.
- Respect parents' opinions and beliefs about their child. They have spent years with their child and know him well. In addition, many parents have spent a great deal of time and energy learning about ASD and have, therefore, become "experts" about it.
- Explain in simple language what you are doing, the goal you have in mind with each activity, the process, and techniques.
- Be sensitive to the impact of words like "mental retardation," "disability," "special education."
- As we have said, always be aware of parents' need for emotional support.

HELPING PARENTS SEE THEIR CHILD'S UNIQUE QUALITIES

- Help parents take a new look at their child to discover what his strengths are, what he responds to best, in what situations he shuts down, and how to respond best to his needs.
- Use videotaped examples from sessions to explore together what captures his interest, what makes him anxious, and what is hard for him.

ACTIVELY GUIDING PARENTS IN SESSIONS

- Build the parent's sense of competence and confidence in themselves and in their interaction with their child.
- Be careful not to "outshine" parents but work together as a team to discover what is successful.
- Help parents to see that they are not alone in finding it difficult to connect with their child. Point out your own errors with their child in the moment; for example, "Uh-oh, I just pushed a little too far that time, Mom. Let me try that again."

- Help parents recognize signs of their child's dysregulation and find ways to calm the child.
- Help parents recognize the importance of small steps of progress, such as the child's turning to the parent to share a response or the decreasing length of meltdowns.
- Learn what will bring some joy to the parents in the interaction; help them recognize and experience that joy so that they become invested in building on it.
- Adjust sessions to the mood of the child—some days she may be more agitated and dysregulated than others—as well as the mood of the parent. Be aware of stressors that make it difficult for a parent to be hopeful and engaged.

Increasing the Amount of Time Parents Spend Engaging Their Child

In all of our work we emphasize the value of having parents carry on the Theraplay approach at home; this is absolutely essential for the child with autism, who often shuts down when he is not actively engaged.[3] Home is the natural environment that provides a multitude of opportunities for engagement through play activities. It also helps the child transfer skills learned in Theraplay sessions and to consolidate skills in relating to others. Preparing for bed, taking a bath, cooking, and eating are all regular times in a child's day when parents can engage with, nurture, and challenge their child by playing and enjoying their time together. We have found consistent, active, authentic parental involvement to be an important factor in achieving good outcomes with children with ASD. The following case study demonstrates this point.

THERAPLAY IN PRACTICE

Using Theraplay at Home

Zeke, a six-year-old boy diagnosed with PDD-NOS, began Theraplay treatment with Dr. S. Once the sessions had settled into a routine, the parents began to bring Theraplay strategies

home (Bundy-Myrow, 2005), first incorporating calming, nurturing activities into the morning and nighttime routines. Using a pattern they had learned in sessions, they would "greet, meet, and complete" their routines. "Greet" meant that Mom or Dad would physically go to Zeke rather than calling out to him. "Meet" meant that Mom would adjust her actions, tone of voice, volume, and timing to ensure Zeke's attention. For example, Zeke was slow to rouse in the morning so Mom slowly "discovered" her boy as she rubbed his arms and back with long, firm strokes. To "complete" their routines, they used a playful "island-hopping" game they had learned during a Theraplay parent-coaching session. Because Zeke had associated the "pillow islands" with playful, warm engagement, he liked the idea of moving from the "bed island" to "bathroom island" to the "breakfast island." Each hop included the signal, "Ready, set, go" and squeeze-hugs at each island landing.

Two areas remained difficult for Zeke and his parents to manage: transitions and unstructured time outside of the home. Zeke could not yet independently recognize his own physiological cues or accurately read the social cues of others, nor could he implement strategies learned in a different context. During Theraplay sessions Zeke had responded in a calm, positive manner to the use of cocoa butter lotion and had spontaneously associated it with a happy experience at the beach. Using this association, Dr. S. and Zeke developed a strategy he could use wherever he went. The cocoa butter lotion became a regular part of Zeke's Checkups. He especially liked Dr. S. to rub it on his wrist, elbows, and neck so Mom could find and kiss the lotioned part when she entered the room. Zeke then practiced a relaxation sequence of taking a big smell of the lotion on his wrist, criss-crossing arms and legs as he tensed and squeezed his muscles, followed by relaxing like his floppy dog at home. He practiced this sequence of smell, squeeze, and relax in different activities: for example, in a game of "levitation," lying in the blanket with Mom and Dad raising him up off the ground when he made his body stiff;

practicing waiting under the beanbag for Mom to find him; and to show his "ready position" in anticipation of a verbal or visual cue to "Go!" This lotion sequence was called "the beach" and the secret signal was to raise wrist to nose to "smell." Mom, Dad, or Zeke could start the sequence to indicate, "Let's play beach!" Mom began carrying a small ziplock bag of lotioned cotton balls in her purse. The family practiced this activity in the restaurant, before church, and riding in the car. The parents became proficient at anticipating and responding to Zeke's needs. He asked to carry his own cotton balls and proudly told Mom he "played beach" on the bus!

Throughout this chapter we give examples of how we involve parents in the work with their child. In the next section we address the specific dimensions of Theraplay and how we help parents make use of them in interacting with their child.

USING THE THERAPLAY DIMENSIONS TO MEET THE CHILD'S NEEDS

The following descriptions and case studies illustrate how the four Theraplay dimensions are used and adapted to meet the unique needs of individual children with autism. A chart illustrates the role and actions of the therapist and parent and the desired effect on the child for each dimension.

Structure

For children with autism the dimension of structure is especially important. This is not only because it provides a sense of safety and predictability for the child, but also because it allows you to keep the child with you physically and emotionally. You must set the stage for the action to unfold and then sensitively interact, based on the child's response (see Table 8.1).

PLAY SPACE AND POSITIONING. The simple, comfortable play space that we use in Theraplay is especially helpful for children with autism to create safety, predictability, optimization of sensory input, and

STRUCTURE	
Therapist or Parent Role	**Desired Effect on Child**
Arrange space and positioning for maximum comfort and impact on the child.	Child is able to focus without distraction.
Assist child in achieving optimal sensory arousal.	Child is not over or understimulated.
Lead child through a variety of simple, organized, interactive playful sequences.	Child is intrigued and enticed into participating in simple play sequences. Child is regulated-organized by the adult's regulation-organization. Child begins to follow another person's lead.
Develop ability to prolong interaction.	Child can stick with an interaction for longer periods of time, more turns.
Develop ability to transition between activities.	Child moves from one activity to another calmly and with positive affect.

Table 8.1. The Essence of Theraplay for Children with ASD: Structure

reduction of distraction so that the child is free to focus on the interaction. We typically sit on mats on the floor with a designated seat made from pillows or a beanbag chair, arranged against a wall for support. The therapist or parent sits directly across from the child or sometimes holds the child on her lap. If we stand up for an activity, we return to this seat. Because some children with autism may avoid interaction by wandering away or actively leaving the scene, it is very important that you find ways to keep the child physically with you. The firm pressure of holding a child on your lap (or having her sit in her parent's lap), propping her on pillows, or snuggling her into a beanbag chair will help her feel organized and give her a sense of security. Some children enjoy being rolled up in a blanket before being placed in their parent's arms for rocking and feeding. Other children find laps too stimulating and do better in a beanbag chair. Simple containment helps to regulate and modulate the child's fragile sensory nervous system. This focus on helping the child feel safe and comfortable in the relationship makes it possible for him to respond calmly and become more emotionally alive and spontaneous.

CREATING OPTIMAL AROUSAL. Healthy development and learning requires the very kinds of physical contact and playful interaction that children with autism often find too stimulating and anxiety provoking. The challenge for treatment, therefore, is to determine

what sensory modalities to use as well as how and when to use them. It is also important to determine the right level of arousal to engage the child effectively without creating an overwhelming and aversive experience that could either lead him to withdraw (in a flight or freeze response) or to react in a physically aggressive manner (in a fight response). This is crucial; if the child feels the need to withdraw, shut down, or fight to avoid feeling overwhelmed, she will continue to miss the essential opportunities for social, emotional, and cognitive learning that her condition has made unavailable to her. See Chapter Seven for details on regulatory principles and activities.

LEADING THE CHILD THROUGH PLAY SEQUENCES. The essence of structure is the guiding of the child through simple play sequences that organize and regulate him. In this way, the child gets into rhythm and begins to look to another person in anticipation of the pleasure of interaction. Because the Theraplay relationship is initiated and directed by the adult, its success is not dependent on the child's abilities. The adult can ensure that the activities build on the child's strengths and can support the child in achieving even higher-level responses. As the young child with autism often has difficulties with body awareness and motor planning or simply does not understand what is expected of him, it is useful to take his hand and help him execute the action. Hold his hands to play Patty-Cake, or nudge his arms to help him push you over. This guidance helps the child understand what it is that you expect and gives him the physical feeling and practice of doing the activity. Soon he will be able to initiate the action without help.

Because the child with ASD is often anxious when faced with a new activity that he does not fully understand, it can be tempting to back away from activities the child doesn't appear to like. You should not, however, permit him to "turn you off" or "tune you out." Much as he might appear pained by your insistence, you must persist, in order to help him to experience, in a safe setting, the carefully managed interactions that he so badly needs. For instance, seven-year-old Jeff was reluctant to go underneath the body of an adult forming a human tunnel. Rather than allowing him to back away, a co-therapist helped to guide Jeff through the tunnel. The third time he did this activity, Jeff moved with confidence through the tunnel and emerged at the end with a big smile on his face.

Songs and music are particularly compelling for children with autism. The familiarity and predictability of an oft-repeated favorite song gives the child many opportunities to remember the words and join in the gestures. Many familiar nursery rhymes and rhythmical finger plays are activities that work well to engage the child. It is helpful to pause so the child can insert a missing word or action into the nursery rhyme or song. Because many children with autism have delayed auditory processing abilities or poorly developed motor planning skills, they need long pauses and many repetitions in order to have sufficient opportunity to say the word or execute the action.

PROLONGING INTERACTIONS. Crucial to a good outcome is not merely initiating engagement, but also sustaining the child's attention and focus, gently preventing her from becoming distracted, withdrawing, or fleeing. Grandin (1995) in her account of her own experience as a child with autism, emphasizes how important it was to her development that her mother found ways to entice her out of her withdrawal, to engage her, and to help her learn.[4] Once you set up an activity, keep it going through more turns and repetitions; as treatment progresses, you can add variations and complexity to activities.

COPING WITH TRANSITIONS. Typically, children with autism are uneasy with change and become agitated and anxious when they do not understand what is happening or when things "move on" too fast. With an understanding of the child's difficulty in coordinating and processing bits of information, Theraplay can help her overcome this challenge. By gently and safely guiding the child through many transitions between playful activities, the therapist teaches her to handle transitions. By ensuring that there is plenty of repetition of familiar activities, and by providing the secure reassurance of a predictable structure for each session, the therapist creates the safety within which this lesson can be learned. An outline of the sequence of activities in pictures can be helpful for some children. A written schedule can be helpful for children who can read. Whatever the means of communication, the schedule helps the child to cope with and prepare for transitions from one activity to another and to accept the beginning and ending of sessions.

THERAPLAY IN PRACTICE

Using Structure to Regulate Play Sequences and Enhance Shared Attention and Focus

Cammie was a nine-year-old girl who was diagnosed with autism at the age of three. Her mother requested a Theraplay consult to work on reciprocal social skills. She reported that Cammie could speak fairly well and read, but had the social skills of a much younger child. Play with peers was limited and had to be facilitated by an adult.

The MIM and initial Theraplay sessions revealed that Cammie was easily dysregulated, especially in the face of new challenges, unstructured situations, interactions with new people, and unfamiliar circumstances. The therapist, Alan, and Cammie's mother agreed that Cammie could benefit from learning some simple play sequences that she might be able, in time, to play with family members and friends. Alan chose two activities: playing Cotton Ball Blow back and forth between Cammie's and his outstretched hands and making a Stack of Hands together.

Cammie's mother helped her sit cross-legged on the mat and lean against the wall. Alan held his hands together palms up in front of his mouth and told Cammie to do the same. He placed a cotton ball in his palm and blew it gently into Cammie's hands. Cammie immediately began giggling uncontrollably and fell over on her mother. Alan said to the mother, "Oh, oh, I went a bit too fast. Let's show Cammie how the game goes." The two adults demonstrated a successful sequence, blowing it back several times between them. Cammie spontaneously said, "One more time" and her mother replied, "No, two more times!" Again, Alan held up his hands and this time Cammie blew the cotton ball back; Alan and her mother congratulated her and encouraged one more try. After she accomplished the second round in a much calmer fashion, Cammie smiled at her accomplishment and the three of them exchanged quiet high fives.

Alan explained that he had a second game they could play. He extended his hand palm down and told Cammie to place her hand on his. Cammie quickly made a stack of hands but then began rolling on the mat and laughing. On the second attempt, Cammie began to blow and Alan said, "Oh, you were thinking about blowing. We just used our hands to blow the cotton ball. Here, Mom and I will show you the hand stack game." Alan then demonstrated a slow, methodical hand stack with Mom. Cammie resisted doing this with Alan, but said she would do it with her mother. Together they completed eight stacking movements and it was clear that Cammie now understood the activity. She then did it once more with Alan. In order to use Cammie's language skills to regulate and extend the sequence, Alan began to count with each hand movement and Cammie chimed in, counting to twelve. Cammie and her mother left the session with a plan to show the games to Cammie's father that evening.

Engagement

After establishing the safety and regulation of structure, engagement is the key Theraplay dimension when working with children with autism. Because children with ASD find it difficult to engage with others, the Theraplay principle of becoming an intriguing force that the child notices and takes into account is crucial. You must, as we have said, do this with great sensitivity so that the child is not frightened or made so anxious that she might withdraw or flee. The goal is to provide the maximum engagement the child can tolerate in a fun and spontaneous way. Greenspan and Wieder (2006a, p. 69) describe the importance of engagement for the child with autism as follows: "Through engagement we enter the child's world with warmth, joy and trust. This helps the child to regulate herself because the focus is on the engaging caregiver. This engagement leads to a desire to communicate, and establishes a foundation for pleasure in relating to others and attending to the outside world."

Unlike many treatment models, Theraplay does not overtly teach the social skills that a child with autism so sorely lacks. Instead it

ENGAGEMENT	
Therapist or Parent Role	**Desired Effect on Child**
Focus on child intensely and exclusively, noticing special physical and interaction attributes.	Child feels "seen."
Acknowledge child's reactions, likes and dislikes, distress and pleasure.	Child feels "felt"—she experiences affective connection with adult.
Help child focus on and attend to therapist.	Child's major focus is on therapist rather than toys or props.
Draw child's attention to adult's face and body and facial expressions and gestures.	Child attends to adult's facial expressions, gestures, and simple directions. Child recognizes the other as a special someone to interact with.
Draw child's attention to the play actions and simple materials.	Child experiences joint attention.
Share and increase positive affect through the interaction.	Child experiences more positive affect because of the interaction with another person.
Imitate child to turn his behavior into a communication.	Child experiences self as able to make an impact on adult, able to start something.
Develop turn taking.	Child is able to complete several turns of back-and-forth sequences, anticipate actions of another, predict what will happen.
Encourage all means of nonverbal and verbal communication.	Child increases nonverbal and verbal communication attempts.
Respond to all communications.	Child feels "heard."
Develop a repertoire of play interactions.	Child initiates a familiar game already played in the treatment.

Table 8.2. The Essence of Theraplay for Children with ASD: Engagement

helps the child to learn these skills in a variety of more subtle ways. At the heart of the relationship that is being developed with the therapist and the parents is a growing understanding of what it means to be in social intercourse. The responsiveness, sharing, and awareness of others that develop in this one-on-one interaction are at the core of all social skills (see Table 8.2).

FOCUSING ON THE CHILD. Just as the parents of an infant watch their baby in fascination, counting fingers and toes and noticing every new action and reaction, the Theraplay therapist provides that experience to the child with autism. This is most clearly seen in the Checkups that begin sessions but occurs throughout the session as well. The

experience of being seen by another is the beginning of learning about self, others, and connection.

ACKNOWLEDGING THE CHILD'S REACTIONS. Theraplay therapists acknowledge the child's likes and dislikes or pleasure and distress as they occur in the moment by copying the child's reaction nonverbally in a slightly exaggerated fashion and putting words to it. For instance, when Becky frowned and withdrew her hands in a clapping game and covered her ears, her therapist scrunched up her face and said, in an annoyed tone, "Too much clapping, Sharon." At all times the therapist tries to figure out a child's intention and give meaning to gestures and reactions; for example, by checking to see what the child wants when he extends a hand. By acknowledging the child's gestures you heighten her awareness of her own reactions and intentions.

FOCUSING ON AND ATTENDING TO THE THERAPIST. We start with face-to-face interaction, leaving toys out of the picture until the child has discovered more pleasure in interaction. Simple props are used to advance the interaction; for instance, reaching for a cotton ball stuck to the therapist's nose with a dot of lotion. The face-to-face position allows eye contact to occur naturally. Because we know that the face is constantly changing and can be too much stimulation for a child to attend to while also listening and moving, the therapist is sensitive to the child's tolerance for direct eye contact and does not insist on it, but does encourage the contact by doing many activities near the face of the therapist. For example, when playing with bubbles, hold the bubble that you have caught on the wand right in front of your nose so that the child will see your face when she pops the bubble with her hand or foot. We acknowledge eye contact when it does occur with a pleasant smile, a facial expression, or a "Wow, there you are."

Avoiding eye contact is one of the most commonly noted ways that children with autism regulate overwhelming experience. All children turn away from time to time to regulate their arousal level, but the child with ASD who is hypersensitive to visual stimulation will do this much more often. Finding ways to help a child to tolerate and even enjoy eye contact is an essential step toward engaging him in a productive manner. Enjoyment is the critical issue. You must assess what is making the child anxious, fearful, or overwhelmed and make him as comfortable as possible. Eye contact should never become a

task to be mechanically rewarded. Instead, for each individual child, plan activities that are motivating and delightful and that enhance effective sensory processing and sensory integration.

In addition to focusing on the child's reactions, the therapist draws attention to the adult's nonverbal behavior. One purpose is to establish the basis for recognizing others' intentions. For example, the therapist reaches for the lotion bottle and finds that it is cold. She raises her eyebrows, widens her eyes, and shivers a bit, saying "Oh my, this is too cold to put on you." She squeezes lotion into her hands and rubs them together, saying, "Warm it up, rub, rub, rub." She pauses briefly, opening her hands and looking at the lotion, then shakes her head and continues rubbing, saying, "A little more." Then she holds out her hands to the child, saying, "Now I'm ready," and applies the lotion to the child's hand with firm strokes.

ESTABLISHING JOINT ATTENTION. Many of the activities that successfully engage a child with autism are found in the play between a parent and a young child. With help the parent and child can experience this basic interactional play, which may have been offered earlier but which the child could not receive. Being simple, these games allow the child to be successful and to feel competent. Games such as Peek-a-Boo use an element of surprise that captivates the child and focuses his attention. In your first sessions with very young children with ASD, you should use a limited repertoire because the child needs time to become familiar with the activities and to feel comfortable with them. Just as with a baby, repetition of familiar games is appropriate, especially when the child indicates that she wants "more." It is important, however, to distinguish this from perseveration that shuts out awareness of new experiences. Once such interactive play is established, you can progress to interactive play with simple props and toys, such as popping bubbles and catching a beanbag dropped from your head.

SHARING POSITIVE AFFECT. It is impossible to exaggerate the importance of play, fun, and laughter in engaging children with autism. The goal is not only that the child can experience pleasure, but that he can do so because he is interacting with another person. The focus on fun and flexibility—in the context of empathic attunement to the child's needs—gives Theraplay an advantage over more rigidly planned treatment programs. Treatment methods that break tasks

down into small isolated units and focus on teaching skills as a number of individual steps negate the relational goals of spontaneity and warm interaction; what should be a delight becomes a chore. The surprise and delight that accompany well-attuned, fun activities lead to a bypassing of the fear and confusion that so often are felt by these children. It helps to build a much-needed relationship.

IMITATING THE CHILD. Children with autism may have difficulty imitating another person, so we begin by imitating the child. This often results in an interaction between the child and adult that leads to the child's feeling that she was able to "start something" and make an impact on the adult. We refer to this kind of copying as "mirroring." With all children, affect attunement and mirroring lead to awareness, mutual engagement, acceptance, and trust. For children with autism, a more deliberate form of mirroring can also be particularly useful. This kind of mirroring includes imitating all of the child's verbal and nonverbal responses while matching or exaggerating the affective intensity of your response so that it can be noticed; it thus truly makes an impact. The mirroring of a child's sounds is similar to the playful babbling that parents do with their infants; it is an important precursor to communicative language for children with language delays, as it calls attention to the child's sounds and turns them into an interactive communication. This is the beginning of interactive reciprocity and turn taking, initiating an active interchange that can lead to true communicative language. Devon was immediately engaged, for example, when Margaret imitated his spontaneous gurgle; a lovely "conversation" ensued. Mirroring the sounds of a child who needs to return to the beginnings of communicative language makes it possible to help him turn his echolalic speech into true communication.

We use a slightly different form of mirroring in order to engage a child who is pursuing his own perhaps repetitive or avoidant activity. We try to discover what the value of the activity is to the child and then we create an interactive version with similar qualities of sound, motion, or soothing. In other words, we expand the child's activity into one that everyone can share. We join the child's own rhythm and intensity, make ourselves part of her action, and attempt to replace her isolated activity with an interactive substitute. This process of inserting yourself into the child's activity may at times annoy the child. In describing his efforts to follow a child's lead

and draw him into a shared world, Greenspan says, "I didn't mind annoying him because by looking at me for a moment and vocalizing to me purposefully, . . . he was at least acknowledging my presence and relating to me a little bit" (Greenspan and Wieder, 2006a, p. 71).

TAKING TURNS. You cannot truly take turns unless you recognize that there is another person with you. Theraplay therapists set up simple, achievable play activities that have a strong back-and-forth quality. By participating in the play, the child learns to anticipate and look forward to the actions of the other person. For example, Sue, the therapist, puffed up her cheeks, leaned slightly toward Ryan, and gently popped her cheeks with her own hands two times. She then took Ryan's hands in hers, brought them to her cheeks, and helped him pop her cheeks. Sue encouraged Ryan to puff up his cheeks and he almost managed to do it; she gently pressed his face and made a popping sound. Sue leaned forward again with cheeks full of air and Ryan smiled and reached out to her face; now he understood the game. Whenever Sue puffed up her cheeks, Ryan reached forward to her. He began to greet Sue by puffing up his cheeks for their special game.

ENCOURAGING COMMUNICATION. Because of its focus on engagement and reciprocal communication, Theraplay is in a good position to foster the beginnings of speech and language in the nonspeaking child with autism. It also can help to develop truly interactive communication in the child who has well-developed speech but who uses it in an atypical or ineffective fashion. Often children begin to speak during Theraplay without a specific focus on teaching words and phrases.

Beyond these spontaneous, natural beginnings of sound play, mirroring, and the use of songs and rhymes already described, the following guidelines can be helpful:[5]

- Keep your language simple and direct. Avoid long, complex sentences and elaborate vocabulary. Chose your language to match the child's receptive language needs.
- Combine natural gestures and signs with your words. Children need the visual bridging in order to understand. You can also use pictures, encouraging the child to point to what he wants.

- Use "present" language to refer to what is going on at the moment and to refer to visible objects, instead of talking about the past, absent things, or distant events.
- Label what is happening. Comment on the child's action just as a parent talks to and for a young baby. As the child reaches toward his foot, you might say, "Touch your foot," taking a gesture within the child's repertoire at the moment and naming the intention of his action. Acknowledge briefly what you think the child is feeling. "Lotion is good." "Bubbles are fun."
- Initially, if you offer choices, provide the opportunity for an eye-pointing response, a picture or object selection, or a physical gesture.
- If the child cannot respond verbally, assist him in an appropriate physical response by using physical guidance or hand-over-hand assistance while labeling and stating the action.

RESPONDING TO COMMUNICATION. Throughout the Theraplay interaction, try to decipher the child's intentions, wants, needs, and messages so that she experiences being heard by another. We say aloud what the child may be communicating and make sure that we respond in some way to her.

DEVELOPING A REPERTOIRE OF PLAY INTERACTIONS. Through participating in Theraplay, the child and parent expand the number of things they can do together. A mother of a child with autism noted, "We could do these games in those in-between times when we're at home and there's nothing to do—those times are hard." Another parent who mostly engaged in roughhouse play with his easily dysregulated son learned quiet, gentler ways to engage him as well.

ENCOURAGING ENGAGEMENT IN THE SCHOOL SETTING. Beyond Theraplay sessions and a home life that incorporates the preceding principles, the child with autism also needs a supportive school program where the adults are prepared to follow Theraplay's playful, engaging approach. This requires that you find ways to explain and, if possible, demonstrate the Theraplay approach to everyone who works with the child. The following case demonstrates the

effectiveness of preparing the staff of a day-treatment center to incorporate Theraplay principles throughout the day.

THERAPLAY IN PRACTICE

Maximizing the Engaging Impact of School Staff and Peers[6]

Jeff, a seven-year-old boy with autism, was admitted to a school-based day-treatment program because of problems in social interaction, aggression toward peers and family members, and increasingly "oppositional" behavior. He made no moves toward contact with peers, and he avoided eye contact and any physical touch. His speech was mainly echolalic. His academic skills were well below grade level. After an initial intake and assessment, his therapist, Dave, introduced Jeff to Theraplay. His parents were enthusiastic and committed to the process.

Jeff's individual sessions were held once a week over the course of his fourteen-month stay in the program. During sessions, Dave made every effort to engage Jeff in affectively meaningful activities. He balanced playful and engaging activities with those that were calming and nurturing: playing Peek-a-Boo, crawling through pillow tunnels, wrestling, using lotion, and feeding. He developed every gesture and every sound that Jeff made into a cheerful give-and-take. This mirroring began the process that led to Jeff's using more and more spontaneous and appropriate language.

Jeff was at first highly resistant to the sessions. He tried to wiggle out of Dave's arms and buried his head in Dave's chest to avoid eye contact. Dave maintained a gently insistent pursuit, attempting to keep physical contact at all times and making eye contact with Jeff as much as he could tolerate. Gradually, Jeff became more comfortable with this interaction and soon he was able to let Dave touch him without flinching and his eye contact improved. Once Jeff had reached this stage of comfort, the members of the day-treatment center staff were invited to become more involved. Very soon Jeff's eye

contact improved, not only in sessions, but with peers, family, teachers, and other staff members.

The principle of lighthearted but insistent engagement was carried over into the broader milieu of Jeff's day-treatment program. It became a deliberate, systematic plan, agreed on by all staff members, that everyone should interact with him as often as possible. They would engage him in conversation or playful activities, make physical contact with him, and playfully move into his line of sight in order to make eye contact. They wanted him to be continuously aware of them and to relate to them. He was seldom allowed to withdraw or retreat. Indeed, it was the combined efforts of all of Jeff's peers, staff, and family that made his progress so dramatic.

In addition, the other children in the milieu, many of whom were diagnosed with ADHD, were powerful therapists for Jeff. Their high levels of activity and natural intrusiveness were tailor made to draw him further out of his shell. Group Theraplay was used extensively with Jeff and his peers. Activities such as having the youngsters rub lotion on one another's hands or cheeks, pass a hand squeeze around the circle, or name someone and throw a soft ball to him across the circle kept Jeff alert and constantly engaged. This boy who had mastered the art of evasiveness as a self-protective measure, now found that all the important people in his life were constantly and consistently present and available and no longer allowing him to withdraw. In fact, he no longer needed to protect himself from experiences that he was finding increasingly interesting and acceptable.

By the end of his stay in the program, Jeff had improved dramatically in social skills. He was one of the more popular members of his peer group. He made and sustained several friendships. His eye contact had improved, and his echolalia was only manifested in times of stress or uncertainty, such as when meeting new people. His academic skills also had improved greatly. Jeff joined the regular second grade classroom in his local school, where, because his teachers

followed the plan to engage him as much as possible, he continued to do well.

Jeff is now twenty-two years old and holds down a full-time job with a local office maintenance company. He recently received a promotion within the company. He still lives with his parents, but it is a realistic goal for him to live independently.

Nurture

The Theraplay dimension of nurture is also important for these often sensitive and anxious children. Nurturing makes the most fundamental connection between human beings, providing comfort and a sense of safety and security. Many children, due to their discomfort with being touched, have missed the benefits of the basic nurturing experience of being held and nursed or fed from a bottle. It is therefore especially important to find nurturing activities that are truly soothing to the child with autism (see Table 8.3).

MAKING NURTURE COMFORTABLE AND PLEASURABLE. When the therapist finds a way to provide nurturing touch that is acceptable and comforting, the child will be able to experience and enjoy the focused, intimate interaction of being taken care of by a caring adult. One child may not be able to tolerate being fed in her mother's arms, for example, but she may be able to accept it if supported on a pillow or on her mother's knees face-to-face. The child will see the

NURTURE	
Therapist or Parent Role	**Desired Effect on Child**
Provide nurturing touch that is comfortable to the child.	Child experiences, accepts, and comes to enjoy the very focused, intimate interaction of caregiving.
Soothe the child when upset.	Child is able to be calmed by the intervention of another person, experiences interactive repair of negative emotions.

Table 8.3. The Essence of Theraplay for Children with ASD: Nurture

pleasure on her mother's face as she feeds her bites of a cookie. The mother will adjust the firmness of the strokes while massaging her child's fingers to prolong the interaction. We want the child to come to understand that other people have good things to offer and are a source of pleasure.

USING NURTURE TO CALM AN UPSET CHILD. Nurturing also has the potential for calming and soothing a child who is agitated. If the therapist can help the parents discover how to soothe the child when she is upset, the child will learn that she does not have to depend entirely on her own capacity for isolated self-soothing or self-stimulation, but can experience the comfort of a calming intervention from another person. She will also begin to enter the world where interactive repair of negative emotions is possible.

THERAPLAY IN PRACTICE

A Mother Finds a Way to Nurture Her Sensitive, Isolated Adolescent Daughter

The following account was written by a woman who had just completed her first Theraplay training course.

Recently I completed Introductory Theraplay training as part of my work with high-risk families. During the first two days of training I not only thought about how to implement Theraplay techniques in my professional role, but I also considered the possible benefits that Theraplay might bring to my personal circumstances as a mother of an eighteen-year-old daughter with autism.

My daughter Emily has a mild learning disability along with ASD. She does not socialize easily or spend time with her peers; she spends a great deal of time in her bedroom watching TV alone despite my efforts to include her in family life. Emily is uncomfortable with touch and physical contact. This problem has contributed to her lack of physical and social interaction with others.

I discussed my question: "Do you think I could use Theraplay with my daughter?" with one of the trainers and she

suggested starting with some of the playful games. I headed for home with a plan to try to engage Emily in some of the games we trainees had played that day.

I introduced Theraplay to Emily in an unstructured way giving her the opportunity to explore the list of games I "needed to practice." I suggested that we play a cotton ball blowing game. We had a great deal of fun and, surprisingly, Emily relaxed and allowed me to hold her hands. I soon found Emily keen to practice new games so I helped her stand on an increasingly tall stack of pillows. She allowed me to assist her in climbing and balancing as the stack grew taller.

I also wanted to encourage Emily to maintain eye contact, so we held hands, stood face-to-face and I signaled her to move left or right with the direction of my eye blinks. Emily clearly found this activity difficult to do, often breaking eye contact, but reengaging with my encouragement to see where to go next.

A game which was particularly challenging for Emily was "fish and chips," with Emily saying "Chips" with the same speed, volume, and intonation as I said "Fish." Because Emily finds communicating, using expression, and saying new words difficult to do, I made this activity brief and as easy and achievable as possible.

After a great deal of fun and giggling Emily stated she would like me to do the manicure activity. I was quite taken aback by her request but grabbed the opportunity as this is a very intimate activity and probably the last one I would have expected Emily to choose. Whilst applying lotion to Emily's hands we checked for hurts and observed the lines on her palms. I was surprised to hear Emily say that she was happy for me to do this activity every day if I wished.

Emily also has obsessive compulsive disorder; she rigorously checks that her cutlery and crockery are clean before use and she will not permit others to handle or use them or any food she eats. This was a barrier for doing the feeding activities. We ended the session by making Emily's favorite frothy hot chocolate drink together.

Emily describes the Theraplay experiences we share as "fun and relaxing." She says the games are easy to do (except eye contact and feeding games) and that it makes touching and holding hands much easier.

Theraplay has created invaluable opportunities for my daughter and me to re-engage physically and have fun. We continue to enjoy the different Theraplay based activities several times each week. Emily now enjoys having lotion applied to her arms as well as her hands; I would not have believed this possible until now. I have found that Emily instigates physical touch more frequently and she is more relaxed in accepting hugs too.

Until my introduction to Theraplay I struggled to successfully engage Emily in physically intimate and challenging ways. Now as a parent and as a professional I can truly say that Theraplay has shown me ways to engage with children irrespective of age, ability, or additional needs.

Challenge

The Theraplay dimension of challenge will often be used in small increments with children with ASD. Beginning with the simple baby activities of engagement, you must gradually introduce new activities and new challenges so that the child can feel increasingly competent and comfortable facing new situations. This will expand the range of the child's ability to participate in interactions with another person, and will help him tolerate a variety of new activities (see Table 8.4).

TOLERATING NEW ACTIVITIES. Although simple familiar activities may engage the child, a new or unfamiliar activity may not be accepted at first. It is very important that you keep trying. The child may need time to understand what it is you expect; he may need additional time for planning, processing, and responding, as well as time to make the transition to something new. It is therefore important to slow down, exaggerate your movements and expressions, demonstrate with gestures, use hand-over-hand guidance, and present the activity enough times so that they begin to make sense to him.

CHALLENGE	
Therapist or Parent Role	**Desired Effect on Child**
Assist child to tolerate a variety of new activities.	Child is able to participate in more and unique interactions with another person.
Encourage and assist child to complete activities that are mildly difficult.	Child has the experience of accomplishing something a little difficult with the encouragement or assistance of another person; child feels capable.

Table 8.4. The Essence of Theraplay for Children with ASD: Challenge

ACCOMPLISHING MILDLY DIFFICULT ACTIVITIES. For these children, the challenge may lie in the very act of completing an activity that was mildly difficult, or in staying with an interaction for a longer period of time. By developing the ability to take more turns, for example, she has met a challenge. The child will then have the experience of accomplishing something a little difficult, with the encouragement or assistance of another person. Some of these new challenges will involve being able to tolerate the stimulation she has rejected before. If you introduce these experiences gradually, the child can learn that they are not as overwhelming as she fears. In presenting challenges, you will need to begin just at the point where the child can easily manage an experience and then move her forward one step at a time. Just as a parent provides a finger for her almost-ready-to-walk toddler, you must lead, guide, and support the hesitant child to take her first steps. A small dab of lotion firmly applied to the palm of the hand of a child who is tactilely defensive, or perhaps a dot of powder first, will move the child forward in her ability to cope with and accept new tactile experiences. It is worth repeating that, for children with autism, challenge will come, not necessarily from doing specific difficult activities, but from doing things that have earlier made the child uneasy.

Theraplay's challenge is useful for children with Asperger's Syndrome who have difficulty understanding and using nonverbal cues, social bids, and social conventions. Paris Goodyear-Brown (2009) provides a lively illustration of the use of structure and challenge to help a child attend to social cues. She describes the treatment of a

nine-year-old child with poor social cue reading, a restricted range of interest, limited awareness of others' lack of interest in what he was talking about, poor eye contact, and limited understanding of cues about physical proximity and physical boundaries. She devised a variation of the Beanbag Game that initially used cue words from the child's topic of interest and gradually shifted from those words to nonverbal cues of eye blinks. She challenged him by requiring longer waiting times and increased length of gaze and achieved a significant increase in eye contact over the course of treatment. Activities in which he and his mother mirrored each other's body motions helped him recognize the position of his body in space and its relationship to the body of his mother. To help him respond to the cues of others about boundaries, the therapist had him check out comfortable distances using licorice ropes as measuring tapes. She then fed the licorice ropes to him, thus combining nurture with challenge. Another exercise in maintaining appropriate social distance began with the therapist, mother, and child developing a list of nonverbal gestures that signify "that's close enough." These gestures became the "red light" in a Red Light, Green Light game. The child walked toward the parent on a green light signal and stopped moving when he saw the red light gestures. The therapist and mother cheered when he accurately read the "that's close enough" gestures and stopped at an appropriate distance.

THERAPLAY IN PRACTICE

Introducing Challenges

We return to the treatment of Zeke, a six-year-old boy with PDD-NOS whom we met earlier in the example of bringing Theraplay activities into the home. In an early session, Dr. S. led Zeke through a Beanbag Game, placing a beanbag on her head and dropping it into Zeke's outstretched hands, and then in turn catching it from Zeke's head. As he began to enjoy this activity, she added to the fun and the challenge by having him balance two or three beanbags, one on top of the other, before dropping them into her hands. To interrupt Zeke's tendency

to perseverate, Dr. S. sometimes changed the activity to having Zeke balance a beanbag on his head and walk across the room toward his mother to drop it into her hands. As Theraplay treatment progressed and Zeke displayed improved attention, regulation, and prolonged ability to engage, she devised a more challenging Beanbag Game. Dr. S. handed five beanbags to Zeke and five to his mother as they sat across from each other in front of a mirror. Dr S. said, "Mom, you balance a beanbag on Zeke's body and he is going to put one on the same place on you." Mom carefully placed a bag on Zeke's knee and he giggled as he placed one on Mom's knee. Mom elaborately studied Zeke to decide where to place the next bag; Zeke carefully studied his mother to match his up just so. Mom and Zeke continued until they had a beanbag on each knee, each shoulder, and on their heads. Dr. S. had them turn carefully to the mirror so they could admire themselves. "Now Mom, you tip your head and Zeke will catch that one; now Zeke, you catch Mom's. Okay, here come the shoulders!" They shrugged each one off and bounced off the ones on their knees. Zeke's shining eyes, joyful giggles, and spontaneous kiss to her cheek told Mom that she was providing the right dose of stimulation and challenge to connect with Zeke in order to develop a new, shared world together.

INCREASING THE IMPACT OF TREATMENT THROUGH MULTIPLE INTERVENTIONS

Throughout this chapter we have emphasized the importance of having the family carry the Theraplay approach into the home. In Jeff's case, we saw the importance of increasing the impact by incorporating Theraplay principles throughout his day-treatment setting. We turn now to an example of work with a child with ASD whose very severe difficulties and delays required multiple interventions in addition to Theraplay to maximize the impact of treatment.

As we have seen, Theraplay can provide the basic emotional and social foundation for the child. The provision of nurture and

structure enables the child to feel safe and secure so he can begin to learn; engagement and challenge encourage him to reach out and to experiment with new experiences. But we know he may also need other treatments, which he will be able to accept more readily once he has become engaged through his Theraplay experience. He will need additional support in the areas of his special challenges.

THERAPLAY IN ACTION

Including Multiple Interventions

Kalish, an eleven-year-old boy with a diagnosis of autism, displayed severe and frequent behavioral problems, including self-injurious behavior (SIB), physical aggression, and noncompliance. Intellectual impairment was significant but difficult to evaluate accurately; his autistic symptoms included repetitive hand flapping, limited social interaction, and absence of communication. Kalish spent much of his free time at home in his bedroom. Independent play was limited to hiding under covers and poking his head out at people. With parental prompting he would eat or participate in basic sensory play, occasionally laughing, jumping, or flapping his hands. He was not toilet trained. New activities were met with fear reactions and resistance, but he greatly enjoyed certain sensory experiences, such as having his back rubbed vigorously or playing in water.

The comprehensiveness of deficits associated with autism often demands that multiple intervention strategies be employed to assist such children. In addition to the common social problems, repetitive and stereotyped behaviors, and communication deficits outlined in the *DSM-IV-TR,* many individuals with autism operate at the level of serious mental delay. This combined profile of deficits adversely affects development of friendships, ability to navigate in the community, learning of self-care tasks or domestic chores, safety awareness, academic and vocational learning, play and

recreational participation, and taking responsibility for one's own health care.

Intensive work with children with severe needs, particularly autism, in both residential treatment centers and outpatient treatment programs has demonstrated that five key domains must be addressed in order to progress toward independence and positive social functioning:

- Social-behavioral functioning, which includes reducing harmful or maladaptive behaviors and increasing prosocial behaviors
- Communication in some form
- Recreational skills, while demonstrating nonviolent and calm behavior
- Community integration, which includes staying safe from traffic or other physical and social hazards
- Adaptive daily living skills for personal or domestic care

When autism is involved, no treatment program can be used in isolation as the sole treatment. A combination of techniques involving behavioral therapy, social skills training, speech therapy, occupational therapy, and special education, for example, are nearly always required. However, Theraplay can be a highly useful tool in promoting the success of a treatment plan that includes the components listed above and, for some behaviors, can be the primary intervention.

Kalish's treatment program demonstrates the integration of Theraplay treatment techniques into a comprehensive program for improving the behavioral health and functioning of a child with severe cognitive delays and autism. An assessment and treatment plan was developed that included the following:

- Functional Behavioral Analysis
- Theraplay to work on engaging emotionally with other people, accepting structure provided by caretakers,

learning cooperative play skills, and enhancing recreational opportunities

- Community integration practice (he spent almost all waking hours in a single room)
- Communication training using the Picture Exchange Communication System (PECS)
- Use of a positive reinforcement system to promote compliance with practicing cognitive and developmental skill games
- Training in self-care skills using a step-by-step task analysis, prompt hierarchy, and backward chaining (a technique that promotes errorless learning)
- School consultation and advocacy for an Autistic Support Classroom.

Theraplay Sessions

Theraplay was delivered in the home in brief sessions, sometimes only fifteen to twenty minutes at a time. The plan for the initial session included Peek-a-Boo, Pop the Bubble, the Slippery Slip game with lotion, Row, Row, Row Your Boat with rocking back and forth holding hands, tracing feet and hands on paper, and measuring him with fruit roll-up candy and feeding him the pieces. Activities not overtly resisted were often passively received with little effort at cooperation or collaborative interaction. Peek-a-Boo was met with only partial success; he occasionally showed his face out from under the blanket. He showed only mild interest in bubbles and was unable to blow bubbles at all. He strongly resisted the Row, Row, Row Your Boat game and having his hand traced on paper. The only task he clearly enjoyed was eating the fruit roll-up candy.

The Theraplay program was designed around his sensory interests and his cognitive, developmental level. Sensory play activities using paint brushes and rollers, a back massager, buckets of beans, vibration toys, and scented lotions were incorporated into the Theraplay sessions, along with continued persistence with developmental games, such as

This Little Piggy, Balloon Balance, Pop the Bubble, Row, Row, Row Your Boat, and Patty-Cake. Some activities, including deep pressure massage, were provided by an occupational therapist.

Including Family and Therapeutic Support Staff (TSS)

To maximize the frequency and consistency of therapeutic activities, parents and the TSS were trained to become active participants in treatment sessions early on and to provide similar interaction on a daily basis. Within six weeks of starting therapy, progress notes documented increased smiling and participation in activities, including using a shaker to make rhythmic music, allowing aluminum foil prints of his feet to be made, and playing a game of hiding gummy candy on his body and having someone find it.

Integrating Theraplay with Communication Training

The family and the TSS were also trained in the basics of using the Picture Exchange Communication System (Frost and Bondy, 2002). Phase I of this system focuses on teaching the child that a picture can be traded for a desired object; in Kalish's case, for food items. The TSS and his Theraplay therapist acted as communicative partner and prompter. When Kalish reached for the food held by the therapist, thus demonstrating his desire for it, the prompter would guide his hand to pick up the picture and give it to the therapist in exchange for the food. Kalish immediately got the idea; during the course of multiple sessions, Kalish generalized to communicating with multiple individuals in the family. This approach was a break from traditional Theraplay in which food is given noncontingently as a method of nurture. However, it was essential to help Kalish develop some method of communication. In order to maintain the nurturing atmosphere of sessions, the therapist did not require him to ask for food in every session or setting.

Integrating Theraplay with Functional Behavioral Assessment and Teaching Skills

A significant symptom at the beginning of treatment was Kalish's intense self-injurious behavior (SIB), typically slapping himself in the head. The first step in addressing this issue was to track the incidents of SIB using hourly incident tracking. His level of SIB was over a thousand incidents per week. The head slapping could be intense enough to cause abrasions and bruising and, as his agitation increased, he could become physically aggressive toward other people. Video recordings of Kalish, made to track the frequency and context of the behavior, showed that self-injurious behavior occurred most frequently under demand conditions, such as being asked to perform a skill or participate in a learning task, second most frequently when alone, and very infrequently during nondemand play. This profile suggested specific behavioral intervention strategies. First, the SIB when alone suggested that some head slapping occurred for internal, self-stimulation reasons that Kalish could not explain. A possible nasal infection was suspected and treated. Second, the high relationship to situations where he was being asked to do a task suggested the need to reduce the level of difficulty of demands, to move at a slower pace when teaching new skills or introducing new therapy activities, and to increase the frequency or strength of positive reinforcement for participating in a new or difficult task. Third, it suggested that frequent play breaks, using well-liked Theraplay and sensory activities, could prevent agitation or reduce escalation of frustration if introduced early enough.

Developing Basic Skills

Basic personal and domestic skills as well as cognitive skills were promoted. Kalish would choose a picture of an item he desired, a PECS skill, and complete three tasks, receiving a star

for each one, putting them on a template. When the three-token template was filled he could exchange the tokens and picture for a desired item. Theraplay breaks were offered if he showed signs of frustration and sensory activities were sometimes used with him during his work to maintain a sense of emotional rapport, engagement, and calm. Over the course of a year he progressed from working for five minutes or less to working for over forty-five minutes at a stretch on challenging, table-top, and skill-building activities.

Using Theraplay to Promote Social and Community Integration and Recreational Options

Kalish's participation in Theraplay games steadily increased through the daily practice with his parents and his TSS. He developed an enjoyment of balloon hitting games and was able to engage in reciprocal play with family members and therapists through this game. Soon he was able to enjoy playing outdoors with his father, kicking a soccer ball back and forth. Kalish began to enjoy reciprocal play with bubbles, which included relaxed periods of laughter. Although he never learned to blow bubbles himself, he enjoyed popping them for the therapist. This skill of watching and waiting was later used to play domino games in which he would allow the therapist to set up a row of dominos that he would then push down. In order to help Kalish develop a greater sense of social play and social communication, a group of socially healthy children from the community, including his sister, were brought into sessions. He was willing to play balloon games with the children under therapist supervision and he also played Ring-Around-a-Rosy, which he had previously practiced during Theraplay. Playing these games during Theraplay sessions had given him the skills to play with others. The children also allowed Kalish to practice communication skills with them. They easily understood the principle of a picture exchange and Kalish was quite willing to communicate with them through icons when they held food items he desired.

Once a strong rapport had been established with the therapist through Theraplay, community outings were attempted, starting with walks around the neighborhood. Because of his lack of safety sense and the possibility of his darting away, two adults were required at all times for safety on such walks. Because he was unable to understand the "Mother, May I?" game, the therapist made a simpler version in which Kalish was expected to follow a therapist directive, such as "Let's run . . . now stop." The "reward" for accomplishing this would be a strong high five, rubbing his back, or a food treat. Over time, longer walks became possible and he was able to participate in some activities at a community recreation center, such as riding a stationary bike.

Outcome

The entire course of treatment with Kalish and his family was fourteen months. This included the two-week initial intake and assessment, followed by four weeks of limited intervention, other than family support, during which time the following was completed: observation sessions at home and school to assess skill levels, development of a behavior recording system, generation of an overall treatment plan, development of a behavior support plan, and initial training of the TSS.

Severity scales of functioning level were used to evaluate the behaviors at baseline and again at follow up. These scales of functioning (SOF) were standardized for each level based on risk, intervention needed, and interference with life functioning. A level 1 is most severe to the point of being life threatening, whereas a 10 is above average. A level 3 indicates an inability to function in some life domain (for example, school, socialization, community outings) or the behavior has created need for medical care or line-of-sight monitoring.

In the initial evaluation, Kalish's behavioral levels in the areas of physical aggression, SIB, and noncompliance were so severe that they required one-on-one supervision. The risk of physical aggression was very high and very persistent; the SIB

intensity required that he wear a helmet for head safety, and it was almost impossible to get him to accomplish self-help or academic activities. Pica (persistent eating of nonnutritive substances), a much less severe problem for Kalish, was managed by verbal promptings. Grunts and gestures were his only form of communication.

Evaluation at the end of six months and one year showed significant improvement in behavioral severity as shown by the improved ratings in Table 8.5. The table shows a trend in the scores for steady improvement in aggression, SIB, tantrums, and communication level. Improvement in communication is correlated with accomplishments with PECS. Toileting problems initially improved but hit a plateau, prompting outside consultation with specialists for this. Kalish displayed continued improvement in six of the eight areas at six months and five of the eight areas at one year follow-up.

	Severity Score		
Behavior	**Baseline**	**6 Months**	**1 Year**
Physical Aggression	3	5	6
SIB	2.75	4	5
Noncompliance	3.25	6	5
Tantrums	2.75	4	6
Pica	5.5	5	6
Encopresis, Enuresis	2.25	5	5
Sensory, Sexual	6	6	6
Communication Level	2	3	4

Table 8.5. Kalish: Comparison of Baseline and Follow-Up Scales of Functioning

Theraplay was an integral component of the treatment process for Kalish. It was essential to building the rapport and emotional connection that made the application of all other therapies possible. Theraplay was critical in providing the context, relationship, and reinforcement for participating with another person in play, skill building, and cooperative activities. It was integrated into teaching social-recreation

skills, teaching daily adaptive skills, promoting community integration, enhancing communication, and reducing disruptive behavior.

WIDENING THE SOCIAL CIRCLE: GROUP THERAPLAY FOR CHILDREN WITH AUTISM

Our ultimate goals for children with autism include greater independence, the ability to make friends, to work with others on a common goal, and to have a sense of belonging. Theraplay starts the process of improving social relatedness in the therapist-child and parent-child relationship. Although some children can generalize these skills to other relationships and settings without specific treatment, others will need more assistance. Group Theraplay is a way of explicitly extending social relatedness skills to the child's larger world.

In Group Theraplay, a leader, a group of children, and other facilitators (an adult or older child) come together regularly to play in an organized way. The "rules" of Group Theraplay (described fully in Chapter Twelve) summarize the process:

- The adult leader is in charge of planning and leading the interaction, incorporating the dimensions of structure, engagement, nurture, and challenge.
- The leader makes sure there are "no hurts"—physical or emotional—ensuring safety, caregiving, inclusion, and respect for all members.
- The group "sticks together" and so the focus is on being with others in a pleasant, productive way.
- All "have fun" using the joy of play to reach, regulate, and motivate the children.

Group Theraplay is adult directed but child focused in its provision of engaging, comfortable, nurturing, and playful experiences. The sessions take place at a specific time and in a particular place with clearly defined boundaries. The session plan is highly structured with a specific activity for the beginning and for the ending; often a list of the activities planned for the session is placed where the

participants can see it. The activities, ranging from highly active to quiet, are designed to fall within the abilities of the children and slightly above their current developmental levels. Children are encouraged to participate and are discouraged from withdrawing physically or emotionally from the group. The Group Theraplay spirit is participatory, respectful, caring, and fun.

The goals for all children in the group include increasing awareness of self and others, making connections and developing relationships, and developing a sense of belonging and being accepted by others. Children learn to communicate effectively through turn taking and initiating and sustaining interactions. They learn to nurture others and accept nurturing from others. Within the group situation they develop trust and a feeling of safety. Finally, the group experience can enhance confidence and self-esteem and develop a feeling of self-worth.

In order to help you understand what happens in group, we describe a typical sequence of activities for a forty-five-minute session of six-year-old children with autism and language learning difficulties:

- *Entry Song ("The More We Get Together"):* All join hands in a circle and sing.
- *Toss Ball with Greeting:* Thrower says, "Hello, Jane. How are you?" Catcher says, "I'm fine thanks, how are you?" Catcher repeats greeting, tosses ball to another person.
- *"Head and Shoulders" song:* Adding the following verse, "Head and shoulders, knees and seat; Clap your hands and stomp your feet. Head and shoulders, chin and chest; Clap your hands and yell 'I am the best!' "
- *Motor Boat Rhyme:* All join hands and move in a circle at varying speeds while chanting, "Motor boat, motor boat, go so slow . . . ").
- *Powdering Hands:* Children partner with each other and rub powder on each other's hands, examining lines and shapes.
- *Balloon Toss:* Seated group members toss and tap balloon to keep it in the air. All count the number of hits before the ball touches the floor.
- *Parachute Rocking:* Each person gets a turn being rocked by the rest of the group in a sturdy cloth sheet. All sing a favorite lullaby song.

- *Categories Chant:* Leader sets up a clapping pattern, chants, "One, two, let's go, [category name, item name]." Group members take turns naming items in the category at correct time in chant.
- *Feeding Potato Chips:* Therapist feeds each child in the circle. Then children feed each other a chip. They make loud crunches and listen to each other.
- *Ending Song:* Everyone in a circle holding hands. "Bom, bom, bom, bom, bom, good-bye everyone, well, it's time to go-o; bom, bom, bom, bom, bom, well, I'll miss you so. We had such fun, more than you'll ever know, well, good-bye everyone, good-bye. Bom, bom, bom, bom, bom — oh ya!"

These simple activities are rich in opportunities for building social skills. To take just one activity as an example, when one group member catches the ball, then greets and tosses the ball to another group member, we see the following skills being used:

- Self-regulating to a transition
- Following visual and auditory cues
- Participating as an individual and as a group member
- Recognizing self and others
- Acknowledging self and others
- Addressing each person as part of the group
- Showing caring
- Building trust
- Making eye contact
- Initiating interaction and maintaining interaction
- Engaging, shifting, and reengaging attention
- Listening
- Taking turns
- Using memory, auditory, visual, and working: who has been chosen, who hasn't, who needs to be?
- Making a choice and a decision
- Developing eye-hand coordination

- Saying and doing simultaneously
- Taking risks, building confidence, and feeling worthy

Evidence for the Effectiveness of Group Theraplay

There are many anecdotal reports attesting to the effectiveness of Group Theraplay for children with ASD. We first look at a report of a successful Group Theraplay experience that took place in New York state special education classes. Following that, we report on a controlled study of the outcome of Group Theraplay with preschool children in Hong Kong.

THE NEW YORK REPORT. Over a five-year period, children with ASD and their classmates in primary and intermediate special education classes in several public schools in western New York participated in Theraplay group twice weekly as part of their social-emotional curriculum (Bundy-Myrow, 2000). The students learned to anticipate and "stick together" for four group segments: (1) hello and Checkups, (2) game, (3) snack share, and (4) good-byes. The beginning and ending segments were repeated each week and were learned quickly. The children eagerly prepared the chairs and watched the clock for Theraplay group to begin. Rather than promoting perseveration, the consistent initial and ending group segments promoted increased spontaneity and verbalizations. When one boy suddenly added a funny face and smile to his greeting, the group clapped appreciatively. At the beginning of each week, new activities were introduced in the game and snack components that were again repeated in the second session. The children accommodated to the new activities more readily at the second session and became increasingly willing to try new activities as the group progressed. Activities started with adult-child dyads and progressed to child-child dyads with adult support. Favorite activities had a set beginning and end; for example, blowing cotton ball "cars" down aluminum tracks to a friend. The leaders attended to each child's unique needs while maintaining group cohesion. As the sessions progressed, the Theraplay atmosphere blossomed with fun, spontaneity, safety, caring, and motivation.

Five years after the group sessions, a parent of a now high school–age student reported that she had kept in contact with some students from her son's old school. As a parent representative in her school district, she was also familiar with other students with ASD.

She noted that, despite their wide range of abilities, the students who had received Theraplay were more social and more interested in others than students who had not received Theraplay's personal, relationship-based experience.

THE HONG KONG STUDY. A study that took place in Hong Kong evaluated the effectiveness of Theraplay in enhancing the social responsiveness of Chinese preschoolers in an eight-week summer program for children with autism (Siu, 2009a). Two groups of children with ASD were randomly assigned to a Theraplay group or to an Expressive Arts group. Parents participated with their children in both groups. The Theraplay group followed the pattern we have been describing here. The Expressive Arts group used music and movement in a structured program that included warm-up activities, singing games, and movement activities.

Data on pre- and postinterventions as well as at one-month follow-up were gathered through parent interviews and the use of the Social Responsiveness Scale (SRS) (Constantino and Gruber, 2005). Both programs led to a significant increase in social motivation, the motivation to engage in social-interpersonal behavior, as measured by the SRS. In addition, the creative arts group showed a significant increase in social communication, which includes the motoric aspects of reciprocal social behavior. The Theraplay group showed significant improvement on two other measures: social awareness, the ability to pick up on social cues; and social cognition, the ability to interpret social cues.

Parents in both groups were very positive about the experience and felt that their children were happier and better able to relate to others. At the one-month follow-up, the parents in the Theraplay group showed more carryover from their active involvement in the group, being able to name more activities that their child liked and describing why their child liked them. They also had gained a sense of competence as parents of children with autism. Of the Theraplay parents, 75 percent were still using the activities, compared with 50 percent of the Expressive Arts parents.

Our final group example includes typically developing preteen facilitators as Group Theraplay partners for young children with ASD.

THERAPLAY IN PRACTICE

A Group Using Preteen Facilitators

A group was created for five children with ASD, ages three-and-a-half to six years, exhibiting varying degrees of difficulty with relationships and communication. One typically developing "facilitator," aged eleven or twelve, was assigned to each child. The group was led by a Theraplay therapist with the assistance of two other Theraplay-trained adults who oversaw the interactions and helped out as needed. The sessions, which lasted forty-five to fifty-five minutes, took place weekly for eight weeks.

The group of preteen facilitators proved to be very nurturing. All of them were personally known to the leaders. By chance, and not by prerequisite, all had passed a babysitting course. The fact of their taking this course demonstrated an interest on their part in learning to look after the needs of younger children. A two-hour orientation was provided for the facilitators prior to beginning the group. During the orientation the facilitators practiced the Theraplay activities they would be doing with the children in upcoming sessions. Special needs of the children were also discussed.

The first group session followed a pattern that would be the same in all sessions. It began with everyone sitting in a big circle on a large blanket. Each small child sat between two larger people. The session proceeded as follows:

- Beginning whole-group activities
  - Greeting song
  - Whole group watches as one child at a time has lotion put on any hurts. Each child is given a hug by the leader and a group "hoorah." Children then break into facilitator-child dyads and apply lotion to each other with assistance from an adult.
- One-on-one activities

  - Two to three more activities in facilitator-child pairs
- Whole group activities
  - Second welcome song in whole group circle
  - Four to six group-based activities
  - Closing activities
- Feeding activity
- Group chant ("Everyone is special")
- Good-bye song

Some children were able to accept attention from other group members right from the beginning. It even served to calm some children who experienced initial distress in the new situation; they took notice of being noticed. Other children initially experienced the group attention as overwhelming, but they soon accommodated to it. They were eventually able to accept and even enjoy the attention directed toward them by the group. When the group recognized others, each child was led to make overtures that they would not normally make. In addition, they were helped to remain present to the interactions, as they received attention from the group and joined in recognizing others. The children showed improvement in responding to their name, initiating and returning eye contact, and initiating and responding to greetings.

One activity that helped the children see themselves and others as individuals was the Blanket Swing, in which an individual child is rocked by the whole group. The vestibular stimulation from the rocking movement produced feelings of elation. The children who were helping with the rocking shared the enjoyment of the child in the blanket. It was thrilling to watch the children as they benefited from the wholehearted involvement of giving and receiving inherent in this activity. The children were so eager to have this joyful experience that they would clamber into the blanket, not always waiting their turn. With help from their facilitators,

they became very aware of when it was not their turn; this helped them learn the difficult task of turn taking.

Another favorite was Musical Hula Hoops. Each child was paired with a facilitator; when the music began, the facilitators encouraged the children to dance; when the music stopped they stood together inside a hula hoop. Initially there were enough hoops for each pair. Gradually hoops were removed, requiring more children and facilitators to crowd into fewer hoops. Eventually, with only one hoop left, all group members (twelve bodies) squeezed into it. The children accepted the closeness and some even welcomed it. This activity helped the children to see themselves and others as individuals, while helping them to tolerate close physical proximity.

New activities were repeated for several consecutive sessions. Beginning and ending activities remained constant, as in a typical Group Theraplay session. A pleasant sense of anticipation appeared to arise for the children, possibly because they knew what was coming next. In contrast with typically developing children, for whom novelty is often necessary to keep their interest, children with ASD require repetition and familiarity in order to feel secure enough to relax into and engage in the play.

The familiarity of activities in this group, combined with the natural flow of any Group Theraplay session, eliminated much potential for transition problems. Transitions were especially seamless when activities involved standing and holding hands with two larger people; even children with motoric challenges could easily follow along. The group naturally provided physical guidance as it began to move in a circle. One group goal was that the children would experience the pleasure of connecting with another human being in fun and joyous ways. The exaggerated but not overwhelming interactions drew the children into a state of positive emotional arousal. The children began to seek engagement with other people.

By the eighth and final session, the children appeared settled and calm and were enjoying themselves like happy children at play. This was in stark contrast to the first session

in which several children looked pensive and others seemed disorganized, distressed, and uncomfortable. The children appeared more trusting of the process, more aware of their environment, and more interactive. Far fewer physical and verbal prompts were necessary to help them join in with the activities. The children smiled and looked around the room at each other and at the facilitators and leaders. They also displayed more reciprocity than they had in the early sessions. A boy who had cried at first, smiled and laughed during the last few sessions. He even took the risk of feeding people. Having been urged to feed the camera person a grape, he gave a little jump of triumph over his accomplishment and his fellow group members noticed!

Group Theraplay has been found to be very effective in developing engagement, interaction, communication, language, and social skills in children with ASD. The children soon get beyond any initial hesitation about interacting and have great fun together. If we were to wait for them to take the lead without providing them with guidance or facilitation, the interaction might never occur. Group Theraplay sets up natural opportunities for interaction. The children learn from each other as they "see" the "how" of the experience and practice the activities together. This process of shared experience and practice leads to bonding, relationship building, and increasingly deeper learning and understanding.

This chapter has described the principles and practice of individual and group Theraplay for children with autism spectrum disorders. We believe that Theraplay will continue to be a useful tool in unlocking the potential of children with autism.

Notes

1. The following section about working with parents is based on material provided by Karen Searcy.
2. Ken Moses (1987) prefers the term *states* because he does not see it as a progressive series, but rather as states that parents can go in and out of as they work toward resolution.

3. Parents using the Lovaas method (Lovaas, 1977; Maurice, 1996) hire therapists to spend up to forty hours a week with their child. Greenspan and Wieder (1997) also emphasize the importance of spending as much time as possible interacting with the child in a variety of ways, including interactive play, speech therapy, occupational therapy, and enrolling the child in an integrated preschool program (where one-fourth of the class has special needs and three-fourths are typically developing children).
4. For very enlightening accounts of personal experiences as autistic children, see Grandin and Scariano (1986), Grandin (1995), and Williams (1988, 1993).
5. These communication strategies are a compilation of ideas from several authors, including Prizant and Wetherby (1989), Weitzman (1994), and Bruner (1984) in his concept of scaffolding.
6. This case study originally appeared in somewhat different form in "Theraplay as a Treatment for Autism in a School-Based Day Treatment Setting" by Fuller, *Developments in Ambulatory Mental Health Care: Continuum: The Journal of the American Association for Partial Hospitalization,* 1995, *2,* 89–93. Reprinted with permission from *Continuum.*

CHAPTER NINE

Theraplay for Children with Histories of Complex Trauma

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Many Theraplay therapists work with children who have experienced severe trauma; for example, those who have lived in neglectful, unsafe situations with inconsistent and abusive caregivers or who have experienced multiple losses. The impact of such assaults on a child is so significant that many children cannot overcome them without some type of intervention. The reasons that clinicians find Theraplay effective in helping these traumatized children stem from the essence of the treatment:

- *Theraplay focuses on building the attachment relationship.* When trauma has occurred within a relationship, it takes a healthy relationship to heal it. We know that trauma can disrupt the parent-child relationship, and disruption (being placed in foster care or an adoptive home) can cause trauma. Theraplay involves caregivers so that disrupted relationships can be repaired or new relationships developed. By nurturing the parent-child relationship, Theraplay creates a safe haven in which the child can

feel wanted and valued and can develop his own unique personality.

- *Theraplay helps the child feel calm and safe.* We know that traumatic experiences cause the child's neurophysiology to become hyperaroused and the child to feel fearful and easily dysregulated. Through a variety of calming, soothing activities as well as appropriate, nurturing touch, we help the child modulate her agitated state and feel calmer and safer.
- *Theraplay helps the child learn to have fun.* Because Theraplay helps to decrease the child's state of fear, she can feel safe to be a child and to play. Theraplay also teaches parents how to play with their child yet still retain their parental authority. Play and joy regain their proper place in the lives of children and their families.

In this chapter we describe what happens to the brains of children who have suffered chronic trauma and how we sensitively adapt Theraplay to meet their needs. Thus we are focusing on how to address trauma issues. Many of the children we describe here are in foster or adoptive homes and therefore must form an attachment with new caregivers. In Chapter Ten we focus on the issues related to forming a new attachment.

UNDERSTANDING DIAGNOSTIC ISSUES

We use the term *complex trauma* to designate the range of ongoing early trauma that includes abuse, neglect, deprivation, multiple placements, and institutionalization. As of the publishing of this book, there is no one agreed-on diagnostic label. The National Child Traumatic Stress Network (NCTSN) uses the term complex trauma (Cook et al., 2003) because chronic trauma within relationships results in damage to seven areas of development, and hence, is "complex." Others are using the terms *developmental trauma* (van der Kolk, 2005) and *relational trauma* (Schore, 2001b), the first referring to trauma occurring during early brain development, and the latter referring to trauma within caregiving relationships. Whatever the term, this type of trauma is different from trauma due to a single catastrophic event such as a fire, a flood, or an auto accident.

Complex trauma occurs when those who should protect and nurture the child, sadly, do the opposite and repeatedly harm the

child physically, emotionally, or both over extended periods of time. We are not talking about typical stress levels that would be associated with crying for ten minutes when parents are hoping that their baby will learn to self-soothe and fall asleep on his own. We are talking about chronic patterns of neglect, abuse, humiliation, and emotional abandonment which convey to the child that there is no one who can provide emotional or physical protection. Complex trauma involves (1) the loss of a secure base; (2) the trauma itself; and (3) being alone with the dysregulation (Schore, 1994; Main and Hesse, 1990). These children have lived a life filled with fear and a primal shame that can make it very difficult for them to attach to others without very sensitively executed work.

UNDERSTANDING THE TRAUMATIZED BRAIN

We look now at what happens to a child's brain when he is not protected by his caregivers and is chronically subjected to frightening and life-threatening experiences. When a child's system is stressed, the emotional-anger center of the brain—the amygdala—is activated, setting off chemical responses associated with fear and anger (Gerhardt, 2004), including the release of the stress hormone cortisol, which acts on an emergency basis to draw energy away from the digestive and immune systems so that the body can protect itself by fighting or fleeing from perceived danger. As stress becomes chronic, various systems can begin to break down. Cortisol destroys neurons in the hippocampus, the center for explicit memory. Chronic high levels of cortisol can cause receptors to malfunction and stay in the "on" position, keeping the child ever on the alert, suspicious of large or small sensations that might signal danger. The sympathetic nervous system remains in high gear. In an attempt to return the child to homeostasis, the parasympathetic system kicks in. This should be good news, but in a dangerous environment, a relaxation of vigilance could mean more abuse and even death. While the brain tries to calm itself, however, the alert system remains on. It is as if the brain is pushing down on the accelerator and brake at the same time (V. Kelly, personal communication, February 28, 2009). The nervous system is literally in a fight with itself, wearing down other functions and systems. The thalamus, which plays a critical role in the conditioning of incoming stimuli, malfunctions so that

sensory information becomes disconnected and fragmented, causing a fear response to unpredictable triggers (Fisher and Kelly, 2007). The autonomic system can become stuck in parasympathetic mode so that fear is hidden behind freezing and dissociative behavior.

Understanding Areas of Developmental Impairment

As stress and the fight for survival persists, damage occurs in many domains of development. The White Paper on Complex Trauma (Cook et al., 2003), prepared by the National Child Traumatic Stress Network (NCTSN), identifies the seven areas of impairment listed here. Many of these directly relate to our Theraplay work.

- *Attachment:* Children can have body boundary problems, be highly distrustful and suspicious, feel socially isolated, have interpersonal difficulties, have difficulty with perspective taking, not be able to attune to others' emotions, and have difficulty enlisting others as allies.
- *Biology:* Children can have sensorimotor, coordination, balance, and body tone problems, analgesia and hypersensitivity to physical contact, difficulties locating skin contact, somatization, and increased medical problems.
- *Affect regulation:* Children can have difficulty regulating emotions, describing feelings and internal experience, knowing and describing internal states, and communicating wishes and desires.
- *Dissociation:* Children can experience altered states of consciousness, amnesia, especially for trauma-related memories, depersonalization, and derealization. Also, there can be two or more distinct states of consciousness with impaired memory for state-based events.
- *Behavioral control:* Children can show poor impulse control, self-destructive behavior, aggression, pathological self-soothing behaviors, sleep disturbances, eating disorders, substance abuse, overcompliance or oppositionality, reenactment of trauma in play, and trouble understanding or following rules.
- *Cognition:* Children can have problems with executive functions, such as difficulty with self-regulation, focusing and completing

tasks, learning and language, planning and anticipating, object constancy, orienting in space and time, and acoustic and visual perception and comprehension.

- *Self-concept:* Children can show a lack of continuous, predictable sense of self, poor sense of separateness, body image disturbances, low self-esteem, and pervasive shame.

Understanding the Long-Term Effects of Trauma on the Brain

As trauma becomes chronic, the child's neurophysiology organizes into trauma pathways. The brain becomes "fear-driven" (Fisher and Kelly, 2007) or "kindled" (van der Kolk, 1991), conditioned to fire up and react reflexively at the slightest hint of the past trauma. It becomes overfocused on nonverbal signals of safety or threat (Perry, 2006). The trigger—a stimulus that generates in the amygdala an implicit body memory of the sensations of the trauma—sets off a protective, unprocessed, right-brain reaction that others perceive as an irrational overreaction. This is, indeed, an overreaction in the present because it is fundamentally a response to a threat in the past. The brain is hijacked into an automatic, unconscious reaction to a present stimulus that has some similarity to the original trauma (LeDoux, 1998). Survival behavior kicks in and brain signals go to the muscles for fighting or fleeing or, if escape is impossible, for shutting down and freezing. At this moment, the child is functioning primarily from her brainstem, the area responsible for assessing and responding to immediate threat in the environment. Bruce Perry and his colleague (2007) speak of this state as the "alarmed" state on the arousal continuum; the child is no longer able to engage in abstract thought and learning. She cannot think about consequences for behavior and reacts impulsively or aggressively toward the perceived threat. She cannot access the associative cortex to reassess the situation and realize that, "I'm really safe now." The child is experiencing a trauma moment with part of her past intruding into the present.

Understanding the Characteristic Behaviors of the Fear-Driven Child

These neurological trauma reactions to a conditioned fear lead to behaviors that can be confusing and very challenging for therapists and parents. These behaviors can include

- Being more susceptible to pervasive shame or rage

  When a child feels chronically alienated and terrified within a caregiving relationship, the result is a sense of pervasive shame (it's my fault; I'm no good; I shouldn't even be here). This triggers the self-protective need to withdraw or to attack violently, and can paralyze and damage relationships if not healed. Shame is different from guilt, which is a feeling that leads to the repair of the relationship.

- Being easily dysregulated

  Reactivity comes from (1) being hyperalert to possible danger (trauma), and (2) feeling easily shamed. Dysregulation can be masked by dissociation or freezing.

- Needing to control to feel safe

  Because they feel so chronically out of control, these children seek to control whatever they can in the external world as a desperate attempt to feel some degree of safety. This is different from the conscious wish to control others.

- Fearing intimacy, nurturing, and love

  When trauma is wired in the brain, neutral and even positive aspects of the situation can be associated with the dangerous experience. In complex trauma, interpersonal contact, eye contact, and touch can become part of the trauma experience so that these are now perceived as dangerous and are avoided.

- Avoiding deep feelings or only feeling big feelings

  Some children work hard to avoid deep feelings of need, sadness, and even anger, blocking off their emotions from parents and therapists. Conversely, others, whose dysregulation is outwardly expressed, persistently bombard parents and therapists with big feelings in ways that can feel traumatizing for those trying to help.

- Misinterpreting intentions of others as threatening

  Traumatized children have learned to expect the worst; even positive facial expressions, voice tone, and words can be experienced as angry and negative.

- Acting out of a fragmented inner working model

  These children have unstable mixtures of positive and negative inner working models. At any moment, they can flip from positive to negative without much apparent provocation. Misinterpreting the intentions of others and being hyperalert to danger makes it easier for them to shift into the negative model in which everything in their environment is dangerous and hostile.

- Making choices out of a warped sense of conscience

  Children who have been profoundly deprived of early empathic caregiving have not had the developmental experiences required for conscience development. Accepting responsibility for their actions is toxic to them, and blaming others is common.

- Seeking constant attention

  The fear under this behavior may be that they do not exist, can be easily forgotten, or cast away (as happened when earlier caregiving relationships were disrupted).

- Acting out more when trust starts to develop

  They may either be trying to provoke a repeat of abandonment or they have become afraid of losing their parent.

Calming Trauma Reactions

Bessel van der Kolk and Bruce Perry, leading trauma researchers, recommend that in order to calm the aroused brain, therapy must address the person's physiological state (Wylie, 2004; Perry and Szalavitz, 2007). Both researchers believe that physical action, body work, attention to arousal level, and soothing and comforting are prerequisites for processing trauma using conscious thought and attention. Perry's neurosequential approach (Perry and Szalavitz, 2007) suggests that treatment be geared to the level of the brain which has been damaged by relational trauma. If these lower brain areas—implicated in the alarm and numbing responses—are in a constant state of arousal, then neurological functions at higher levels cannot develop normally. The lower, earlier-developing brain areas respond to the healing effects of rhythm and touch. Perry recommends, as Theraplay does, that such calming activities be done in the context of a caring and nurturing relationship. Theraplay activities, such

as Blanket Swing, "Twinkle" song, Row, Row, Row Your Boat, and Caring for Hurts, provide rhythmic and physical contact experiences that are regulating and calming.

MODIFYING THERAPLAY FOR CHILDREN WHO HAVE EXPERIENCED COMPLEX TRAUMA

Because the child's brain is kindled and he is so easily threatened and reactive, we need to modify Theraplay in the direction of greater sensitivity and more attention to the child's fears, always being ready to calm trauma reactions. At the same time, we want to offer fun and attachment-promoting interactions to help heal negative experiences of the past. In the following section we present our suggested modifications for Theraplay with traumatized children. Because each child will have different needs based on how he has coped with his traumas, clinical judgment should be used in choosing which modifications to use.

Knowing the Child's History

You will want to know as much as possible about the child's trauma history, including the timing and frequency of the traumatic events, the child's living conditions, the number of caregivers he had, and the number of losses he experienced as a result of changes in placement. If the child was with neglectful birth parents for any length of time, was he moved back and forth between extended family and the parents many times? If the child was adopted from overseas, it is important to know the quality of care in the child's particular orphanage so that you are aware of the extent of the neglect and lack of stimulation. You must try to reconstruct every aspect of the child's journey in order to make an educated guess as to the amount of trauma he may have undergone. The more you know about what happened to the child, the more you can attune to the child's fears and needs and help parents do the same.

It is also your job to help the parents extrapolate from the little they do know about their child's environment and generalize to the global effect on their child's development. Two very loving parents brought in their three-year-old daughter, Bella, adopted from China at fifteen months, because she was aggressive toward their other children. They stated that care in their daughter's orphanage had been relatively good in comparison with other Chinese orphanages.

The orphanage was clean, brightly lit, the ratio of caregivers to children was not as abysmal as in other places (but in practical terms this meant one worker for every ten infants), and they were well fed and medically well cared for. The couple could not understand what could possibly have been so traumatic as to cause their daughter, two years after leaving the orphanage, to behave so aggressively toward their other children. After several conversations about the child's history, the mother casually stated that she had witnessed a scene in the orphanage when she happened to pass by a room that was "off limits" to visitors. She saw the nine- to eleven-month-old toddlers being taken out of their cribs and placed in walkers. One worker held a common bowl and spoon. In order to prevent the girls from grabbing the spoon, their hands were tied to their walkers at their wrists. The baby girls would scoot up toward the worker to get a spoonful of porridge. After receiving her spoonful, the worker would push the child away so that the next child could approach the bowl. When the food was gone, the girls were placed back into their cribs and handed a bottle.

Bella's parents were unaware that they had indeed witnessed a traumatic scene because all the girls had been compliant and had not been screaming or crying. However, Bella's therapist knew that the entire experience, from the tying of her hands to having to compete with her orphanage sisters for food, set her brain into a tremendous state of anxiety. It is likely that Bella had felt chronically deprived, anxious, and threatened. By expanding on this example and explaining how it affected Bella's brain and perception of the world, the therapist helped Bella's parents see why their daughter would feel threatened and become aggressive toward her adoptive siblings. Helping parents understand their child's history lays the foundation of empathy that parents must have for their children in therapy.

Educating Parents

You will need to help parents understand how behavior can be triggered by trauma and why their child needs support, calming, and empathy instead of punishment and time-outs. Parents need to understand how much stress their child is in and that this may be hidden under the outward show of indifference, passivity, or bravado. By educating parents about how conditioned reactions to trauma become automatic survival mechanisms for children, we can

help them recognize this as a trauma reaction, rather than a personal reaction to themselves. In addition, many traumatized children have sensory issues because of neglect and the lack of stimulation and social interaction. If an occupational therapy referral appears warranted, explain why this is important. Parents of children adopted from orphanages will need to understand how damaging orphanage living is to a child's emotional and social development. Finally, when there is evidence that birth parents abused alcohol or drugs, parents need to be educated about the effects on the child and which skills are likely to be hard for their child to develop.

Establishing Safety

The child's sense of safety—both physical and emotional—must always be in the forefront of your mind. If you are working with a child where it is known or becomes known that she is being abused, the first task is to make sure she is safe. Only after the child's safety is assured should you consider Theraplay as part of her treatment. If a child is with her past abuser, who presumably is now considered safe, or with the parent who didn't protect her, the parents must repair their profound lapse of judgment by taking full responsibility. Again, unless this reflective repair has taken place, Theraplay should not be used.

Even though the child is in a situation that you consider safe, the child may continue to feel unsafe. We cannot assume that any of these children feel safe just because the abuse has ended or happened far away. Rather than observing that the environment looks safe to us, we need to help parents create an environment that *feels* safe to the child. Establishing a sense of safety for children with histories of complex trauma is the first step in treatment. Theraplay can play a part in this process.

Traumatized children have experienced many stressors, including being abused and frightened by caregivers, experiencing the disruption of the caregiving relationship, or being removed from their familiar home and being placed with strangers. Your major goals will be to help the child feel safe and calm, help him learn to trust, and help establish normalcy in his life.

FEELING SAFE. In order to feel emotionally safe, the child needs to feel both protected and respected so that the fight, flight, or freeze

response is calmed. You will need to help parents accept the child's feelings and behaviors so they don't inadvertently elicit feelings of shame or rejection in her. While you work to create the safe environment within the family, you will also need to help the child understand and begin to integrate the abuse she suffered. If you are trained to do trauma work, you can provide it as part of the treatment as well. Otherwise, refer the family to someone who can do this work. Because children are so easily precipitated into a hyperaroused state by talking about their experiences, however, they are often unable to make use of talk therapy. Perry (1994, p. 3) says, "A frightened child doesn't 'hear' words; they 'hear' (process) emotions." Also, children cannot constantly process trauma. A combination of trauma work and Theraplay is ideal, as it allows you to shift from one modality to the other as the child's tolerance for the work dictates. This is where the experiential nature of Theraplay can be very helpful.

DEVELOPING TRUST. Trauma and abuse undermine trust. As long as the child is in a state of alarm, he is unable to learn to trust. Theraplay treatment can be used to help the child move out of the alarm state and develop a trusting relationship. The focus should be on making the child feel safe, calm, and comforted, and on helping him begin to learn that he can count on adults to be there when he needs them. Structure and predictability, as well as chants, songs, and rhythmic movement can quiet the child's alarm system; engagement and nurture will help him feel cared for and special. Paying special attention to any "hurts" the child brings to the session conveys a comforting message. You can make a caring ritual out of Checkups, including putting lotion on bruises and Band-Aids on scratches, so that the child gets the message that his body is worthy of loving care. Accidental bumps or hurts that occur during a session should be attended to and the activity should be repeated more safely: "Let's do that again more slowly, so that it's really safe." In this way the child comes to see that he can trust his caregivers to attend to his needs and to keep him safe.

ESTABLISHING NORMALCY. The third goal of Theraplay treatment is to help the child return to normalcy. You can help parents establish predictable routines during the day and develop nighttime rituals as well so that the child is comforted and reassured. You can help them find ways to have fun and lighten their child's life. These children

need to be allowed to have the normal experiences of other children, including play.

Involving Parents More Than in the Typical Theraplay Protocol

Your work with parents is likely to be more complex than with typical Theraplay cases. Because of the extremely challenging and confusing behaviors they have to deal with, parents need more support and help with their reactions to their traumatized child. Almost always, you will have to do some work on the parents' own trauma or attachment histories. In Chapter Ten we describe how one therapist helped an adoptive mother process her own early experiences that were getting in the way of forming a secure attachment with her child. Unresolved issues leave parents more vulnerable to being reactive to the child's responses and can prevent parents from being positive, accepting, and nurturing. If you are experienced in adult psychotherapy, it can be an advantage to work with parents yourself because you will understand better what is triggering them. The empathy that you show toward parents around their own attachment history can become a powerful model in supporting their greater empathy toward their child's history. Otherwise, refer them to a therapist who understands attachment issues. We have found it helpful to use both Daniel Hughes's approach (2007) to working with parents and Francine Shapiro's Eye Movement Desensitization and Reprocessing (EMDR) (1995), but how you work with each parent should be based on your clinical judgment and training.

You will want to build parents' skills in engaging with their child despite her avoidance and rejection. Some parents feel emotionally abused by their child's hurtful or threatening behavior. If they actually fear their child, it will seriously interfere with their ability to be emotionally or physically close. In such a case it is essential that you resolve the issue enough to make it possible for parents to participate in Theraplay and then gradually desensitize them by practicing activities in which they get physically close to the child.

As parents come to appreciate how damaging their child's early experiences were, they will need your help and support as they process their sadness about what she went through and at not having been there to protect her. Finally, warn parents that as their child feels safe enough to let herself be vulnerable, she may act much younger

during nurturing activities because her unmet need to be cared for can emerge.

Defining Your Role as Promoting Interactions Between Parent and Child

In Theraplay with children who have suffered complex trauma, as well as with adoptive families, we strongly advise that the parent be present in sessions from the start. We do not want children to think that we will separate them from their parents as has been done to them before. And most important, we want to ensure that the primary attachment we facilitate is between the child and parent. During the therapy process, the child may develop a parallel, yet less significant, attachment toward you, but be alert that this does not grow so strong as to foster "splitting" in the child. Children who have not developed an attachment to their caregiver or who have had repeated disruptions from caregivers may be all too ready to see you as another caregiver and to cling to you rather than to their parent. You need to be clear about your role. Explain to the parent and to the child that you won't become the child's parent; that your role will be to help their family feel closer and have fun together.

Should a child try to hug or kiss you, gently say that hugs and kisses are just for family. Or excitedly claim: "Wow, how wonderful that you know how to hug and kiss! That is special stuff that belongs to Mom and Dad," and gently redirect the child back to the parent (V. Kelly, personal communication, February 28, 2009). You can also say, "I know you may be confused about who you should hug or kiss. I will help you figure it out." To further soften this correction, you can create a special handshake that will honor your important relationship with the child and his family.

Explaining Why You Are Playing

Children who were not played with as babies have not developed expectations that play is an opportunity for fun and good feelings; instead, the intense and close contact with an adult may be experienced as something uncomfortable and possibly frightening (V. Kelly, personal communication, January 7, 2009). Because of their early upbringing in an environment hostile to their development, these children fear that everyone will be hostile toward them. It is important that you let the child know that you understand his fears and that you

be explicit with parents and the child at the beginning of therapy, and throughout, about why you are playing these fun, happy games. You should tell the child, "Little babies are born smiling and ready to play, so that learning for them can be easy and lots of fun. But sometimes children don't get those good experiences, and they have to spend all their time learning to stay safe. I think that's what happened to you. Now that you're with your forever Mom, I am here to help you learn how to be comfortable having fun and being happy with her."

Developing a View of "Resistance" as the Child's Need to Self-Protect

Working with a child who has suffered complex trauma requires a different appreciation of resistance than when working with a nontraumatized child. Nontraumatized children resist because they have taken a role in a family dynamic that they seek to maintain. This is unconsciously learned behavior, familiarity-driven but not fear-driven. The internal working models for these children may be something like the following: *I'm difficult, annoying, too demanding, or needy—my parent can't handle me, is worn out, angry—the world is unpredictable, unreliable, or rejecting.* When we treat these families, we "shake up" the family dynamic, working with parents and child so they can experience the healthy, close interactions essential to the development of a positive inner working model. In contrast, what looks like resistance in a traumatized child is coming from a desperate need to stay safe. Traumatized children have had experiences that literally threatened their lives and led to internal working models such as: *I'm hateful, not worth anything, undeserving of anything good—no one really cares about me—no one and nothing is to be trusted—the world is dangerous and hostile.* We have to work much harder and even more sensitively with these children to avoid triggering a fear reaction *in the current environment* because it will reinforce the child's experience of danger within the family and with you.

Theraplay's positive, spirited approach may stir up "resistance" for these children because it is so discrepant with their negative inner working model. Engagement and nurture, even when done with positive intent, can trigger anxiety or anger. Not only do these children have difficulty with fun, they also need to keep their distance and be on guard. It is as though the child insists: *Fun and nurturing care cannot be part of my life. I don't deserve it, it is foreign and*

dangerous to me and I don't understand it. It could bring me closer to my parents, and I will feel things I'm afraid of feeling. I must guard against that happening. To such a child, being in control of her world is the only way she has been able to survive. When the therapist or parent takes the lead, she feels threatened at her very core.

Acknowledging and Respecting Child's Fears

Some children are clearly fearful and hypervigilant; their bodies are stiff, their faces are frozen, and their eyes are darting. You should acknowledge the child's fear and convey that you will protect him and keep him safe. Some concrete ways to respond to his anxiety about what to expect include having your materials out and answering any questions he may have about them. In the same vein, you can allow him to scan or explore the room with you and to ask questions about it. Thus you calmly respond to his fears and accept his need to know what is going to happen. When you sit down to play, don't expect to take his shoes off immediately because that could feel too intimate and exposing. You should also describe new activities in order to give the child a warning that something different is about to happen, for example, "Now, I'm going to help you stand up so I can measure you against this wall." This prevents surprises that can feel dangerous to a traumatized child. The presence of a trusted caregiver can reassure the child and calm him.

THERAPLAY IN PRACTICE

Respecting a Traumatized Child's Fears

Shana was a seven-year-old girl placed in a potential adoptive home six months before starting Theraplay. Her early life was filled with severe neglect, exposure to domestic violence, and instances of physical abuse from both parents. She had several foster placements between the ages of three and seven that were terminated when the care and protection was deemed to be inadequate. Her new mother described her as anxious, critical, and quietly controlling. She had noticed that when Shana was redirected or reprimanded, she "went blank." Shana did not share her feelings or likes and dislikes with her

parents. In the MIM Shana displayed a constricted affect with little facial expression, no initiation, and quiet responses to her mother's questions and attempts to engage her.

The therapist, Tom, planned the first treatment session keeping in mind Shana's tendency to dissociate. In order to help her feel safe and comfortable, her mother was in the room with them. He focused on playful engagement and challenge rather than nurture, he eliminated surprises, and he limited his physical contact with Shana to the matter-of-fact contact necessary to carry out the play activities. At the first session after the MIM, Tom met Shana and her mother at the treatment room door with a balloon in his hand. "Good to see you both again!" he said as he shook their hands in greeting. Then, paying special attention to Shana's hand, he said, "Mom, you told me Shana was good at badminton and playing the piano. You know, I think you have the perfect hands for this game. We're going to tap this balloon between us and try to keep it up in the air while we walk over to our pillow seats." Tom picked this activity to signal that the session would contain fun, manageable challenges. Mom, smiling and raising her hands to catch the balloon, said, "Well, I guess we can do that." Shana smiled slightly, but looked unsure, so Tom said, "Mom, I'll tap it to you and you tap it to Shana. Let's get it going and then we'll start walking over there." When they reached the pillows, Tom said, "Here's your pillow, Shana, and Mom, you sit on that one right next to Shana." Shana noticed the several sheets of newspaper, a cotton ball, and crepe paper streamers lying on the floor next to Tom's pillow. He had purposefully left these materials out rather than keeping them in a bag or basket in the hope that it would reduce Shana's anxiety about what might happen in this new situation. Shana asked, "What's that?" Tom answered, "Those are the things we're going to play with today." Then, highly aware of her new surroundings, Shana pointed to the TV in the corner of the room and asked, "What's that for?" In a relaxed way, Tom answered, "Yes, I have a TV in my office; we won't use it today." Shana went on. "What's that door for?" Tom: "That's

where the bathroom is. You know, I think it's a very good idea to check out things when you're in a new place. Let's do it together, what else do you see?" It was important that Tom accept and normalize Shana's hypervigilance. So, for five minutes, Shana noticed details of the room, and Tom talked about each one with her. At the end, Tom successfully brought the focus back to Shana, saying, "Did we get it all? Wow, you've got really sharp eyes to notice those details! Here's what I know about you already, you've got good hands, sharp eyes, and a great brain to know what all these things are. I have the crepe paper so you and Mom can make some measurements. Mom, take the streamer and measure how long Shana's right hand is from her palm to her longest finger."

Increasing Your Sensitivity and Attunement

Children who have suffered complex trauma have experienced very little attunement from caregivers. Had their caregivers been attuned to their child's needs, the neglect and abuse would not have happened. As part of the healing process, you must give the child a different experience. Increase your sensitivity and attunement by paying attention to small signs of tension, discomfort, or stress. A subtle tensing of the body or flick of the eye may signal that she is scared. These signs are not always easy to read, however, because traumatized children can miscue about their needs. They might laugh or tickle you when uncomfortable, or suggest an activity when nervous. Or their eyes may simply widen or narrow, hinting that they are feeling an important emotion. You need to respond with curiosity and gentleness to let the child know her signals will be respected.

THERAPLAY IN PRACTICE

Attuning to an Anxious, Reactive Child

Ashante was an eight-year-old girl in long-term foster care. She had experienced multiple placements, was abused in at

least one of those homes, and had now lived with her foster parents for three years. Her parents described her as "jumpy" and hyperactive. She did not stay still for long, and made most interactions into wild, highly stimulating games with loud sounds, swinging her body and long hair back and forth, and often ignoring the limits her parents tried to set. She was good at "turning up the volume," putting interactions into "fast forward" so she could shut out her parents. In her first Theraplay session, Ashante and her mother were met by her therapist, Mindy, who whispered that they would walk in slow motion to the beanbag chair. Mindy had the mother sit across the room to observe the session. When Mindy and Ashante sat down, Mindy began Checkups. Ashante watched intently as Mindy counted her fingers, noted her sparkly eyes, found special spots and hurts. Mindy noticed that Ashante's body was tense and stiff. While counting fingers, Mindy felt a brief muscle change when Ashante tried to pull her arm back. Rather than ignore it, Mindy said, "Oh, I wonder if you're not so sure about this game. What am I doing, counting your fingers? Nobody's ever counted my fingers before! Well, Ashante, I think it's good for kids to have someone count their fingers because they will feel important and special. So I'm going to count your fingers now. Get ready." And Ashante, not yet so sure but feeling safer because of Mindy's sensitivity to her cues and thoughtful preparation about what was to come, kept an eye on Mindy, but relaxed her arm so that Mindy could count comfortably. Throughout the session, Mindy noticed and commented on the small signs of anxiety that Ashante communicated through her body, for example, "You're not so sure about this, are you?" At times, Ashante would shake her head "No," and at other times, she'd just look back, surprised by Mindy's attunement. When Ashante said "No," Mindy would modify the game slightly saying, "Okay, how about doing it this way?" Otherwise, Mindy would proceed in a gentle, confident manner that helped Ashante feel safe and supported. The session provided many opportunities for attunement, and Ashante stayed connected throughout.

Using Matter-of-Fact, Nonthreatening Touch

You should gradually help the child be more comfortable with touch because that is the only way for him to experience what healthy touch is. If the child has been taught that people must ask permission to touch him, affirm that as a very good rule that protects him from people who do not respect him. Add that his parents and you respect him very much and will help him learn how to accept all the good touch you have to offer. Always accept the child's "No," and verbalize it for him when you see fear or discomfort even when he hasn't said anything. This is the opposite of the experience he had during past traumatic incidents and can be very empowering.

Your touch should make sense within the context of the activity and be used for the purposes of providing support and structure, engaging the child, or helping her regulate. Your touch should be matter-of-fact and nonthreatening in order to help her differentiate it from seductiveness or aggression. Most children find firm touch calming. Tickly, soft, light, or tentative touch can be stimulating and should be avoided. Any touch that comes from your feeling that the child is just so appealing that you want to touch her, such as stroking her arm or hair, is not appropriate because it is meeting your need and not the child's. You need to recognize this as a countertransference reaction. You can increase your awareness of your countertransference feelings and behaviors by watching videotapes of your sessions and by getting consultation. If you see parents touching their child this way, you need to help them stop because this type of touch actually distracts a child from the therapeutic play you are offering.

Maintaining Optimal Arousal for Engagement

Optimal arousal can be challenging to maintain for the child who is easily dysregulated by the perceived spontaneity of Theraplay. You can help a child stay within an optimal range of arousal by

- Approaching gently yet remaining playful and engaging
- Minimizing stimulation associated with eye contact
- Increasing predictability
- Offering choices
- Using activities requiring left-brain or left-right-brain integration

APPROACHING GENTLY. For the anxious, hypervigilant child, you should reduce the level of stimulation so as not to trigger alarm. Quieting your voice and moving more slowly can keep excitement down. Be confident and remain gently playful to communicate that he is an interesting, likable child and that you are a trustworthy, fun-loving, and caring adult.

MINIMIZING STIMULATION ASSOCIATED WITH EYE CONTACT. Sometimes a child is threatened by face-to-face contact with you or her parent. She will stay engaged in activities if she can avoid direct visual contact. Use activities in which she can hide her eyes, be under a pillow or blanket, or sit facing away from the person she is not ready to look at. We see an example of this in Carl's case.

INCREASING PREDICTABILITY. Structure and predictability will help the child anticipate what will happen. One way to increase predictability is to review with her the list of activities that you plan to do during the session. Developing predictable sequences in your sessions can help her feel less anxious and be able to stay more engaged. You could start and end sessions with the same games or songs, or play a few activities and then give her a break, after which come more activities.

OFFERING CHOICES. Another option is to present an activity and have the child take a turn doing it his own way. In order that he feel more in control, he can be the one who does the activity first—such as hiding a cotton ball on you or putting lotion on his father's hand. When starting to use lotion, for example, you could say, "I'm going to put lotion on your hands and Dad's hands. Do you want your hands to be first, or Dad's?"

USING LEFT-BRAIN OR LEFT-RIGHT-BRAIN ACTIVITIES. When a child gets noticeably agitated, you should reduce the intensity of the interaction to keep her engaged. Switching to a left-brain activity or one that requires left-right-brain integration can calm the right brain and prevent dysregulation. Reading an attachment-related children's book focuses the child's attention on something that is more impersonal, yet consistent with Theraplay. We refer briefly at the end of this chapter to the use of attachment-oriented children's books in treatment.

THERAPLAY IN PRACTICE

Keeping an Avoidant Child Engaged

Carl was a four-year-old boy, adopted from Russia at thirteen months. He needed to be in control so much that you could always count on his doing just the opposite of what he was told to do. Because paradox worked every time, his therapist, Pat, got him to sit in his mom's lap by gently challenging him not to. Once there, Pat allowed Carl to sit turned away from Mom and facing Pat for Cotton Ball Touch to decrease the intensity of face-to-face contact with his mother. Pat asked Carl to choose whether Mom should touch a hand or a cheek. Carl said, "Hand." Mom, from behind, touched Carl's hand with the cotton ball, and he said that Mom had touched his other hand. Pat expressed amazement that he could feel the touch way over on his other hand. They continued like this, with Pat asking Carl to choose which body part Mom would touch, Mom touching Carl from behind because that was the level of intimacy that Carl could tolerate, and Pat accepting that the touch appeared on the opposite side of Carl's body. Then Pat suggested that Mom and Carl pop bubble wrap together. Carl would have none of this. "I can do it myself," he said emphatically. Pat said, "Sure you can. Show me." Carl popped a few bubbles successfully. Then Pat said, "Now, can you pop one and then Mom pop one? Who should go first, Carl?" Carl said he would go first, so he popped one, then Mom popped one. Quickly, Pat told Carl to pop one after Mom. Pat had to count each pop with some emphasis to hold Carl's attention. If he had realized how well he was cooperating and taking turns with his mother, he might have stopped playing. Eventually, Mom and Carl got into a rhythm, and he began simply to enjoy the challenge and the fun.

Some children, however, are so easily alarmed that no matter how predictable your session or gentle your approach, your offering of games and activities is perceived as a threat to their safety. The child may violently reject any confident overture you make toward her

and immediately run away, throw things at you, or yell "No!" In these instances, it is necessary to reevaluate whether her basic needs are being met and whether she is ready for Theraplay treatment. There are many variables that may interfere with the child's ability to benefit from Theraplay. In addition to our suggestions on calming the dysregulated child (see page 384), we recommend the following:

- Increase your work with parents to make sure the level of emotional and physical safety at home is therapeutic
- Refer the child for a medical or psychiatric evaluation
- Seek consultation

Building the Child's Tolerance for Positive Interactions with Parents

Because traumatized children resist activities that are fun and nurturing, it can be hard to find games that help them relax into natural reciprocity with their parent. We suggest a number of strategies:

- Repeating activities that work
- Building closeness whenever possible
- Introducing nurturing and intimacy gradually

REPEATING ACTIVITIES THAT WORK. When you discover an activity that captures the child's interest and excitement, do not hesitate to repeat it within a session, across sessions, and to suggest it for "homework." The best way to develop patterns of positive interaction is to practice, practice, practice.

THERAPLAY IN PRACTICE

Practicing a Favorite Game

Kay was a four-year-old girl with a fear-driven brain, adopted from Romania at age fifteen months. To feel safe, she had to control everything and could not engage in play if she wasn't in charge. Happily, a few activities were consistently able to engage her. An example was Cotton Ball Hide, which seemed

to "grab" Kay in spite of herself. After doing this activity for the first time in a session, Mom reported that, at a restaurant, Kay let her ball up a napkin which Kay hid under her shirt so that her mother could find it. The therapist made it a point to have Kay and Mom repeat this game in their Theraplay sessions.

BUILDING CLOSENESS. In order to develop personal interaction, seize any opportunity to initiate or expand on a Theraplay activity and to model and promote closeness and touch between parent and child.

THERAPLAY IN PRACTICE

Building Closeness with a Shut-Down, Touch-Avoidant Child

Jerry was an eleven-year-old boy who had been rejecting his parents' touch and closeness since he was adopted as a preschooler. Now in Theraplay, Jerry shrugged off any type of touch, friendly or not. Kit, his therapist, initially chose games that did not include touch: Balloon Bop, Measuring (with minimal touch), and Feather Catch. Next, Kit had Mom look for lines and letters in Jerry's hand and asked Jerry to find lines in his mother's hand. This was too intimate, and Jerry quickly said, "I don't want to do this," pulling away from his mother. Noticing Jerry rubbing his hands together, Kit asked, "Did that tickle you? Let's rub our hands fast like this." Jerry and Mom imitated her. Quickly, Kit said, "Feel my hands. Which one of ours is the warmest?" Jerry took Kit's hands. Seizing the moment, Kit told Mom to hold hands, too, so that the three made a circle. "Okay, whose hands are the warmest?" Jerry said his were, but actually Mom's were warmest. Jerry cheerfully said, "I'm second!" Now with Jerry engaged, they all rubbed hands again to see if Jerry could win.

INTRODUCING NURTURE AND INTIMACY GRADUALLY. Nurturing and intimacy are particularly tricky to introduce to a child whose brain is fear driven. These types of interactions can involve intense eye contact,

close body contact, and the experience of being given to. Receiving nurture can frighten a child because of its potential for eliciting deep feelings of need and longing which, in turn, can trigger sadness and grief for experiences missed and people lost. Also, to fully experience intimate nurturing, the child needs to let go. Because opening up to painful feelings and letting go of control can be hard for traumatized children, they often avoid tender, caring activities. You will need to introduce intimacy and nurturing slowly so the child will not be alarmed and become defensive.

THERAPLAY IN PRACTICE

Introducing Nurturing and Intimacy with an Independent Child

Leah was a six-year-old girl adopted from China at twenty months of age. Prior to adoption Leah lived in an orphanage and was reported by caregivers to be a very independent child. Once adopted, she wanted to do things for herself and was often critical of her mother, especially when she tried to care for her. This pattern was evident in Theraplay sessions. Leah was receptive to nurture and engagement from her therapist, but was critical and rejecting of her mother. For example, when Deborah, her therapist, put lotion on Leah's hurts, she relaxed and accepted it. But when her mother provided the nurture, Leah pointed at her arm and stated harshly, "You're not doing it right. Don't rub it like that. You're using too much lotion." In response, Deborah said, "It's hard for you to let your Mom take care of you." Leah agreed. Deborah said, "That must be hard not to be able to let your Mom take care of you. You had to learn to be big and strong when you were just a little baby when you should have had a Mommy to take care of you and keep you safe. Now it's so hard to trust and feel safe with your Mommy. You want to keep doing it for yourself and be a strong, big girl."

Helping Leah and her mother understand Leah's rejection was important, but they also needed experiences that would

help Leah relax and accept closeness and care from her mother. In order to build a tolerance for nurture and intimacy, Leah needed repeated experiences that would create positive connections in her brain associated with her mother. To help Leah accept intimacy, Deborah chose a game of stickers. Deborah offered Leah a sheet of stickers and instructed her to put one on her own face. Leah did. Deborah allowed Leah to choose her own sticker and place it on her face in order to give her a sense of control, yet Deborah maintained structure by clearly guiding Leah in what to do with the sticker. Next, Deborah showed the stickers to Leah's mother, asked her to choose a sticker, and place it on the same spot on her own face to match Leah's sticker. Mom then put a sticker on her own face and asked Leah to put one on herself in the same spot. Deborah had them lean close together to look at themselves in the mirror. Leah smiled and turned briefly to look directly at her mother. Because Leah was so receptive, Deborah continued this game for a few more rounds. Leah was enjoying this activity, working hard to place her own sticker in exactly the same place as her mother's and thinking carefully about where to place her own. She was not rejecting or criticizing her mother in any way. Soon she was smiling and laughing. She joyfully pointed out, "We have stickers in the same spots!" The next step was to initiate direct touch. Deborah asked Leah to place a sticker on her mother's face, and then had Mom put one on Leah's face in the same spot. Leah relaxed and accepted touch from her mother and gently gazed into her eyes as they put stickers on each other. For the remainder of the session, Leah would reach and touch her own face to feel her stickers, making sure they were still there. Then she would look to see if Mom's stickers were still on her face. When it came time for Mom to feed Leah a snack, however, she would not let Mom feed her. She reminded Deborah, "I can feed myself!" Deborah decided she would let Leah feed herself a bit, and then go to the next step of Mom holding the cracker while Leah held Mom's hand so Leah could guide the cracker into her mouth, and finally Leah let Mom feed her a few crackers.

Developing Ways to Calm and Comfort the Dysregulated Child

Because these children can be easily dysregulated, even the most experienced therapist will find that his young clients have moments in which they become out of control, avoidant, wild, angry, or enveloped in shame. Although we try to avoid such extreme reactions by modulating the child's sense of shame and threat, it is very hard to predict what the child will overreact to. Rather than seeing his reaction as "resistance," you should recognize it as the child's desperate attempt to keep himself safe. Once the alarm state occurs, your primary concern is to calm down, regulate, and reassure the child.

The following description by Bruce Perry of his approach to a severely maltreated child who was in a state of panic at the approach of any stranger provides a model for helping a highly dysregulated child calm and begin to feel safe. "I tried to be as non-threatening as possible: no quick movements, no eye contact, trying to speak in a low, melodic, rhythmic tone, almost like a lullaby. I approached him as one would a terrified baby or a frightened animal" (Perry and Szalavitz, 2007, p. 131). In a Theraplay session you can provide a safe, comforting area of the room that can help to reduce extraneous stimulation, which might be additionally frightening to the child. If a child hides her face, do not make it into a game as you might with a typical Theraplay client, but allow the child to climb into pillows or under a blanket to calm herself. It may help to stoop down to the child's level so she feels less threatened by you standing over her. At the same time keep some distance between you to reduce her heightened fear of being attacked. You can offer her food or drink. While the child is calming herself down, you can talk sensitively with her parents about what she might be feeling and why. Putting words to the child's experience, coupled with reassurance, can help her feel understood. Once the child is calm enough to reengage, you should do what is necessary to repair the relationship. We will discuss relationship repair in the section following the next case example of helping a dysregulated child calm down.

THERAPLAY IN PRACTICE

Allowing a Dysregulated Child to Soothe

Hal was an easily dysregulated child. He would frequently scream "NO!" when told to do simple things like drop the

Beanie Baby in his father's hands. If the therapist acknowledged that he was upset, he would immediately hang his head, frown, and then hide his face in the pillows. If his father tried to press him to talk about what made him angry, he would become more upset and hit his dad. When his therapist tried to engage him in play, Hal would kick or try to run away. The therapist learned that it was best to limit her talking and instead quietly support and praise Hal for hiding his eyes and covering his face. After a few moments of silence, the therapist quietly commented to Hal's father that these behaviors were Hal's way of saying that he needed a break from his strong feelings. He did not want to get overwhelmed, so he was smart to take a break. The therapist helped Hal's father wait quietly while she offered Hal juice and a cracker. When she felt he was ready to reengage, she chose an activity that was mediated by an object (making a handprint in Play Doh, aluminum foil, or powder), decreasing the focus on interpersonal interaction and making it easier for Hal. This helped Hal regain equilibrium and reconnect to his father and the therapist.

Repairing Relationship Breaks

Attunements followed by breaks in attunement occur as part of normal development. During the early months, parents are delighted with everything their baby does. She can "do no wrong." Babies feel their parents' attunement when they respond promptly and with sensitivity and understanding to their needs. When the child starts to move about and explore the environment, however, parents begin to have more expectations of their child as well as needing to set limits. They say "no," "stop," and "wait," while their faces show negative emotions. Hearing a vehement "No!" the child suddenly feels alone and out of favor. Her universe is crushed, and she feels a new emotion: shame. With downcast eyes, her body freezes. Her father, seeing the dramatic effect of his "No!" on his child, moves quickly to reconnect. He picks her up, pats her back, and says, "It's okay, it's okay. I didn't mean to make you feel bad. I just don't want you to break the vase. You're okay. I'm here." His comforting and his mantra calm her shame and her fear of him, and she slowly looks in her father's face and sees his concern followed by a loving smile.

Her father has repaired their relationship and she feels once again in his favor and good about herself.

A very painful experience at first, these breaks in relationship become less traumatic over time because the child comes to trust that the people most important to her will repair them. She will grow up able to try new things, risk making mistakes, and tolerate normal frustrations. Breaks that are repaired well are integrated into the child's overall sense of herself as good, and the self develops in a healthy direction, able to handle challenge and adversity.

Children who have experienced complex trauma, in contrast, have had so many experiences of unrepaired shame that they come to hate themselves deeply. Breaks that are chronically unrepaired lead to a pervasive, visceral sense of being wrong, humiliated, and disgusting. Shame is a damaging emotion that causes a child to want to disappear or to lash back in rage. When shame persists it becomes the foundation of the child's inner working model, starting the process toward complex trauma. Only attuned repair can begin to heal the child.

Our goal in Theraplay is to be as attuned to the child as a mother is with her young baby. But just as with a mother and toddler, there are times when breaks inevitably occur. If this happens in a session with a child who has suffered complex trauma, you may be faced with a major shame or rage reaction. Difficult as this may be, however, this is a moment that presents an opportunity for healing if you can repair the break. The first step is to convey to the child that he is not out of favor. Your response of concern for him, rather than rejection or blaming, will tell him you still value him. Then you try to understand what happened and explain your understanding to the child. Many times this means that you will take responsibility for triggering his shame. Finally, you acknowledge that the child's response was self-protective, that he probably reacted as he did because it felt like all those earlier times when he was scared or made to feel like a bad child. After this you can reconnect using nurturing or engaging activities.

For example, you might have gotten too exuberant during a Theraplay activity and the child hit or kicked you. When you stop the activity and remind him that there are no hurts allowed in your sessions, he will experience shame. Then as part of your repair you can think out loud about what might have upset him. His hitting or kicking was his way of telling you something important. "Oh,

I wonder if you didn't like how loud I yelled 'You did it!' when you punched that paper. I think I might have surprised [or scared] you. You were just trying to tell me that with your hit. I will try to remember not to get so excited next time." Your understanding that he was protecting himself from perceived danger will help ease any shame over his behavior. When you let the child know he hasn't lost favor and that you can figure out together what happened, he will learn that negative states can be tolerated and managed, and that you think he is important and worthy.

Extending the Therapeutic Support System

Involving extended family and the larger community in Theraplay is valuable for any child, but it is especially helpful in the treatment of traumatized children who need to feel consistent, positive messages in order to solidly internalize them. When grandparents, uncles or aunts, cousins, teachers, and classmates join a child's session, it gives a unified message of support to the child and also helps these important people to understand the child better.

THERAPLAY IN PRACTICE

Bringing an Extended Family into Theraplay

As thirteen-year-old Samuel entered the room with his adoptive parents, grandparents, and two new therapists, his face said it all, "What is going on here?" Samuel's past therapy experiences had included only himself and his therapist. There had been some toys or board games, and lots and lots of talking, mostly done by the therapist. Never before had his family attended sessions with him. He had never taken his shoes off for therapy, played silly games, or had anyone put lotion on him or feed him. After almost two years of traditional therapy, Samuel's parents still saw no improvements in his aggressive, defiant, and oppositional behaviors or his apparent lack of conscience. The family's level of commitment to Samuel was unwavering, but they did not know how to engage, discipline, or nurture him, and they were seeking help.

A week before Samuel's first Theraplay session, his parents and grandparents participated in a Group Theraplay session just for themselves. Afterwards Grandma said, "We loved it, it was lots of fun, but I don't think Samuel will do these things." Their skepticism was quickly dispelled at the first session. Samuel, his parents, grandparents, and both therapists all stood in a circle and took turns tossing a beanbag to someone across from them while naming that person. As the therapists added another and yet another beanbag into the game, everyone watched Samuel's face light up with joy and delight. Soon everyone became relaxed and comfortable as they batted a balloon around and balanced beanbags on their heads. Samuel's openness to nurture surprised his family as he allowed his parents to feed and put lotion on him. Including Samuel's extended support system gave him permission to enjoy himself and be silly while strengthening their relationships and helping him feel accepted.

Because the therapist wanted to help Samuel's parents and grandparents understand Samuel and the Theraplay process more, she had them watch the second session from another room with the interpreting therapist. They were amazed to see Samuel allow the therapist to care for his hurts with lotion, and they watched him stand on top of a stack of pillows and turn around like a helicopter. The interpreting therapist used this opportunity to discuss Samuel's need for developmentally versus chronologically appropriate experiences and how to incorporate activities into daily life that would meet his younger needs. Samuel's parents and grandparents gained more empathy and understanding, which resulted in more sensitive and attuned parenting and grandparenting.

The adults continued to experience "aha" moments as they participated in treatment, and within a short period of time reported a decrease in Samuel's aggression and defiance and that he now could feel guilt when a relationship with one of them was damaged. Including his grandparents in Samuel's treatment made a huge impact because he felt the enveloping support of his entire family. In the emotionally and psychologically safe environment created by this extended community, Samuel began to flourish.

Obtaining Consultation

Because of the trauma issues, the fear-driven behaviors, and the strong emotions that can be stirred up in all involved, working with children with complex trauma histories is especially challenging for any therapist. We recommend that anyone working with these children seek professional consultation. Having a trusted colleague to consult with will help you remain aware of all the complexities inherent in this work as well as countertransference issues that may be triggered.

WORKING WITH CHILDREN WHO HAVE BEEN SEXUALLY ABUSED

Using Theraplay with a child who has been sexually abused requires specific skills and a great deal of self-awareness—even more than when working with the children we have been describing. Theraplay's healthy intimacy and playfulness can be confusing to the child, because sexual abuse often starts out as harmless play that becomes more physical and gradually more intimate, eventually crossing the subtle line into abuse. The child may have been gradually seduced by a playful person she trusted. Now we are asking her to trust play again. Having had such an experience, she is wise to be cautious. We believe that Theraplay can have a very important role in the healing of such a child, but you must be very thoughtful about how you use it with child victims of sexual abuse. Theraplay provides the child with the experience of safe, nurturing touch as well as the experience of interacting with a well-attuned, responsive adult. Often well-meaning professionals develop safety plans that include a "no touch" provision. If this comes to mean that the child receives no touch from trusted adults, the child will never receive the good touch she deserves and will never be able to distinguish good touch from bad touch. She will continue to believe that the only touch she deserves to receive is sexual or abusive. According to the Association for Play Therapy's "Paper on Touch" (March 13, 2009), (1) touch should not be withheld from a child because of a history of abuse; (2) safe, healthy touch may be necessary for healing; and (3) touch should be thoughtfully integrated into the child's treatment plan. If you suspect, but do not know for sure, that there has been sexual abuse or exposure to sexual behavior, you should also follow these guidelines.

When using Theraplay with a child with a history of sexual abuse, the following recommendations should be followed:

- You should have someone with you in sessions.
- You should clarify your intentions.
- You should set clear boundaries.
- You should respond to sexualized behaviors in a calm, nonshaming manner.

Having Someone with You in Sessions

Though we have stated throughout this chapter that parents should be involved in their child's therapy, it is particularly important that you not see a child with a sexual abuse history alone for two reasons: (1) having another adult present ensures that what you are doing doesn't feel secretive to the child, and (2) it protects you from false accusations. The parent can either be directly involved in the session or can observe with or without an interpreting therapist. If you cannot have a second person in the room, videotaping sessions is strongly recommended.

Clarifying Your Intentions

It is very important that you acknowledge to the child at the beginning of treatment that you know about the abuse and then proceed with full disclosure of your intentions. If there are already words that the child uses to identify what happened ("had sex"; "slept with me without clothes on"), use them. If no words yet exist, you may need to help the child find the words that are right for him. Tell the child that the adult was responsible for her own actions and that those actions were wrong. Explain that you will be playing together in sessions and that you will also be touching each other. Tell him that you have no intention of touching or hurting him as the abuser did but that, because of what the abuser did, he may be mixed up about what kind of touch is okay and what is not okay. Because sexual abuse can start out with touch that feels good but slowly becomes sexualized, the "good touch" you intend to do with the child can still confuse him, cause discomfort, and trigger a conditioned sexualized response. It is also important to remember that, for some children, the abuse was not experienced as all bad. The emotional closeness, seduction,

and even the sexual contact (if not physically forced) may have felt pleasurable to a child. The child can feel extreme guilt, however, because he felt good about something that others are now describing as "bad, hurtful, and wrong."

Setting Boundaries

It is a challenge to help a child who has become sexualized to learn how to set healthy boundaries. You need to be very clear about defining what "good touch" is in Theraplay and to help establish these boundaries for the child. Boundaries also pertain to bodily feelings: the feelings in response to "okay touch" are different from sexualized body feelings, and you will need to keep checking to make sure how the different types of touch you are using feel to the child. You may want to draw a simple picture of her, and then talk about what parts of her body can be touched and by whom (V. Kelly, personal communication, March 8, 2009). You can also help her learn that there may be different boundaries for people as she gets to know them better and as she finds out how her parents feel about them. This obviously also pertains to you as her therapist. These strategies will help her begin to trust that you will not harm her and that, if she gets confused, you will make sure that she feels safe again. With older children, go into more detail about why touch is a necessary part of their therapy and how you will use touch in the Theraplay sessions. Tell the child that because touch is important for all people, you want to help her learn that touch can be safe. You may also have children twelve years or older sign a consent form stating that they have been informed that touch will be part of their treatment.

Responding to Sexualized Behaviors

You will need to be prepared to respond to sexualized behaviors during sessions in a way that does not produce further shame in the child. If a child does behave in a sexual manner, you should respond very sensitively while acknowledging that in the session—a touch or a look—caused him to act that way. The vignette of Maggie that follows gives an example of the language you can use. For some children, it may be helpful to create signals for communicating with their parent and therapist about sexualized feelings and trauma triggers. For example, you can help the child create a specific word to

represent emotions and triggers. If he is able to use this word to inform parents that he is feeling his body respond as it did to the abuse, parents can then empathize and help him regain his sense of safety. Parents can also use the word when they observe their child having difficulty, which will help him learn to identify his own emotions and triggers. Use these signal words during your Theraplay sessions.

People sometimes worry whether activities such as putting lotion on a hurt, bouncing a child in a game of "This Is the Way the Farmer Rides," or rocking a child while singing the "Twinkle" song might trigger a sexually abused child and therefore should not be used. As it is impossible to predict what will trigger a flashback of abusive experiences, we do not avoid these activities just because we assume that for some children they might be triggers. Sexually abused children deserve the full range of comforting, nurturing, playful experiences that nonabused children receive. However, you must be highly attuned to the child's nonverbal reactions and be aware of signals of discomfort or dysregulation. These signals could include squealing, high-pitched laughter, turning the head away, getting up, running away, suddenly becoming very still or distant, or alternatively chattering or making strange noises, and being overtly coquettish or flirtatious. These behaviors may be indications that uncomfortable feelings are being stirred up for the child and that the interaction should be modified by, for example, increasing physical distance, adding more structure, clarifying intent, or changing to a new activity.

Navigating the touch issue in Theraplay with a sexually abused child is not an easy process, but it can be a highly corrective emotional experience for her if it is handled well. Theraplay can offer a beautiful reparative experience of closeness, nurturing, and play in which healthy boundaries can be articulated and respected (V. Kelly, personal communication, March 8, 2009), thus helping the child heal and internalize what good touch really is.

THERAPLAY IN PRACTICE

Responding to a Sexually Triggered Child

Maggie and her adoptive mother began Theraplay treatment when Maggie was four years old. Maggie had a history of sexual abuse and had received previous treatment with

a therapist who specialized in treating sexual abuse in young children. This therapist helped Maggie and her mother develop a way of communicating about sexualized feelings and triggers and provided a safe environment in which Maggie began to explore the abuse through play. Maggie's sexualized behavior greatly decreased during the course of treatment largely as a result of her mother's increased awareness of Maggie's triggers. Although her mother was extremely pleased with this progress, she was fearful about touching or holding Maggie due to how sexually reactive she had been in the past. Her mother was also concerned about Maggie's controlling behavior and hoped that Theraplay would address both issues for her and her daughter.

Prior to treatment, the Theraplay therapist, Claire, spoke with Maggie's sexual abuse therapist to get an understanding of her past treatment. During her initial sessions with Maggie's mother, Claire also spoke with her about her fear of touching Maggie and prepared her for the confident use of touch in the sessions.

It was crucial to establish a safe environment for Maggie right at the beginning of treatment, so Claire acknowledged that she knew that someone had touched Maggie inappropriately and confused her about touch. She stated in a matter-of-fact manner that she would never touch Maggie that way and that her mother would not either. Claire explained to Maggie that she would be playing with her and her mother and would help them to have more fun together and to learn how to get closer and touch in ways that were not confusing or hurtful. She also stated that Maggie might still get mixed up sometimes and think that her mom and the therapist were going to touch her the way her abuser had. Claire reassured Maggie that such confusion would be understandable given what had happened to her, and together her mother and therapist would help her understand her feelings and would also help her receive safe touch from adults who cared about her

From the very first session, Claire simply directed Maggie to sit in her mother's lap and initiated the Theraplay interactions. Maggie's mother was surprised that Maggie did not resist this type of seating arrangement. Claire was confident, however,

that Maggie would react positively to being seated in her mother's lap if she were immediately engaged in an interesting activity that would take the focus off her anxieties about touch. After a few sessions of playing in this seating arrangement, Claire was able to switch Maggie to sitting in her lap so that Maggie could interact with her mother face-to-face. Treatment progressed well for Maggie and, after just a few sessions, she was accepting nurturing touch from her mother, including Caring for Hurts and relaxing in her mother's arms for a snack.

During the fifth session, Maggie was sitting on her mother's lap while Claire was interacting with her. Claire and Maggie were blowing a feather back and forth, catching it on small pillows that they each held in their hands. Maggie was laughing and smiling, but started to become overly excited as she blew the feather faster and laughed louder. In order to help Maggie regulate, Claire directed Maggie to blow the feather to her quickly, then she stated in an inviting, soft tone, "Now let's see if we can blow the feather very slowly." Maggie squealed and arched her back. She pulled on her mother's hair, nuzzled into her mother's neck, and whispered into her ear. Maggie's mother said to Claire "Maggie feels bad that she blew the feather so fast that it went past you."

Claire nodded and said, "Are you worried about that? That's okay that you did that. It was getting exciting and we were both blowing very fast." However, Claire suspected that Maggie's reaction was not about how she blew the feather, but that Maggie heard her tone as seductive, and this triggered a physiological trauma reaction. So Claire explored further, "I'm wondering if what upset you was the way that I used my voice. I wonder if my voice made you feel uncomfortable." Maggie nodded and nuzzled into her mother further.

Claire continued, "I wonder if when I used my voice that way it reminded you of your uncle [abuser], and maybe your body felt just like it did right before he would touch you." Maggie nodded again with a sad look on her face.

"Maggie, it is not your fault that you felt that way. What your uncle did to you mixed you up. He should not have done that. Adults are not supposed to touch kids that way. It was

not your fault." After a pause Claire said, "Let's see if I use my voice differently, if that feels okay to you." Then in a very clear, matter-of-fact tone she said, "Okay. I'm going to blow this feather over to you as slowly as I can." Maggie smiled and got her pillow ready. Throughout the rest of the session Maggie remained well regulated and comfortable.

In their subsequent session, Claire began by talking with Maggie and her mother about the previous session. "Last week you had some mixed-up feelings when we were playing. Your body got confused and remembered just what it felt like before your uncle touched you." Maggie sat quietly next to her mother, intently focused on Claire. Claire continued, "I am so sorry that you felt that way. I do not want to make you have those feelings. I want to help you feel safe about your mom and me and learn to have fun with us and know that we won't touch you that way. Today when we play I'm going to be checking that out with you. After we play some things, I will stop and ask you if you're having any mixed-up feelings. If you are, that's okay. We will help you with that. If not, that's okay too. It's most important that you feel safe here while you're learning how to let your mom get close to you." Claire then began noticing what Maggie had brought with her to the session that day, commenting on her wiggling toes, her neat laugh, and her bright brown eyes. Claire allowed Maggie to stay at a safe distance, cuddling with her mother.

For the rest of the session, Claire paused after each activity and checked in with Maggie about her feelings and also asked Maggie's mother if she noticed anything that would tell her how Maggie might be feeling. Each time, Maggie reported having fun and feeling good and not having any mixed-up feelings. This type of careful check-in was important because it acknowledged to both Maggie and her mother that Claire understood how frightening and surprising it was for both of them when Maggie's trauma was triggered in the middle of a playful time. She also wanted them to see how a fun, playful interaction could take place without Maggie having those mixed-up feelings. During future sessions, in order to maintain the natural flow of the session, Claire did not continue this direct format

of checking with Maggie about her mixed-up feelings. She did, however, continue to maintain a high level of attunement.

In this case, Maggie felt comfortable with the close proximity and touch of sitting in her mother's lap. However, it was Claire's inviting tone of voice, which Maggie misinterpreted as an attempt to seduce her, that triggered Maggie's uncomfortable feelings. Clearly, you cannot know in advance which element of your interaction will trigger a child's uncomfortable feelings. You should be open to the possibility that your gestures, tone of voice, or facial expressions may trigger distress and be ready to explore these possibilities and adjust accordingly.

INTEGRATING THERAPLAY WITH OTHER THERAPIES

Although this chapter has described why Theraplay is an effective way to begin treatment with children who have experienced early trauma, some children need a combined treatment approach that employs other therapies to process issues that Theraplay, with its focus on the here-and-now experience, does not address. Theraplay works to heighten and co-regulate positive affect and, although we certainly help children with negative emotions that come up during sessions, we don't bring up past negative experiences. However, traumatized children have had many negative experiences that went unregulated, leaving what would be called "unresolved" or unprocessed trauma. They need many experiences of having negative affect around those experiences contained and co-regulated. They also need help to make meaning out of early life experiences so that they can develop a coherent narrative. Because these children are or are becoming verbal, they can bring words to bear on experiences and emotions and can benefit from a multidimensional therapy approach.

There are other reasons why you do not want to limit yourself to using only Theraplay with traumatized children. You may find that some children react to Theraplay by being indifferent toward and rejecting of the parent, exactly the opposite reaction from Theraplay's purpose. When this reaction persists despite your efforts to improve the parent-child relationship, it needs to be explored. Another reason

is the issue of incongruence in Theraplay. As we discussed in Chapter Two, an important aspect of Theraplay that leads to change is that we present to the child a view of the world that is incongruent with his negative inner working model in order to stretch him toward health. However, in complex trauma situations, if our positive, upbeat attitude is too discrepant from the child's internal state, he will reject outright our view of the world. It will jeopardize his trust in our ability to understand him, and our therapeutic effectiveness will be compromised. For these reasons, we need to integrate other treatment approaches into our work so that we serve these children well.

Theraplay can be integrated with other approaches in a variety of ways. For some children, you may choose to address trauma in a more direct manner before beginning Theraplay treatment, as we have just seen with Maggie. In other cases, you may begin with a course of Theraplay treatment, and then shift to another modality to further address the trauma history. Or you can introduce another modality into a section of each Theraplay session and make that the new predictable pattern for your sessions. For example, you might begin a session with the typical Theraplay sequence of entrance, Checkups, and goal-related activities, and follow these activities by working on a child's time line or creating a narrative. End your session with nurturing through swinging, feeding, and a song. Theraplay can also be integrated with other approaches in a more spontaneous fashion, based on the therapist's attunement to the child's present need within the session. Throughout this chapter, we have given examples of how we speak with children about their past within a Theraplay session. In this section, we will describe other treatment modalities that we have found to be a good fit with Theraplay in helping traumatized children heal. We will also provide some case examples to illustrate how you can integrate Theraplay with these approaches:

- Dyadic Developmental Psychotherapy
- Family Attachment Narrative Therapy
- Eye Movement Desensitization and Reprocessing
- Time lines
- Psychodrama
- Grief work
- Bibliotherapy

Dyadic Developmental Psychotherapy (DDP)

DDP (Hughes, 2007) utilizes the "Attitude" of Playfulness, Acceptance, Curiosity, and Empathy (PACE) to help therapists and parents create emotional safety for their child so that he can explore feelings and thoughts related to past traumas, states of shame, and current triggers. DDP is playful, engaging, attuned and involves emotional co-regulation and here-and-now healing interactions as does Theraplay. Like the Theraplay therapist, the DDP therapist is very active in the therapy and allows the child to have an effect on him and for this effect to show. The DDP therapist believes that engaging in a genuine relationship with the child, rather than hiding behind a neutral façade, promotes emotional health and self-understanding. Parents are involved in sessions and guided to provide an emotionally supportive environment at home. In contrast to Theraplay, DDP facilitates verbal and affective processing of past traumas and the cocreation of meaning in order to resolve and integrate them. We have found DDP and Theraplay to work extremely well together in balancing the child's need for play, nurturing, and trauma work (Rubin, Lender, and Mroz Miller, 2009).

THERAPLAY IN PRACTICE

Integrating Theraplay and DDP

Ann was a seven-year-old girl, adopted from the domestic foster care system at age four after extensive abuse, neglect, and many losses. Her parents described her as trying hard to be happy but that her happiness was not genuine. She would often go into fits of rage over seemingly small disappointments and redirections, and would kick and throw objects at her mother. She was bossy toward her younger adopted brother and the family pets. Family outings were difficult for her; she would often get in trouble and have to be taken home early.

Ann's early deprivation, abuse, and loss of multiple caregivers caused her to have serious fears about her adoptive family. Because her early experiences were not relaxed and happy, she was uncomfortable in a family that celebrated birthdays with joy, merriment, and love. Ann's therapist knew

that Theraplay would also be a foreign experience for her. She would have to go slowly and try one small thing at a time to see how Ann responded.

To Ann's therapist, it was clear that Ann felt uncomfortable about herself. It also became apparent that Francene, Ann's mother, tended to avoid Ann's uncomfortable feelings and rush Ann into feeling "happy." Within the first few Theraplay sessions, Ann stated that she was "sad" and that the activities were hard, despite the fact that the level of challenge was minimal. Ann's feelings were triggered directly by the Theraplay activities, and the therapist used DDP to help Ann expand upon and understand her emotions.

In one instance, Ann and her mother were engaged in a game of Feather Blow. Ann did not seem to enjoy the laughter and encouragement Francene gave her during the game. Suddenly, Ann grabbed the feather and turned her back toward her mom. Francene asked, "Ann, why'd you stop? We were having so much fun? You are such a good blower." The therapist said gently to Ann's mother, "Mom, it didn't look like Ann was having so much fun just then." Then Ann's mom, looking very disappointed, said, "Ann, what's wrong? Are you mad about something?" Ann furrowed her brow and mumbled incoherently. But the therapist had a hunch that anger was not the primary feeling Ann was having. Ann's therapist gently placed a hand on Mom's arm and said, "You know Mom, I'm guessing that Ann may not be feeling mad so much as just confused." Then speaking directly to Ann, "Ann, your mom was blowing the feather and laughing, and I was smiling, too, and we both wanted you to have fun and laugh, too. And I'm wondering . . . (the therapist paused to get Ann's attention), I'm wondering if you just didn't feel that that activity was as fun as we did? Maybe it even felt weird or kind of scary?" Ann looked at the therapist from the corner of her eye, her brow unfurrowed, her eyes full of surprise, as she nodded her head "yes." This was the therapist's signal to continue. "It makes sense, especially when there's been so much hurt and disappointment in your life before you came to Francene's house." The therapist paused as Ann now looked deeply into her eyes.

Then the therapist looked at Francene and said,"Mom, you know, your daughter here, she got really good at surviving before she came to live with you, and that meant that she had to stay on guard all the time—always watching out for the next thing that might hurt her. So there might be some times when we try something for fun and her brain might start saying "Hey, watch out—this could hurt you."

Francene nodded her head, looked at Ann tenderly, and said, "Yes, of course you would sometimes be afraid of the fun things we do here." By now Ann was fully turned toward her mother and the therapist, still clutching the feather in both hands. The therapist judged by Ann's attentive eyes and quiet body that she was open to more processing. The therapist continued, "Do you know why we play these games?" Ann responded, "Why?" "Well, it's easier to learn to feel safe and loved when we can laugh with each other. That is the way it's supposed to be. That's how babies learn the world is a good place. But it didn't go that way for you. You had to learn to take care of yourself and that life was hard. You are smart to try a little play at a time, and then wait a bit when it feels weird or scary. We'll just take our time and you can let me know when you're ready to play again." Ann said, "Okay, can we blow the feather or something?" She looked visibly lighter and eager to move on, so they played a few more rounds of Feather Blow before trying yet another Theraplay activity.

Family Attachment Narrative Therapy

This approach to helping young traumatized children directly facilitates the development of a coherent internal narrative of their experience—the hallmark of a secure attachment. Parents are helped to understand how their child was affected by the trauma, and then coached to develop and tell their child a series of stories that promote trauma processing and attachment (Lacher, Nichols, and May, 2005). Core stories are the Claiming Narrative, Developmental Narrative, Trauma Narrative, and Future Narrative. These can be integrated by using Theraplay before or after the telling of the story, or both. Often, these stories lead to the child's seeking nurturing or play. Theraplay

can provide the framework for parents and children to experience the early interactions they missed out on. In so doing, they can become part of the child's future narrative.

THERAPLAY IN PRACTICE

Integrating Theraplay and Narratives

Nancy was sitting by her mother while listening to the developmental narrative about how she would have learned to walk, talk, and feel safe if she had grown up with her new family from the start. All of a sudden, Nancy moved onto Mom's lap and spontaneously pressed Mom's nose. The therapist quickly switched to Theraplay, suggesting that Nancy "beep" Mom's nose. She did, and immediately her eyes lit up and she said, "This is what I do with Grandpa!" Staying on Mom's lap, they beeped and honked each others' noses, ears, and chin. This was the first time in a therapy session that Nancy had allowed such intimacy and unguarded fun to happen.

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR utilizes bilateral stimulation of the brain—either by the therapist's hand movements or tactile stimulation—to help the client process memories of past traumatic experiences in a safe and controlled therapeutic environment. Negative beliefs, feelings, and body sensations associated with the trauma are articulated, the experience in its entirety is processed, and, finally, positive beliefs replace the original negative ones. EMDR is thought to unlock trauma's unconscious hold on the body and the mind by rewiring the associations to be healthier, more positive, and more realistic. Ultimately, the warning signal aspect of the memory decreases and loses its power to hijack the emotional brain.

Theraplay and EMDR can be integrated in a number of ways (Strauss, 2009). Because trauma work requires the client to trust the therapist, Theraplay can help the child see the therapist as

benevolent, furthering the therapeutic relationship. If a traumatic memory surfaces during Theraplay treatment, bilateral stimulation can be used to soothe the child and help the feelings to fade. After a trauma has been processed with EMDR, Theraplay activities can offer immediate validation of the child's competence by using challenging activities. After the trauma is processed sufficiently, the protocol for adults is that they associate verbal affirmations such as "I'm worthy," "I'm strong, or "I'm safe," with the now deactivated trauma. Theraplay can help children *experience* these affirmations: nurturing will provide an experience of *feeling* worthy, and succeeding in a challenge will help him *feel* strong. After the processing of painful memories, nurturing can provide comfort and ease the feeling of loneliness. Sometimes in a session, there is an impasse in trauma treatment at which point a child may need a break or appear "resistant." Engaging activities can help the child reconnect with you. Also, Theraplay can provide reassuring structure when it is used for beginning and ending sessions. Lastly, because EMDR first seeks to have clients be in a "safe place" psychologically before trauma processing, Theraplay can work to improve the parent-child relationship so it can be the child's safest "safe place."

Time Lines, Psychodrama, Grief Work, Bibliotherapy

These modalities can play a part in helping children heal from complex trauma and can be easily integrated with Theraplay. Developing the child's time line can help him see the chronology of his life, those who came in and out of it, documenting the losses and experiences he had to endure. You can use psychodrama to act out a child's orphanage life, how hard it had to be to be given to a stranger, and to allow the child to feel he is talking to his birthparents and asking the questions he did not get to ask. Grief work that guides a child to talk about those he has lost in his life (birth parents, siblings, extended family, prior foster parents) can elicit the need for nurturing. In terms of bibliotherapy, there are wonderful attachment-oriented books for reading during sessions or at home that allow the child to see and to copy healthy, nurturing interactions with the parent.[1]

Doing Theraplay with a child who has suffered complex trauma presents special challenges that call for even more attunement, reflection, repair, parent work, and the knowledge of other therapeutic approaches than does treatment with nontraumatized children. Yet, Theraplay can offer a deep healing experience for these children, one that can give them the tender, caring, and fun interactions from their parent that they may never have had. Without such experiences, they are in danger of remaining emotionally damaged. Theraplay offers the possibility of experiencing the nourishing, loving, protective relationship with their parents that all children richly deserve.

Footnote

1. The following is a list of attachment-oriented books for reading to children:

- *Pete's a Pizza,* William Steig, HarperCollins, 1998
- *Mean Soup,* Betsey Everitt, Voyager, 1992
- *Hug,* Jez Alborough, Candlewick Press, 2000
- *Owl Babies,* Martin Waddell, Candlewick Press, 1992
- *What Mommies Do Best/What Daddies Do Best,* Laura Numeroff, Simon & Schuster Books for Young Readers, 1998
- *Willie's Not the Hugging Kind,* Joyce Durham Barrett, HarperCollins, 1991
- *Even If I Did Something Awful,* Barbara Shook Hazen, Aladdin Books, 1992
- *The Little Brute Family,* Russell Hoban, The MacMillan Company, 2002
- *More, More, More Said the Baby,* Vera Williams, Greenwillow Books, 1996
- *If You Were My Bunny,* Kate McMullan, Scholastic Press, 1996
- *The Runaway Bunny,* Margaret Wise Brown, Harper Trophy, 1942
- *I Will Kiss You (Lots & Lots & Lots),* Stoo Hample, Candlewick Press, 2005
- *So Much, Trish Cooke,* Candlewick Press, 1994
- *The Way Mothers Are,* Miriam Schlein, Albert Whitman & Co., 1963
- *Love You Forever,* Robert Munsch, Firefly Books, 1986

CHAPTER TEN

Theraplay for Children Who Are Adopted or in Foster Care

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Theraplay's strength in promoting relationships and attachment has led to its successful application with foster and adopted children and their families. These children, perhaps even more than others, require sound parenting and large doses of empathy, fun, and guidance. Theraplay, with its emphasis on building relationships through playful interaction, can act as a healthy antidote to a painful past and can provide the experiences needed for parent and child to bond. In the past two decades, Theraplay has been of increasing interest to parents and professionals working with two special groups of children within this population: the significant number of internationally adopted children who spent part or all of their pre-adoptive life in institutional care; and the increasing number of neglected and abused children removed from their birth families and placed in foster care, awaiting a permanent home.

The children we describe in this chapter have experienced care-giving inconsistencies, failures, or losses early in their lives that have

disrupted or prevented the development of a secure attachment.[1] Many of them will have suffered complex trauma of the sort we discuss in Chapter Nine and therefore there will be overlap in the issues that arise. In this chapter we will focus primarily on how to help children form an attachment with new caregivers. First we consider what the losses have meant to the children and to those who care for them. We then turn to how Theraplay can help. We discuss the particular emotional needs of adopted and foster children, the parenting issues related to each need, and how Theraplay works to help parents address the need. Next we discuss how we work with foster and adoptive parents. Finally, we discuss issues in working with children who have had multiple placements and end with an example of Theraplay treatment with a child transitioning from a foster to an adoptive family.

UNDERSTANDING THE CHILD'S EXPERIENCE

A child of any age who is in foster care or has been adopted has sustained a number of losses, beginning with the loss of a continuous relationship with the birth parent. The child's awareness of and understanding of those losses at each stage in her development will have an impact on her attachments.

All adopted children (even those adopted as infants) share the following experiences (Jernberg, 1990, p. 271):

- They have "experienced a discontinuity between the physiological and emotional style of their original mother and the physiological and emotional style of their later one."
- They had to "adapt not only to two women's physiologies and psychologies but often are expected to do so with the least possible show of stress."
- They have known "loss, rage, and the feeling of grief."
- They "have experienced a serious threat to their self-esteem."

Depending on the age of the child at the time of the separation, the loss will have different psychological meanings. We do not know what the experience means to a young infant beyond having to adapt to changes in physiological rhythms, sounds, sights, smells, and perhaps

temperatures and textures. It is only later that he will need to come to terms with the meaning of having been given up by his birth parents.

Children adopted as older infants or toddlers feel keenly the loss of a caregiver and familiar caregiving routines. These young children also have to cope with the inability to express themselves, and the inability to understand completely what is told to them. Toddlers are at the stage in their development when they would ordinarily be taking their first tentative steps toward independence. Many children who have been removed from inadequate homes or raised in orphanages have not experienced the period of healthy dependence that provides the secure base from which to negotiate this step.

Older children are able to participate more fully in the transition to a new home, but their understanding of events and explanations is limited by their level of cognitive development, which may include magical and concrete thinking. Magical thinking (eighteen months to six or seven years) includes a tendency to personalize events; children believe that their thoughts, wishes, and actions are the cause of whatever happens; they assume cause and effect between unrelated events; and they have difficulty discriminating reality from fantasy. Concrete thinking (ages six to eleven or twelve) includes literal interpretations and thinking in absolutes.[2] At different ages, therefore, children will understand their experience in varying ways.

Some of these children have later shared their childhood beliefs about why they were given up. "What's wrong with me that she gave me away?" "Maybe I cried too much, or didn't eat right or something. . . . I keep thinking that I did something wrong . . . like it was my fault" (Brodzinsky, Schecter, and Henig, 1992, pp. 43, 79). This kind of thinking, combined with early negative experiences, leads to a view of themselves as troublemakers, as unworthy and as bad.

When first in foster or adoptive homes, many children are mourning the loss of parents or earlier caregivers. New parents may have difficulty understanding this, because they know that the child did not receive good care. What they often don't realize is that children's attachment needs lead them to bond with even the most untrustworthy caregivers. No matter what the quality of care, children will have strong feelings about the only caregivers that they ever knew and will experience a love that must be acknowledged and resolved. It is important that new parents respect their child's need to mourn that loss. It is also important that the child be given permission from

his biological parents and earlier caregivers to become attached to his new parents.

At some time in an adopted child's life, he needs to learn about his early history before adoption, be able to talk about his experience, share his theories about why he was given up, and explore all the subtle meanings to him of being adopted. These are traditional "adoption issues" that can sometimes, although not always, interfere with attachment. Many very young children are not developmentally able to address these issues, yet their adoptive and foster parents must respond to behavior fueled by these concerns. Building a secure attachment relationship involves helping new parents understand how their children's inner experiences affect their behavior.

CONSIDERING HOW THERAPLAY CAN HELP

Theraplay builds relationships between parents and their adopted or foster children in the same way that it does with any child. But we face special challenges when we try to form an attachment with a child whose hopes have been shattered. Given this disappointment, forming an attachment takes time, patience, energy, and commitment on the part of adoptive and foster parents. The normal attachment process may have an eager and trusting child participant. The adoptive or foster care attachment process may have a wary child participant who readily reverts to patterns of behavior that helped her survive on her own. Because it is so much more difficult, adoptive and foster parents need a great deal of support throughout the process.

Understanding the General Principles

Whatever the age of the child, Theraplay demonstrates that the child is special and lovable, that the child's world is an interesting, lively place, and that the adults in her world are responsive and caring. Rather than talking about these assurances, the parent and child enact the assurances in the session. With its emphasis on the child's emotionally younger needs, Theraplay recreates the early attachment process for the parent-child pair. Just as a biological child comes to rely on and trust her responsive parents, so adopted children begin to experience their new parents as reliable and trustworthy.

Theraplay is beneficial in foster and adoption work because of its directness and because it brings parents and child together to

learn new ways of interacting. The importance of working with the family system rather than the child alone is supported by experienced adoption clinicians (Reitz and Watson, 1992; Grabe, 1990).[3]

Carrying Out the Assessment Process

Because many of these children have led complicated lives, it is important to obtain a detailed social history, including the child's and family's involvement with the birth parents. When interviewing parents about their experience as a family, ask how the decision was made to become foster or adoptive parents, as well as how bringing the child into their home has changed the marriage and the family. In Chapter Four we suggest questions to use in an intake interview with all parents. The following topics are especially pertinent to explore with parents of adopted and foster children: the parents' experience with children and knowledge of normal development; their knowledge of the attachment process; their plans for the future of the child; whether other caregivers are involved; types of separation from the parents; and the time, desire, and potential to carry out the Theraplay approach at home.

Adoptive parents often say that they do not know much about their child's early history. If looked at closely, however, the few details they do know can be very informative. For example, one couple brought their five-year-old adoptive son, Brian, for treatment because of his immature and explosive behavior at home and at school. During the intake interview, Brian's parents reported that they knew very little about his birth mother's treatment of him but thought she seemed nice and that she loved him, but she was just too young to keep him. They also said that when he first came to them at the age of one year, Brian had a bad diaper rash and could not bear weight on his legs. It was up to the therapist to bridge the information gap for the parents and help them understand that these were signs of neglect and that neglect had a big impact on his emotional development and was affecting him in the present. This helped Brian's parents develop an empathic understanding of their son's current struggles rather than seeing him as deficient or intentionally defiant.

We use the Marschak Interaction Method (MIM) as described in Chapter Four to assess the interaction between the foster or adoptive parent and child. A child who has attachment issues may behave during the MIM in ways that do not seem overtly problematic upon

first view but that can indeed be problematic within the family on a day-to-day basis. You will need to be very aware of subtle dynamics that may not be obvious to those unfamiliar with attachment issues. In our experience we have seen foster and adopted children present during an MIM in the following ways: acting on their best behavior, attempting to control the environment and interaction, and resisting nurture.

One reason the child may be on her best behavior during the MIM is that she thinks she was brought to the assessment in preparation to be "given away" to yet another new family. Another reason that these children behave better during the MIM than at home is that they are more at ease with strangers than they are with their parents when out of public view. For these children, the more intimate the relationship, the more threatened they feel by the vulnerability of their dependency on their caregiver. During the assessment process with you, therefore, the child may appear much more pleasant and cooperative than she does at home. Knowing that she is in public and being taped can bring out a charm and pseudomaturity even with her parents. Whereas children can look better than they really are, their parents can look more troubled because they know and are living with the other side of the child.

We often see children who are trying to be very much in charge of things in order to control the atmosphere in the MIM and the feelings or hard topics that may come up. They may talk a lot, ask what is in the next bag, or try to make the parent laugh and feel happy. Children who are very dramatic may be warding off uncomfortable feelings of sadness and vulnerability.

Other children have particular trouble allowing their parents to help or nurture them; they prefer to do things to their parent (comb hair, lotion, and feed) rather than receive these experiences themselves. When we see a child nurture his parent more than the parent nurtures him, we often wonder whether it is the parent's need that is being played out. However, with the children we are considering here, it may not indicate the parent's neediness at all, but rather that the parent has learned to let the child control the nurturing rather than face certain rejection when she offers it to her child. She may have learned that this is the only kind of nurturing experience the child will allow at the moment. Our goal in Theraplay will be to turn this around so that the child can actually receive the nurture from his parent.

Though open curiosity is important as you observe any MIM and give feedback, it is especially important in cases involving foster care or adoption, because of the subtle dynamics we have been describing that can distort the picture. Rather than jumping to quick inferences based on your experience with biological families, you should withhold judgment until you can explore the interaction from the parents' point of view. In order to do this you can show them segments of the MIM that you are curious about and ask what they think might be going on. Once you have learned more about the dynamics behind the behaviors you can come to a conclusion and offer your recommendations.

Considering the Length and Nature of Treatment

Theraplay sessions with adopted and foster children are much like those with biological children, but there are some important differences. As the resistance can be greater, the treatment process is generally longer and changes are slower. Because structure, engagement, and nurture are the dimensions that re-create early attachment experiences, they are emphasized more than challenge, which focuses on competence and future independence. A great deal of the work with parents involves helping them understand the child's emotionally younger developmental needs and helping them find ways to become the caregivers the child will turn to for comfort and security. As we stated in Chapter Five, children who have been adopted need their parents to be in sessions from the start to support their role as the child's secure base and source of emotional connection and joy. With children who, because of their history, may be overresponsive to potential new attachments, we do not want to distract from the parent-child relationship or to confuse the child about who is his primary caregiver. You should let the child know that your role is to help the family to have more fun, to get along better, and to feel closer to each other. Because we, as therapists, often need to get our own sense of the child we are helping, we may try out an activity with the child while the parents sit to one side and watch. In order to emphasize the parents' role as the primary caregivers, you should first ask permission of the parent in the child's presence, saying, "Dad, I'd like to teach you and Susie some games you can play together. Is it okay if I play them first with Susie to show you?" Other times, we may practice the activity with the parent as the child watches. The

goal of these practice experiences is always to get the parent and child interacting with each other to build their relationship. In this chapter we will present many examples of how we incorporate the parents in sessions from the start and keep a parent-child focus throughout.

UNDERSTANDING THE NEEDS OF CHILDREN WHO ARE ADOPTED OR IN FOSTER CARE

The literature on children who are adopted or in foster care has identified six important needs which parents must understand and respond to in order to help their child become emotionally healthy (for example, see Hughes, 1997; Fahlberg, 1991).

- To experience attunement and regulation
- To trust and accept parental structure
- To develop mutuality and engagement
- To receive and accept nurturing from parents
- To feel competent and worthy
- To feel claimed as part of a family

As we discuss each need, we first consider how it reflects the child's inner experience and influences his observable behaviors, we next look at related parenting issues, and finally we discuss how we use Theraplay to respond to each need.

Need to Experience Attunement and Regulation

As we discussed in Chapter Two, a parent's emotionally attuned responses (appropriate amounts of touching, rocking, feeding, humming, changes of voice tone, tempo of movement, and facial expressions) are the experiential food for the right brain during early development. If the parent is unable to attune to her baby, he will not feel her presence and will not be soothed. If this happens chronically, he will not learn how to soothe himself and manage intense feelings; he will also learn that no one can help him when he's distressed. Many foster and later adopted children who have experienced misattuned caregiving lack self-regulation skills and will desperately try to keep you or their parents from getting close enough to help them.

Many adopted children have missed out on the experience of having their feelings, desires, and intentions understood without having to put them into words. All of us learn how we feel, what we want, and the meaning of what we perceive through the dyadic experience of our first caregivers' interpretation of our lives and our world. Imagine a baby crying. Her mother quickly responds, "Oh, you must be hungry, I'll feed you!" She gets the bottle ready and feeds the baby who eats and then no longer feels hungry. In this way, the baby learns the meaning of the hungry feeling as well as a whole range of other sensations and feelings. Often parents of older adopted children are frustrated that their child cannot tell them that she's mad or sad and will throw a tantrum or bite instead. This is because children who are not adequately responded to do not learn to identify their bodily feeling states. Not only can they not express their feelings but they also can't believe that their needs will ever be met.

UNDERSTANDING PARENTING ISSUES. The primary task that parents face with their young infants is to attune to their needs and learn ways to regulate them in their day-to-day interactions. In order to do this, they have to be sensitive to small hints and be persistent and sometimes creative in how they respond while they are learning what works for their unique child. For parents of foster or adopted children this task can be very confusing, because the child often miscues about his needs and has serious problems with regulation. As miscuing and misattunement continue, parents begin to doubt their capability and doubt their child's acceptance of them. If anxiety grows, attunement becomes even more difficult.

DEVELOPING ATTUNEMENT AND REGULATION. Theraplay helps parents attune to their adopted children so that the process of co-regulation can occur. We help parents connect physiologically and emotionally to their child so that her right brain is getting the regulation it needs. With a child who is laughing excessively, you might first laugh with her, matching her intensity. Then you might jump across the room together while laughing in time to each jump. Next you could vary the length of the jumps and vary the laughs to match: a loud laugh with a long jump, a soft laugh with a short jump. Then you could jump ever so softly into a beanbag chair. Through this series of interactions you matched the child's aroused brain and then helped to organize it by jumping and laughing together. Then you varied the intensity

of your laughs and helped the child to imitate you. This provided both structure and engagement that helped her calm down and focus attention at a calmer level.

In addition, the Theraplay therapist understands the child's bodily or facial expressions as a clear attempt to communicate. For example, if a child squirms when you touch his nose with a cotton ball, you might say "Oh, that looked like it tickled you when I touched your nose. Let me try it on your hand. Is that better?" In this way, he learns about his feelings and at the same time he learns that you will be responsive to his feelings. There are many opportunities for the Theraplay therapist to attune to the child's feeling states and to help him feel more understood and connected. Speaking on behalf of a child can create an attuned moment. For example, one adoptive mother showed disappointment when her little girl hid her face during the "Twinkle" song and only wanted Mom to hum rather than sing the words. The therapist quietly explained that it might be just too much for her daughter at that moment both to hear and to see her mother singing to her while being held, and that this was okay. The therapist thus communicated attunement to the child and helped the mother develop it.

Attunement also occurs when you sense that a child needs a moment of quiet inner reflection and reorganization when the child sighs, looks down at his hands, and seems to disconnect for a moment. It is your job as therapist to respond to the child's cues and gauge when he is ready to reconnect. You will know this when he looks up after a few moments, as if asking, "What do you have for me now?" These kinds of attunements to bodily states will help the child feel comfortable and connected with you.

Another form of attunement is to read and respond to the child's feelings of sadness, anger, or joy. During a Checkup, for example, the therapist of an eight-year-old adopted girl with low self-esteem noticed a long scratch on her leg. The therapist remarked on the scratch and the girl immediately furrowed her brow as if in shame and looked down. The therapist said softly and curiously, "Oh, you look like you feel really bad about that scratch." The child nodded yes, and then told about a past experience that she clearly felt to be shameful. While this attuned process would occur in any Theraplay session, it is particularly important for an adopted or foster child who may have difficulty recognizing her feelings and may, for a while, need the grown-up to guess with her what she might be feeling.

Need to Trust and Accept Parental Structure

Most children who have experienced caregiving failures have a variety of ways to cope with not getting their needs met. Some children seek to protect themselves by acting passive and withdrawn, in essence saying, "Leave me alone, I don't care about you." Many children, however, try to maintain control at any cost. They do not accept the adult authority, particularly that of their new foster or adoptive parents. This is because these children have learned that the adults in their lives are not consistently trustworthy and therefore they must take care of themselves. Parents misinterpret the child's motivation and often say, "She's defiant, she does her own thing, she doesn't follow the rules, she refuses to cooperate," or "He wants to do what he wants to do—just the opposite of what I tell him to do." Beneath the defiant behavior is a frightened child who believes that she must take charge of things because no one else will. She thinks, "I must make sure that others do what I want so that they won't do the abusive, neglectful things that I fear."

UNDERSTANDING PARENTING ISSUES. Obviously it isn't easy to parent a child who insists on doing things his own way and on his own terms. Such a child threatens adoptive parents' sometimes shaky belief that they have the right to parent him (Reitz and Watson, 1992). Often feeling devalued by infertility or other losses in their own lives, they now feel devalued as adoptive parents. And because they have gone through a rigorous evaluation process to adopt the child, parents may also feel that they have to be perfect. It is therefore hard for them to admit that they need help.

DEVELOPING TRUST. A child needs to feel that a parent is a force in his life, like the scaffolding that holds up a wall before its foundation is fully formed. A parent's provision of structure for a mistrustful child can help him learn that it is safe to lean on someone else. In Theraplay, we help parents stay in charge, set limits, keep the child safe, and help the child complete a sequence of activities. For the child who perceives herself as responsible for her own survival, it is especially difficult to let the adult take the lead, but this is exactly what she needs to do if she is to develop a secure attachment.

In Theraplay sessions, parents can practice guiding and organizing the interaction, helping the child to accept their leadership for

relatively brief periods while engaging in a pleasant game or activity, as in the following example.

THERAPLAY IN PRACTICE

Using Warm and Playful Structure with a Controlling Child

Allan and Becky adopted seven-year-old Lexie from a Russian orphanage when she was two years old. She had been severely neglected but her parents gave her every advantage upon arrival in her new home and she quickly caught up to age level in all developmental and academic areas. Her parents were proud of her high-level reading skills and budding acting ability. At home, however, Lexie had severe behavioral problems. Almost every day she had periods of defiance toward her parents, particularly her mother. She seemed deliberately to do things she was told not to do, such as taking cookies from the pantry before dinner or jumping off the back of the couch in a dangerous way. When her mother tried to stop her, Lexie would become angry to the point of having long tantrums that made Becky reluctant to intervene. Allan, Lexie's adoptive father, also felt helpless. He had tried being firmer, tried to tickle or be playful with her, or tried just to ignore her, but these strategies only made her angrier, and the behaviors continued.

In the Theraplay treatment sessions, Lexie's therapist, Marsha, set up simple, fun activities for her parents to do with Lexie, such as balancing Beanie Babies on her body, having her punch paper and toss it into their arms, and feeding her cookies. When a child needs a high level of structure, therapy should begin with the therapist as the primary person interacting with the child, even when the parents are in the room. Parents who provide too little structure for their child can easily get caught by their child's insistence on running the show; they may need to see how the Theraplay therapist maintains a positive attitude while staying in charge before they can do it themselves. Marsha started out with one Beanie Baby to balance on her head, but Lexie yelled, "No, three!"

Marsha replied warmly but confidently, "First one and then three." Lexie balanced one and walked across the room, demanding, "Now three and then five!" Marsha looked at Lexie with delighted surprise and said, "Wow, you think you can do five? First we'll do *three* Beanies, one on your head and one on each shoulder." Lexie walked with the three Beanies without protest. Expressing her pleasure at Lexie's achievement, Marsha said, "Now let's see if you can do five!" Lexie: "No, I want to play ball." Marsha did not take this as rejection, understanding that Lexie was not used to the good feeling of being responded to and completing a task with another person in a successful and connected way. Therefore Marsha responded, "I think you can do five. You have great balance." And Lexie did it. However, she looked a little deflated because she had not been in complete charge of things. Marsha was able, nonetheless, to end the activity successfully. As her parents watched, they took note of Lexie's familiar frown and quietly told their interpreting therapist their fears of what Lexie would do next.

Sure enough, Lexie grabbed three Beanie Babies and threw them across the room. Marsha looked to where she'd thrown them and said, "Wow, hey!" Marsha paused for a moment and then said, "Let's throw these other two together to the wall on the count of three." She handed three Beanies to Lexie and quickly counted "One, two, three" before Lexie had a chance to consider her options. Together they threw the Beanies to the wall. Then Marsha said, "Okay, now let's crawl over to the garbage can to get them." Marsha did this quickly and Lexie followed along, and then they resumed their seats on the pillows. Lexie's parents were surprised that Lexie had not escalated into another protest.

Later in the session, Marsha invited Lexie's parents to help give her a blanket swing. Together they lifted Lexie up very carefully in the blanket and rocked her gently to the tune of "My Bonnie Lies Over the Ocean." Lexie purposely squirmed in the blanket and hung her legs over the side. Although Marsha had explained the rules clearly the first time, she had

the parents set the blanket down and explained again that Lexie must lie still so she can be really safe while she is being rocked. When they lifted her up again, Lexie slyly stuck out her leg. Marsha immediately signaled to all the adults to put Lexie gently back down. Lexie turned on her stomach and hid her face. Marsha said, "You know Mom, it's our job to keep Lexie safe, so we'll do something else right now. Have you ever done a weather report on your daughter's back?" and proceeded to teach Mom how to do the Weather Report. Lexie continued to hide her face but relaxed as her mother rubbed her back.

The next five sessions continued in this manner, with the responsibility for taking charge moving more and more to Becky and Allan as they found the balance between being firm with Lexie and understanding her fears. Simultaneously, Lexie learned to let go and trust someone. Marsha helped Lexie's parents use confident but warm insistence that she follow through with their expectations while meeting her resistance with playfulness and empathy.

Developing an attitude of playfulness combined with firmness will go a long way toward conveying the message to the adopted child that he can trust his parent to take care of him and keep him safe.

Need to Develop Mutuality and Engagement

As a result of being truly present—being with someone in the moment—a deep attachment develops. The foster or adopted child may avoid being totally engaged with her parent, and instead hold herself back from emotional openness. Children may avoid eye contact, shrug off or avoid physical contact, display a superficial friendliness, appear distracted, and seem not really "there" with you. It is as though the child says to herself, "I'm not comfortable with people. I don't know how to enjoy myself with others, so I will only engage on my terms." The child could also be saying, "I've felt loss and have been hurt before, and don't want to be hurt again. I'm protecting myself from enjoying you and caring deeply about you because then

I'd feel sad to lose you." Some children are indiscriminate and appear to prefer interactions with others more than with the parent. This child could be saying, "I will keep distant from you out of fear of feeling close" or "It's easier to talk and play with someone who isn't going to expect closeness." Indiscriminate behavior can also indicate that the child, having experienced profound loss, cannot trust that anyone could stay with her forever. This child is, therefore, always on the lookout for someone, anyone, with whom to make a relationship. It is crucial that a parent succeed in "wooing" her child so that both can share the attachment experience of "getting lost in each other," similar to what happens to adults when they are falling in love. In these moments of real meeting, which we describe in Chapter Two, there is no guardedness and no self-consciousness. Instead they are high-intensity, reciprocal moments of just "letting go" with each other and having fun for fun's sake, experiences that can help parent and child feel they belong to each other and help the child let go her fear of attaching.

UNDERSTANDING PARENTING ISSUES. Parents find it very difficult to develop a mutual feeling of connection as long as the child rejects their every overture, doesn't look at them, avoids enjoyment, seems unreal, or seems to prefer interacting with others more than with them. Parents can feel rejected, hurt, disappointed, and inadequate, and may become emotionally distant from their child. Feelings of hurt or inadequacy can lead to a parent's feeling angry and sorry for herself. By the time a family comes to you, it is even possible that parents may not take any pleasure in being with their child or feel any love for her because they are getting no affection back. Parents need help to engage the child so that she can begin to respond.

Some of the difficulty in making a connection may come from the parents' issues as well. They may also experience a distance from their child because of their grief over the loss of the child's infancy and young childhood, their distress that they might have saved him from pain if they had adopted him sooner, and the knowledge that he has been parented by others (Hopkins-Best, 1997). Any of these feelings can stop a parent from being able to engage and attach, and need to be addressed in sessions with the parents alone.

DEVELOPING MUTUALITY AND ENGAGEMENT. Theraplay uses very basic and sometimes novel ways to engage the child. The Checkup at the beginning of sessions has the special power of providing foster and adoptive parents an opportunity to do what birth parents do naturally with their infants: check out their child's special qualities in minute detail. You can help the parent focus on the exact blue of a child's eyes, the length of her eyelashes, how much a scratch has healed since the last session, or how much fingernail polish has worn off. Children learn about themselves as parents discover their unique characteristics like a freckle on an ear, a dimple when she smiles, or even an old scar that occurred before she came to them. The Checkup usually captures the child's attention, provides an experience of being truly seen and known, and many children respond with great pleasure at being noticed in this way.

Parents frequently are surprised at the power of these simple observations. They take pleasure in the special qualities that you and they "discover" about their child. Sometimes the child's reaction, though initially interested and engaged, cannot be comfortably maintained and becomes more superficial, distant, or rejecting. You can then acknowledge, "You might think it's silly to spend so much time checking how your elbow pokes out just so, but I know Mom and Dad really think your elbow is neat." At a deeper level, you could say, "You're not sure about this. I think I know why. You didn't have a mom or dad who could do this with you when you were little. But kids need this, and you have a mom who can do it now."

You can help parents make Play Doh moldings of their child's hands, feet, or elbow, have parents blow bubbles toward him and help him pop them with his pinkie, elbow, or chin, guide them in Beep-Honk or Three-Legged Walk, or help them do Slippery, Slippery, Slip. As you watch, you can make appreciative comments, such as what a wonderful pair they are, how coordinated, and what great sounds they are making.

You must have self-confidence and a repertoire of age-appropriate, engaging activities that can entice the resistant adopted or foster child. Repeated experiences of engagement with her new parents and with you provide moments of authentic connection. Your goal is to prolong the sense of connection between parent and child over time through a variety of activities.

THERAPLAY IN PRACTICE

Engaging a Newly Adopted Child

Alice was adopted from an orphanage in China at the age of five years. Her family included her mother and father and a younger sister, adopted from China two years before Alice. She started Theraplay after being in her new home for three months. In the MIM, she showed no attachment to her mother and she rejected and avoided interaction with her father—that is, unless he fed her candy. While she allowed interaction with her mother for Patty-Cake and Lotioning, she was indifferent to her mother's leaving her for one minute, and showed no response when Mom returned and found her looking in the MIM envelopes. She kicked and grunted at her father when he tried to engage her, but when he fed her M&M's, she came close and cooperated. It was not a surprise that she had no attachment to her new parents after only three months, but she was resisting their efforts to reach her and they needed Theraplay to help attachment develop.

Because Sarah, their therapist, wanted to start by strengthening the more readily accepted relationship, the first sessions were with Alice and her mother. Sessions with Alice and her father would take place later. Sarah coached Mom to position Alice so that they were face-to-face and to engage her in young child games like Peek-a-Boo, Patty-Cake, Pop Cheeks, Counting Fingers and Toes, and doing Checkups of nose, ears, and chin. Mom and Sarah had Alice stand on pillows and chairs and jump into Mom's arms on the count of "one, two, three, go!" At first when caught, Alice would simply hang stiffly against her mother as she held her. There was no reciprocal holding on. She had to be coached to "squeeze" Mom; in this way, she learned to hug. Sarah also helped Mom to feed Alice and to develop Alice's interest in staying connected after getting fed. At first, Alice would avert her head as soon as she got the food in her mouth, distancing herself. In normal development, children look at their parents after each mouthful. Feeding can be an experience

of strong emotional connection full of eye contact, imitation, attunement, and play. Alice had experienced none of this. Sarah coached Mom to talk to Alice as she fed her, to call her back to face-to-face contact by saying her name in an inviting way, and then imitating her facial movements of eating, just as parents do in the first year of their baby's life. Gradually, Alice began to enjoy not just being fed, but staying connected with her mother.

After fifteen sessions with her mother, sessions began with Alice and her father. Sarah had Dad do the same activities with Alice that her mother had done. Without her mother present, Alice now was able to relate to her father. He wrapped her in a blanket and sang to her, made powder footprints, and held her in his lap facing him to feed her pudding. Now Alice was interested in looking at her father between spoonfuls of food. Attachment was developing. The test came when both parents were present for a session. Previously, Alice would reject her father when her mother was present. This time, she interacted with both of them as all three played together. They passed a piece of tape, rolled into a circle with sticky side out, between them on their cheeks, made "ah-ah-ah" sounds by patting each other's mouths while saying, "ah," they invited her to run back and forth between them on cue, and they fed each other. She also watched with fascination when her parents fed each other. After six sessions with her father, it was time for a series of four terminating sessions. The last session involved the whole family: Alice, her mother and father, and her younger sister. The therapist started the games around the circle and sat back to watch the family carry them out. They played Pop Cheeks, group Patty-Cake, Hot Potato–Cold Potato, and they all fed each other in various pairings. The session ended with the "Twinkle" song. After therapy ended, Alice's connection with her family continued to grow. Her parents felt therapy had been so successful that they later decided to adopt a third child.

Need to Receive and Accept Nurturing from Parents

Like all children with insecure attachments, children who have been adopted or are in foster care often reject their parents' offers of help.

If they fall and scrape themselves they say, "It doesn't hurt. I can take care of it." They may be quite good at taking care of themselves and may even try to take over the role of caretaker to their parents. When gum got tangled in the hair of one older adopted child, he cut it out with scissors, leaving a bald spot, rather than asking for help. Hughes (1997) describes these children as trying to avoid being loved, feeling special to someone, or needing anyone. Intimacy can feel scary because it elicits strong feelings of vulnerability and need. Such children seem to be saying, "I can't count on anyone to take care of me, so I will do it myself."

UNDERSTANDING PARENTING ISSUES. It isn't easy to care for, comfort, or nurture a child who has learned to expect that no one will comfort or nurture her. These children may allow themselves to be taken care of if it is their idea, but frequently reject the parents' initiation of care. They may be unpredictable, turning to the parents on one occasion and ignoring them the next time they need help. Parents of older adopted children may find it even harder to be nurturing. We all have an innate nurturing response to young children, but we do not have as strong an impulse to nurture an older child. We may even accept the child's greater independence as a good thing. It takes work for parents to remember that, because of early losses, their child has the younger needs of someone still learning about attachment.

Obviously, the younger the child, the easier it is for you or the parent intellectually, emotionally, and physically to provide direct nurturing, but at any age it has a profound effect. Parents who do have the impulse to nurture their older adopted child as they would a young baby may be ridiculed by friends and family members who say the child is "too old for that baby stuff." A mother, hearing about the Theraplay method at a conference on adoptions, said, "I feel so validated! When I brought my six-year-old home, it just seemed like the right thing to do to hold her and rock her and feed her, and she loved it, but everyone else said I was crazy."

Adoptive parents often feel frustrated and rejected when their child who has obvious physical and psychological needs will not allow them to respond to those needs. When the child says he's hungry but won't eat what he just asked for, or when she falls and scrapes her knee but won't let her dad take care of the wound, it creates a tremendous tension in parents: the child is not allowing them to provide the care that they so desperately wish to give. This built-up tension eventually

leads to parents feeling ineffective, resentful, and depressed. In intake sessions, some adoptive parents of children with severe attachment issues can sound quite unloving toward their child, but this is usually the backlash of months or years of thwarted attempts to provide care for their closed-off child. Parents need a great deal of support in order to persist and win their child over in spite of very little positive feedback.

DEVELOPING NURTURING FROM PARENT TO CHILD. Finding ways to nurture a foster or adopted child either directly or indirectly is a major emphasis in Theraplay treatment. Direct methods include caring for hurts (and preventing additional hurts), using lotion and powder, singing to the child, rocking in a cradled position, swinging in a blanket, and feeding favorite foods and drinks from a sports bottle, a squeeze bottle, or juice box—any one of which can be acceptable substitutes for the baby bottle the parents never had the opportunity to offer. You need to help parents make clear why they are nurturing their child in this younger way. They should communicate that they know he didn't get taken care of this way when he was little and that he needed it and deserved it and that they can help him feel cared for and loved now the way he should have felt then.

Direct nurture can make children feel very vulnerable, and they may fight it off. If a parent and child are struggling with nurture you may want to be the first to try nurturing the child to see how he responds and to provide a model for the parents. It may not be appropriate for you to put an older child on your lap but you can sit close to him. The parents can also sit close so that they can be part of the experience, leaning in to hear how loud his crunches are as he eats the treat you give him. If the feeding goes well, you can encourage the parents to feed the child the same way. You can then increase the intimacy by suggesting that the child sit in his parent's lap. You can say, "Dad, I bet your boy would fit so nicely in your lap. You can hold him while you give him this treat." Another way to help children gradually receive nurture from their parents and slowly increase the intimacy, is to use playful ways to feed, such as measuring and feeding with Fruit by the Foot, having the child close her eyes and guess which food she's been fed, and seeing how many bites the child can take from a donut while it's placed on a parent's finger.

When a child will not allow direct caregiving, you can nurture indirectly by using nurturing activities that have an element of playfulness and fun. You should continue to use these activities throughout treatment because they are pleasant and build intimacy. Examples of fun activities that provide indirect nurturing are "painting" lotion or powder on hands or feet to make a print, using finger paint to make the prints (which requires that you wash and dry hands or feet); trying on and admiring the child in a variety of hats; putting on paper decorations or costume jewelry; and hiding a powder touch on the child for the parent to find and rub in. Additionally, because it is *responsive* caregiving that forms the basis of the attachment process, we emphasize noticing the child's facial and bodily cues, acknowledging feelings, and making attuned responses that mirror her reactions. The following is an example of moving from indirect nurturing (fanning the child after a vigorous game) to direct nurturing (holding and feeding an older adopted child).

THERAPLAY IN PRACTICE

Helping an Older Child Accept Nurture

Following a lively tug-of-war with eleven-year-old Michael and his adoptive parents on one side and his two Theraplay therapists on the other, Mom and Dad were directed to sit on either side of Michael on the couch. The therapists grabbed large pillows and fanned the threesome, asking each to check how the others' hair moved in the breeze. They discovered that Mom's hair moved the most, Dad had used some mousse and his hair didn't budge, and Michael's hair wiggled right at his forehead. The therapists spread out a blanket on the floor and told Michael to lie in the middle. They held the blanket at the end by Michael's head, and Mom and Dad took the corners by his feet so that they could see his face. Michael couldn't quite believe that he was going to be swung in the blanket, but as the four adults picked up their corners, he readily stretched out. While Michael was rocked back and forth, the therapists led the parents in singing "Our Michael lies over the ocean / Bring back our Michael to us." Michael smiled and laughed and

asked for a second swing. After a soft landing, Mom and Dad sat on the couch again. The therapists placed him on Mom's lap and Dad supported his feet. Mom fed Michael his favorite juice from a squeeze bottle. Michael laughed and said, "Like a baby," but accepted the bottle and looked up at his parents as they noticed the way he drank it, the sounds and bubbles he made and the neat way he burped when he was finished. The parents said, "Michael, this is wonderful. You didn't have a mom or dad to take care of you when you were a baby. We're so happy we can do that for you now."

When children are defensively independent or avoid closeness, parents may find it difficult to believe that there is deep vulnerability under their child's tough or indifferent façade until the child, within a nurturing Theraplay activity, accepts the care and reveals his vulnerability. Parents are surprised and touched when their cradled child quietly lifts his hand to touch his mother's face in exploration, their ten-year-old solemnly watches his father kiss a boo-boo, or their seven-year-old takes the sippy cup and starts to suck. It can be that rich moment that awakens parents to how truly needy their child is, how much he missed in early life, and how deeply lonely he was as an infant. Thus it can happen that, during a tender Theraplay moment, emotions can emerge in a parent who had previously been able to understand nurture only intellectually.

THERAPLAY IN PRACTICE

Helping a Child Accept Nurture and Intimacy from His Parents

Tate was an eight-year-old child in a foster-to-adopt family. With a history of abuse and multiple foster homes, his anxiety-driven behaviors caused enough distraction and upheavals to ensure that he and his parents would not have the tender moments that he needed so badly. In fact, he was so aloof and indifferent to their overtures that his parents doubted that he needed them at all. In their third Theraplay

session, Dad was asked to close his eyes while Mom and Tate tangled up under a blanket. Dad was to open his eyes and gently feel on top of the blanket to see if he could identify whose arm, knee, head, or hand he was touching. To his parents' surprise, Tate eagerly joined in this activity. When finally uncovered, all could see how lovingly close he had cuddled in with his mom. The most surprising outcome was the impact on his mother. She said that in the year that Tate had been in their home, she had never had such a close feeling with him, nor had she been able to feel his need for her. It would seem that Tate could more easily allow this closeness because he felt it was hidden from view. This helped his parents think of ways they could re-create this experience at home.

Need to Feel Competent and Worthy

Many foster and adopted children feel incompetent, bad, and unworthy. These feelings stem partly from a conviction that they deserved the bad things that happened to them and partly from not having experienced themselves as the object of loving, attentive caregiving. In order to grow into a child who feels competent and worthy, an infant must experience attuned, responsive caregiving and have many experiences of mutual joy with his caregivers. Many children who are in foster care or who have been adopted have experienced abuse and profound neglect. Such experiences intensify feelings of pervasive shame and worthlessness. However, children who are adopted or placed in foster care at birth may also experience such feelings. Just the experience of losing a birth parent can affect a child's sense of worth. Children can feel flawed and "wrong" and blame themselves for the parent being unable to care for them; they may feel they caused their own abandonment. Some children may also have cognitive and developmental problems, which can further fuel their feelings of worthlessness. Hughes (1997, p. 31) suggests that these children define themselves as unworthy and exhibit "pervasive shame" due to a distortion of healthy developmental attachment patterns.[4] When an adopted older boy won a prize at camp, his scout leader reported that he acted as though he did not deserve it, as though he didn't want

even to be noticed. The child seems to be saying, "I'm no good. I can't have been worth much if they hurt me, or if they didn't want me."

UNDERSTANDING PARENTING ISSUES. In order to counteract the child's low self-esteem, it is essential that parents' expectations of the child be geared to the level at which the child can be successful. Adoptive parents may form an impression of a preschool or school-age child's abilities based on her age, size, and school placement. Some adoptive parents may emphasize academic achievement and cognitive development in an attempt to make up for the child's experience of early deprivation. Cognitive and motor development in adopted children ranges widely from above-average levels to those having severe developmental delays (often due to lack of stimulation), but because of the disruption in their attachment relationship, all of them have much younger emotional needs. They often are unable to maintain self-control in situations that other children their age could handle, and they are not capable of as much reciprocity in relationships as parents might expect. Koller (1981) noted that parents may expect the child to experience the feelings of closeness and mutual satisfaction appropriate to a reciprocal level of attachment, when the child actually is functioning more like an infant or toddler who is only able to receive the parents' care and not able to respond in kind.

DEVELOPING COMPETENCE AND SELF-WORTH. Theraplay accepts the child as he is in the warm, caring, attentive manner that we have described throughout this book. Often this means providing more nurturing and caretaking than challenge. When you use challenging activities you must set your expectations so that the child can succeed and experience his competence. You must ignore the message of the child's physical size and attune yourself to the needs of the emotionally immature child underneath. You can, of course, use mildly challenging activities to engage the children who might otherwise be resistant to accepting your structuring, engaging, or nurturing approaches. In Theraplay, you can use the dimension of challenge to help the child move toward age-appropriate achievement by gently stretching his comfort level and showing him that he can be successful. Such activities should focus on cooperation rather than competition. Balancing on stacks of pillows, running cooperative races, keeping a balloon in the air, for example, are good ways to develop a positive sense of self while not challenging a child beyond his ability. Because

foster and adoptive children have already faced tremendous challenges in their lives, including loss of birth parents, possible prenatal exposure to toxins, changes in caregivers, abuse, and neglect, it is very important that we meet their younger needs first before challenging them to move toward age-appropriate achievement. Parents must learn to expect inconsistent performance, differences between intellectual and emotional competence, and differences between performance at school and behavior at home. Some parents are pleased with precocious talents and may reinforce inappropriate and premature independence without realizing that a child may be using these talents to maintain distance and discourage adult caregiving.

THERAPLAY IN PRACTICE

Increasing a Sense of Competence and Worth by Meeting a Child's Younger Needs

Paul was adopted at age four after two foster placements. At age eight, his behavior was age appropriate as long as he was in good spirits and feeling well connected to his parents. But when he was tired, in the midst of a transition, or feeling unconnected, he appeared babyish. He forgot what he had learned, could not handle criticism, and had tantrums. At those times his parents felt that he was not attached to them at all, and they wished he would "try harder" to maintain more self-control.

Sessions with Paul and his parents focused on playful, nurturing activities in order to meet his younger developmental needs and to provide him with the experience of attuned caregiving that he had missed earlier. Such activities included caring for Paul's bruises with lotion, making a family handprint, and feeding Paul a doughnut by having him take bites around it while his mother held it on her finger. Paul's sessions also included mildly challenging cooperative activities in order to build his feelings of competence. These activities included helping him balance on a stack of pillows and jump off into his father's arms and blowing bubbles back and forth in the air until they popped.

The therapist encouraged Paul's parents to shift their style of talking and teaching to one of being with and doing. She focused on helping them understand, anticipate, and actively meet Paul's younger needs; for instance, bringing a snack for him when picking him up from school because he always complained of being hungry at that time. Once they became more responsive to his emotional needs, his parents found that Paul's episodes of babyish, out-of-control behavior diminished and he became much more likable and more connected to them.

Need to Feel Claimed by the Family

All children need to have a sense that they belong to their family. Parents "claim" their children all the time in many simple ways. They announce the birth of their child and practice religious rituals that welcome the child into the family and the world. They hang family photos, share names, and pass on customs. They joyously take note of physical traits and of habits and characteristics that resemble their own. This is all part of the process of claiming a child as belonging to one's family. Vera Fahlberg (1991, p. 37) describes it thus, "Claiming behaviors are those which separate the 'we's' and the 'they's' of the world." Being claimed, however, is not so automatic for children who are in foster and adoptive families. When members of the family are not biologically related, they may be all too aware of the differences; family members may not look at all alike and may have very different habits and mannerisms. The child may also have lived for a time with his birth family and may be very aware that he does not share the traits of his new family. Children who have had multiple placements may feel that they will never really belong anywhere.

UNDERSTANDING PARENTING ISSUES. As mentioned previously in this chapter, some adoptive parents question their "right" to parent their adoptive child. This can have an impact on their ability to claim the child as belonging to them and their family. Parents need support in understanding that this feeling is not uncommon and that it can take some effort and time to work through the feelings associated with becoming a parent to an older child who is not biologically related.

Additionally, if a child resists getting close and exhibits significant problematic behavior, parents may feel that being with the child is undesirable and may feel reluctant to claim her as their child.

DEVELOPING A SENSE OF BEING CLAIMED BY THE FAMILY. There are many ways that foster and adoptive families can focus on the claiming process with their children. They can create special family rituals, hang photographs of the whole family, and celebrate the day the child was placed with the family or the day he was adopted. Theraplay offers some unique ways to focus on the issue of claiming in adoptive families. First and foremost, as the therapist you can help the parent feel entitled to parent her child by making an extra effort to honor her parental role by asking permission to play with her child and taking every opportunity to acknowledge that she is the one who knows him best. This demonstrates to the parent and the child that you see them as belonging to one another and helps them naturally accept their roles with one another.

There are many Theraplay activities that can enhance claiming in families. Any activity in which the family works as a team can create a sense of family unity, teamwork, and shared accomplishment. For example, the Tug-of-War game enacts the claiming of the child and drawing him into the family. With parents on one side and the child and you on the other, parents pull as hard as they can to bring the child to their side. Once the child is on their side, all three can work together to pull you to them. Whether you succeed in pulling the family to your side or the family pulls you to theirs, the end result is the same: a lively, engaged team. You can also spend time in sessions noticing the similarities between the child and her parents. This can include noticing physical features as well as personalities, mannerisms, likes, and dislikes. Although this is superficial, we always like to comment when family members arrive at sessions wearing clothes of the same color. You can acknowledge that this must have occurred because they are a family. It is important not to ignore the differences as well, but rather to respect them and acknowledge that differences always exist within the context of each unique family.

The following Theraplay activity, in particular, created a strong sense of belonging for a family and helped them claim their child. Each parent sat on the floor with a blanket spread out between them; their three-year-old child sat on one parent's lap. When the other parent counted to three, the parents raised the blanket and the child

crossed underneath to the other parent. Each parent delighted in him as he made his way across. Each then added other interesting ways for him to cross to the other parent, such as hopping like a bunny or flying like an airplane. The little boy squealed with delight each time he entered one of his parent's arms. His mother stated that she felt overwhelmed with love for her son and felt very connected to him and her husband at the same time during this activity. It made her reflect that this was what it would have been like if her son had been with them when he was learning to walk.

THERAPLAY IN PRACTICE

Helping a Child Feel Claimed

Howard and Jennifer Connor were foster and adoptive parents who had three children in their home at the time of treatment. Kim (twelve) and Tony (eight) were biological siblings who had been with the Connors for one year and Ashley (six) had been with the family for seven months. Biological parental rights had been terminated for all three children and the long-term plan was for the Connors to adopt the children. The adoption process had already been initiated for Kim and Tony and would be beginning soon for Ashley. There were frequent conflicts among the children that occasionally led to physical aggression, and the parents felt at times as though the children were a team against them. The children frequently said that the Connors were not their "real parents." Each child had participated in individual Theraplay sessions with the two parents as well as having some sessions all together. Two different therapists were working with the family, and they co-led the family sessions. Having four adults present with the three children made it possible for each child to have one-on-one attention as needed during the sessions. The goal of family sessions was to create cohesion among family members and strengthen their sense of belonging to one another in their own unique way.

Every session began with Checkups: each child was admired by the parents and therapists and the unique eye color, hair

texture, complexion, and freckles were recognized and appreciated. The adults also looked for and acknowledged similarities between some or all of the family members. The parents then put lotion on each child's hurts, one at a time. The decision was made that only the parents would do this activity so that they would be the ones to connect with each child. When it was hard for a child to wait, a therapist sat beside him or her and helped the child stay present. The family also created a family cheer that was used at the end of every session; all family members joined hands in a circle and shouted "Yea Connors!" and raised their hands high in the air. During one session, the parents created a family symbol that could be drawn onto everyone's hands with body crayons; each child then added a different part to the symbol. Other activities were making family handprints, Cooperative Cotton Ball Races that included the whole family working together toward the same goal, and Balloon Balance, which was done in a special way. The parents first balanced a balloon between the two of them with their tummies, and then moved around the room adding each child in the order in which the child came into the home until the entire family was able to move around the room with all of them holding the big balloon up against their tummies.

The family Theraplay sessions provided a safe, structured, cooperative, and positive way for the family to be together. The individual Theraplay that the parents had done with each child previous to the family work helped develop dyadic attachment; the family sessions gave them a collective experience that provided a sense of cohesion and fun. The parents reported that the Theraplay treatment provided them with tools to connect with and nurture their children, and that having additional adults facilitating interaction among the children gave them more confidence in how to handle sibling issues on their own. Eventually they felt more confident overall in their roles as parents. After treatment, the children were more cooperative with one another, and the physical aggression ceased. They were also able to enjoy activities together like "family game or movie night" and the children began to call

the parents "Mom and Dad" more consistently than they had prior to treatment. Family Theraplay helped them connect more with each other and feel a greater sense of belonging.

WORKING WITH PARENTS

We have described how hard it is for parents to understand and meet the many needs of their foster and adopted children. Work with these parents includes all the basic steps outlined in Chapter Six for working with parents as well as those we describe in Chapter Nine. In the following section we discuss two issues that are especially relevant to parents of adopted children: the need to develop empathy for their child's experience and the need to understand their own attachment issues.

Building Empathy for the Child's Experience

Parents who have adopted or are fostering children have to deal with needs and behaviors for which they may have had little preparation. Many parents hope that providing a good family and love will be enough for the child to be emotionally healthy and feel "normal." They are surprised when misbehavior occurs, and they may not recognize it as a sign of deeper issues. It can be hard to accept the fact that experiences of early separation and loss, deprivation, and loneliness can have lasting effects on children. One parent, just having become aware of her child's early pain and loneliness, cried and said that she had never thought about that before.

Some parents, unfortunately, are not educated in advance about the long-term effects of neglect nor are they aware that their child may show signs of past neglect or rejection. Your role is to increase parents' awareness and sensitivity to these issues. You need to help parents appreciate that their child was alone and deprived of adequate nurturing before they came into their home. They need to understand how that must have felt to her, and how it will affect her ability to trust them now. They will also need to understand that her past is not gone or forgotten, but is still part of her.

In their excitement about adopting a child, parents often forget how painful and frightening it can be for a child to be adopted—that

is, taken away—by strangers. It is indeed sad that a moment so important and exciting to the parent is often terrifying to the child. When a parent begins to "walk in the child's shoes," she may start to feel guilty for not having been there to protect him and sad that he experienced rejection by and loss of his birth parents. Parents will need support to integrate into their understanding of adoption the pain inherent in their child's adoption experience.

It can be hard for some parents to let themselves feel the full impact of their child's early experience. If they cannot do this, they will not be able to provide the attunement the child so desperately needs to understand herself and resolve past losses. Parents may need your help in accepting the reality of their child's history. If a parent is especially resistant to acknowledging her child's pain, the possibility of attachment issues in the parent's own history may need to be explored.

Helping Parents Who Have Attachment Issues of Their Own

When a child who has serious attachment problems joins the family, a parent's own attachment dynamics are bound to get triggered. This is true whether one is parenting a biological, adopted, or foster child. When faced on a daily basis with a child's rejecting and challenging behaviors, however, a parent may find herself angrier and more out of control than she thought possible. In these cases, it is absolutely essential that you, as therapist, be skilled at working with adult issues or, alternatively, that you refer the parent for attachment-focused adult psychotherapy. The dynamic that is triggered in the adoptive parent often has to do with a replication of an uncomfortable victimization from an important figure in the parent's past.

A study by Mary Dozier and her colleagues (2002) showed that foster parents could help to change their foster child's attachment style from insecure to secure, but only if their own problematic attachment histories did not interfere with their capacity to provide the sensitive nurturing care that their foster child needed. By this we do not mean that a parent must have had an ideal childhood, but that the parent should be able to reflect upon her own childhood, recognize the patterns and pain of her history, and be able to separate her own past experiences from those of her child. She must be able to do what is necessary to meet her child's needs, rather than act from the unprocessed wounds of her own past.

THERAPLAY IN PRACTICE

Helping a Parent with Attachment Issues of Her Own

For Ellen, who had adopted four-year-old Lena from Russia when she thirteen months old, the trigger was Lena's aggression toward members of the family and her strong rejection of Ellen's efforts to connect with her. Lena would walk by Ellen's other adopted daughter, Karen, also four, and hit her randomly. When Ellen would tell her to put her shoes on or would just come into her room to say good night, Lena would say, "Get away from me." Ellen herself had grown up in a verbally and emotionally abusive home and had escaped from her parents' home as soon as possible, at age seventeen. She went to college, achieved a professional career, got married, had what she thought was "a great life." She had convinced herself that she had escaped her past and had never looked back. She prided herself on adopting two deprived children, essentially saving them in the same way she wished she had been saved from her painful childhood. When Ellen brought Lena for Theraplay, her focus was solely on improving Lena's behaviors. After several sessions, however, Ellen called the therapist and told her that she could not live with Lena anymore because she felt completely unable to relate to or interact with her. She could not look at Lena; she felt that Lena hated her and that nothing she did with Lena was successful. The therapist, responding to this cry of distress, asked Ellen to come in by herself to talk about these feelings. Ellen came to the next session with her head hanging low. She sat slumped in the couch and spoke slowly. She did not look like the "put-together" professional and upbeat mother that she had presented in the first several sessions.

The therapist helped Ellen discover why she was having such a highly negative reaction to Lena. Ellen's feeling of dread toward Lena came from a mental merging of Lena and her own mother; Ellen experienced Lena's meanness and verbal aggression as that of her mother. It was no wonder that Ellen wanted to escape the home. The therapist, who was also an

experienced adult therapist, immediately suggested a series of twice weekly sessions to help this very distressed mother. In truth, Ellen was "stirred up" by her very difficult child who opened the floodgate of unresolved attachment problems relating to her own mother.

The therapist and Ellen worked intensively for two months before they resumed Theraplay sessions with Lena. They continued individual sessions every other week to help Ellen further resolve the feelings from her childhood so she would no longer be triggered by Lena's behavior. With this intensive support, Ellen was able to develop much more empathy for Lena. Ellen became more playful and began to truly understand her daughter. Not surprisingly, their relationship as well as Lena's behaviors improved markedly.

WORKING WITH CHILDREN IN FOSTER CARE

Because Theraplay is an attachment-based treatment model, many questions arise when considering using the approach with children in unstable situations where the future is uncertain. Treatment providers, foster parents, and others in the child welfare system may question whether it is a good idea to use an attachment-promoting approach with a child and her temporary caregiver. We believe that developing attachment between children and temporary caregivers is appropriate and necessary. As Vera Fahlberg (1991, pp. 23–24) notes, "Given the potential long-term effects that lack of attachment can have on a child, it is crucial that the foster care system respond in ways that help the child develop attachments with their primary caregivers whomever [sic] they may be. . . . [T]he development of an attachment to foster parents should be encouraged."

The experience of forming an attachment, even to a temporary foster parent, gives the child an opportunity to break out of the emotional isolation imposed by trauma and loss and begin to reach out again in order to complete his grieving and healing. Being able to connect with people is a skill that needs to be developed and used in all relationships. We know that attachment to the primary caregiver makes it possible for children to make a good connection with other

caregivers, family members, and teachers. Similarly, attachment to a foster parent can help the child form an attachment to adoptive parents.

Children who have had multiple placements in foster care, however, have developed very strong defenses against forming an attachment. Many are referred for Theraplay after having years of treatment in other modes of therapy with little effect. This long experience with therapy that seems to go nowhere can result in the child's not trusting the therapist. When working with these children, be prepared for displays of passivity or aggression, which may include outbursts of rage. Caregivers must also be prepared for these responses so that they continue to support treatment and do not withdraw the child. If treatment ceases when the child expresses her anger and despair, she will feel rejected yet again, and will feel that adults are unable to protect her and stand by her through both the good and the bad moments.

Using Theraplay in Foster Care

With children in foster care, Theraplay can be very useful in structuring visits between the children and their birth parents and siblings, with children and foster parents in long-term care, with children and residential program staff, and with children and foster and adoptive parents when the child is transitioning to a preadoptive home. In addition to using Theraplay with individual foster families, child welfare workers have found the Theraplay model useful for foster parent training programs. Use of the Theraplay dimensions of structure, engagement, nurture, and challenge can help explain to foster parents about children's needs and what helpful caregiver responses should be. In order to determine what is most beneficial to the child's well-being, the child's team must be included in deciding whom to involve in the child's Theraplay treatment. You must take into account her permanency plan, court status, and the readiness and availability of caregivers to be involved in treatment. At the end of this section we will present two cases that illustrate Theraplay's usefulness with children in foster care: one where the goal is for the children to return to the birth parent's care and the second in which Theraplay is used to assist the child in transitioning from a temporary foster parent to preadoptive caregiver.

In working with the child, foster parents, and even foster siblings, Group Theraplay can be very useful. It is not as intense as individual Theraplay, yet it builds a community, increases caring within the group, and can teach the family how to have fun together. Use "getting-to-know-you" activities in group or in individual sessions with foster parents and the child. Measuring, noticing eye colors, seeing how far a child can jump, and making handprints are examples of games that can help family members appreciate each other more and get acquainted in ways they likely haven't done before. Challenging activities can be used to engage foster families who may act as if they don't care about fun or nurturing.

Engaging Substitute Caregivers in Theraplay

For Theraplay treatment to be truly effective, temporary parents must come to understand how important they are in the child's life and must make a commitment to attend and participate in sessions. Some temporary foster parents and residential child-care staff may feel that they have little or no effect on the futures of children placed in their homes. Many temporary parents see children come into their homes and leave under less than ideal circumstances. They may have felt heartbroken and helpless over the tragic situations of the children in their care and coped by becoming emotionally disconnected. Engaging such parents in the Theraplay treatment process can be very valuable and can help them feel that they have something to offer their children. It is vital that you educate temporary parents about attachment and how important it is that they develop a healthy emotional connection with their child, a connection that will affect how he views himself, others, and the world for the rest of his life. It is also important that you have empathy for temporary parents. Their willingness to open themselves to a relationship with their foster child puts them at risk for being deeply affected by the loss of that child when he leaves their home.

You will need the support of the foster-care organization and larger system in which you work when using Theraplay with a child in temporary care. If a child is moved abruptly, he will experience another traumatic loss of his attachment figure and any gains in emotional security will be jeopardized. You want to be supported enough that, should any move have to be made, you would be given

time to help the child grieve his loss of the relationship you have helped facilitate.

When a Caregiver Is Not Available for Therapy

When a child is in temporary placement and a foster parent or residential child-care staff cannot be engaged in therapy, Theraplay can still have a place in the child's treatment. If your attempt to recruit someone who is part of the child's daily care has not been successful, you can choose to do Theraplay sessions yourself with the child, acting as her primary attachment figure. When conducting Theraplay sessions alone with a child, be sure that you are in a position to make a long-term commitment to the child and be available to help him transition to his next placement. Again, this is a situation in which you need the support of the system within which you are working, so that you are not taken abruptly from the child without an opportunity to process the loss. As in all work that you do alone with a child, you should videotape the sessions to protect you from any accusations of inappropriate intimacy.

There are certain situations where it may not be appropriate for you to be in the role of primary attachment figure for the child, such as when a placement is very tentative or if the system is not supportive of such work. In these cases the child can still benefit from your use of Theraplay activities and principles. You can use Theraplay to engage the child and provide him with the opportunity to have fun and receive nurture. For example, when he arrives for the session during cold weather, you can help him warm his hands, apply lotion to dry skin, and notice a hurt that needs a Band-Aid. You might then engage him in a game of Balloon Toss and share some laughter and smiles. You can then move on to other treatment approaches that support the child and help him deal with the difficulties of his uncertain situation. Using Theraplay principles in your work with a child can even be as simple as in the following situation. One child, who was living in a residential setting with multiple caregivers, had no one who noticed that she needed her glasses cleaned. Her therapist kept eyeglass cleaner for her and cleaned her glasses at the start of each session.

Using Theraplay to Structure Visits with Birth Parents

Visits between children and their birth parents can be challenging and stressful for all involved. Families who have been separated often have negative patterns of interaction and do not know how to move out of such patterns without help. Typically, visits take place in the artificial setting of an office visitation room. Toys and board games are usually available, but the birth parents are left on their own to try to engage their children, who are often anxious and resistant. Theraplay can provide a predictable structure, guided opportunities for fun for both the children and their parent, and can create new ways of relating with one another. Even if a child is not returned to that parent, providing a chance for them to connect more during visits makes the experience more rewarding and beneficial to both the parent and the child.

THERAPLAY IN PRACTICE

Using Theraplay During Visits Between a Birth Mother and Her Children

Lizzie (seven), Kaitlin (five), and Zoe (four) were placed in foster care because they were not safe in their birth mother's care; she was using drugs and her partner was physically abusing the girls. As part of the plan for reunification, the girls had supervised visits twice a week for two hours with their birth mother, Sandy.

During visits, Sandy was harsh and punitive and used threats and bribery to get the children to behave. The children were clingy with their mother, pushed one another away to get close to her, and cried frequently. In order to make the visits more productive and to increase the mother's understanding of her girls' needs, a plan was made to provide Theraplay during one hour of a two-hour visitation each week.

During the first Theraplay session, Theresa, the Theraplay therapist, began by checking for hurts and making lotion and

powder handprints. The girls sat on the floor willingly with Theresa and eagerly smelled the choices of lotion. Chocolate quickly won out as the favorite. As Theresa was putting lotion on the girls' hands, Sandy said, "That looks like it would feel so good." So Theresa reached over and put lotion on Sandy's hands saying, "We wouldn't want Mom to feel left out. Her hands take care of so many people. They took care of each of you girls when you were babies. Now they are the hands she uses to steer the car to come see you. These are really important hands." As each girl made her lotion handprint, Sandy commented that she would like to be able to take the pictures home. The girls giggled and agreed. Next they blew feathers from pillow to pillow. Kaitlin didn't want to participate and hid under the table. Mom immediately said, "You get over here or I'll put you in time-out." Theresa said to Kaitlin, "Why don't you watch from there and when you see what we are doing you can come join us. Mom, you hold her pillow for her and help her sit on it when she is ready to join us." Within a minute or two, Kaitlin came out and went to Sandy. The girls and Sandy laughed as each tried to catch the feathers. In order to avoid a squabble about who could be next to Mom, Theresa told each girl where to sit when it was time for their snack: one girl on each side of Mom and one in Theresa's lap. Then she said, "I know the girls are big enough to eat and drink by themselves but in this special place, we get to feed them and hold their juice box for them like this." Theresa demonstrated with Kaitlin. After the session was over and the girls were playing with the dollhouse, Theresa took the opportunity to talk to Sandy about her response to the session. In order to avoid Sandy's repeated threats, she explained that during the session she, Theresa, would handle any necessary discipline so that Sandy could relax and enjoy her girls.

After several Theraplay sessions, Theresa decided it was time for a "Pamper Party" for Mom and the girls. Theresa brought in scented soaps and lotions, nail polish, hair decorations, and some necklaces and tiaras. By this time the girls had begun asking for Theresa's activities to be the first thing they did after greeting their mother. Theresa was now staying for the full two

hours and Sandy was talking with her more openly. What fun the Pamper Party was! Each adult worked one-on-one with the girls (pairings switched each week so Sandy focused intensely on each daughter every third week). The silly hairdos and fancy nails were a sight to behold. Theresa took photographs for Mom and the girls to take home. Everyone was delighted by this positive session. Using Theraplay during the visits provided a structured way for the girls to receive the nurture they were so craving from their mother and helped Sandy respond to her daughters in a more accepting and supportive manner. It also gave her some skills that could move her closer to the goal of having her daughters return home.

Using Theraplay to Support the Transition from Foster Mother to Adoptive Mother

In some special situations a child may be in an attached relationship that cannot continue; for example, when a child has formed a strong attachment to a foster parent, as in the next case. The goal in Theraplay is to help the child transfer his emotional attachment to a new parent. A strong attachment will always serve a person well; having had a trusting relationship, he will be able to build another, after a period of grieving his loss. This final case shows how Theraplay can honor and support the grieving process and at the same time help the child develop new emotional connections.

THERAPLAY IN PRACTICE

Using Theraplay to Transition from Temporary Caregiver to Preadoptive Parent

Anthony was four years old at the time he began Theraplay treatment. He was removed from his birth mother's care when he was eighteen months old due to severe neglect. He was placed with Mary, a temporary foster parent. A single woman with three adult biological children, Mary had fostered many children in her home. She provided good care to her foster

children, keeping them clean and well fed. She helped them advance academically and exposed them to many enriching programs. She was physically affectionate with the children, but often spoke of how she needed to keep herself somewhat detached in order to make it less difficult for the children and herself when they left for another home. The original plan was for Anthony to return to his birth mother; however, after two years of services and no progress, parental rights were terminated for Anthony's birth mother. At that time a search for a permanent placement began. Tom and Laura, a childless couple, were identified as a preadoptive placement for Anthony. Tom and Laura began visiting Anthony in Mary's home, spending time with the whole family, having not yet been identified to the children as Anthony's potential adoptive parents.

Mary described Anthony as a very active child who rarely settled down in one spot for long. He was sometimes aggressive when he did not get what he wanted, but Mary felt that she was able to redirect and manage his behavior. Mary said that Anthony rarely cried even when hurt and did not seek her out for help.

The initial goal of Theraplay treatment was to provide a structured, safe environment in which Anthony could experience both mothers working together and engaging him in positive interaction. Treatment would also provide a setting to help transfer care from Mary to Laura. The therapist, Audrey, also had sessions with Mary, Laura, and Tom to discuss important information about Anthony's care, how each was feeling about the transition as well as educating all three about the importance of attachment and the significance of Anthony's early history. Audrey also taught the parents about Theraplay dimensions and goals and practiced activities with the adults. The focus in the early sessions was on the transition of care between the two mothers and, therefore, Tom was not included at the beginning.

In order to provide security and predictability to Anthony, the Theraplay sessions were very structured. Audrey posted the list of activities planned for the session on the wall for both

parents to see. She then led Mary, Laura, and Anthony into the room and instructed them to begin the first activity together. Audrey remained outside the circle in order to allow the interactions to be between Anthony and his two mothers. For the first session, Audrey took charge of starting and stopping each activity, though she did not directly participate. During later sessions, each of the activities on the list was done three times. Either one of the mothers could suggest a repeat of the activity. For example, Mary would say to Laura, "Wow, Laura, I could tell Anthony really liked Row, Row, Row Your Boat; his smile is so big and bright. Let's do it one more time." Then after they had done Row, Row, Row Your Boat three times, Laura would say, "Oh Anthony, you have a hurt on your hand. I'm going to put some lotion on it. . . . Mary, do you see any hurts on Anthony?"

Audrey remained outside of all of these activities but was available to support the mothers and intervene if necessary. For example, during one session Mary was searching for hidden cotton balls on Anthony when he began to squirm and shout, "It tickles!" He then arched his back and kicked his feet at Mary. Mary laughed and continued to search, intentionally tickling Anthony, who grimaced and kicked and wiggled even more. During a previous parent meeting, they had discussed attunement and the importance of not overstimulating Anthony with tickles or rough touch, but Mary had forgotten. She mistook Anthony's reaction as a signal that he was having fun and wanted to be tickled. Audrey then intervened, stating that it was important to make sure that Anthony was feeling comfortable. She asked Mary to stop searching and demonstrated on Mary how to use firm, confident touch while looking for the cotton ball. As Audrey demonstrated the touch on Mary, Anthony watched and settled down. Audrey then had Mary resume the search, and Anthony was able to stay well regulated and connected.

After several sessions and visits over a period of six weeks, Anthony was told by Mary with Tom and Laura present, that he would be moving to their home. In response, Anthony said,

"Okay," and returned to playing with his toys, avoiding any further discussion with the adults. The next day at the Theraplay session, Audrey immediately addressed this painful issue. After the initial entrance to the room when Anthony was sitting safely in Mary's lap, Audrey told Anthony that she knew he would be moving to Laura's home. Anthony began to fidget, and Mary started to hum and rock him gently as she had learned to do during previous sessions. Anthony settled a bit and hid his face in her neck. Audrey went on to say that it must be hard for Anthony to think about leaving Mama Mary. Though Laura was a very nice lady and he had fun with her, he knew Mary as Mommy. Anthony began to cry, "I don't want to leave Mama." Mary looked startled for a moment, as Anthony rarely cried, and soon she began to cry softly herself. Audrey encouraged her to say something to Anthony about her tears. "I know it hurts, Anthony. I don't want to leave you either." As she watched the tender scene between Anthony and his beloved foster mother, Laura had tears in her eyes as well. Anthony noticed and pointed at Laura, "Why you sad?" Laura, unsure how to respond, looked to Audrey who said, "Anthony wants to know why you're sad, Laura. Can you tell him something about your tears?" Laura took a deep breath and said, "Anthony, I care about you so much. I want very much to be your Mommy and to love you and take care of you. It makes me so sad, though, that you have to say good-bye to Mama Mary. She has taken such good care of you and you really love her."

Audrey then suggested that Mary remind Anthony about why he had to leave her home. Although it's not easy for anyone to make sense out of something as painful as leaving a foster home, she was concerned that Anthony might think it was his fault, that he had somehow been a bad boy and if only he had been better he would have been able to stay with Mama Mary. She then helped Mary continue to empathize with Anthony's pain while explaining that he was not responsible for this move.

Anthony then jumped up. "I'm happy now! You should be happy now too." But in an angry voice, he said, "No more

sad!" and pushed Mary's shoulders. Audrey gently placed a hand on Anthony's arm and said, "Anthony, it's okay to feel sad when you're saying good-bye to someone you love. It is sad." Anthony dropped his head and grimaced, but remained standing in front of Mary, facing her. Audrey helped Anthony receive another comforting hug from Mary. After a quiet moment, Audrey suggested that Mary and Laura swing Anthony in the blanket. Following the blanket swing, they moved on to other engaging, physical activities that Anthony enjoyed. Later in the session he started to cry once again but immediately wanted to push the feelings away. When Mary was able to stay with him in his feelings by empathizing and sharing the sadness, Anthony was able to sit with her and accept her comfort.

After three more sessions with Mary, Laura, and Anthony and after continued preplacement visits with Tom and Laura, Anthony went to live with his adoptive parents. Theraplay treatment then shifted to sessions with Laura and Anthony and eventually with Tom as well. The way that Anthony's transition was handled gave him permission to express his feelings and have them validated by those most important in his life. The experience also made a big difference in how Mary would approach all the children who came to her home in the future. Mary said, "I couldn't believe it when Anthony cried. I felt so bad that I might have caused all that pain. None of the other kids cried when they left my home. But now I realize that they probably felt sad too and I had not helped them with those feelings. From now on when kids leave my home, I plan to help them express their sadness and anger, so that we can say good-bye in a healthy way."

The needs of foster and adopted children run deep and can be complex. But the basic need is to become connected with someone they can trust who can help them answer the following questions: With whom do I belong? Am I wanted? Will I be cared for? Am I important enough to be thought about and played with? Can I trust you to know what I need? Will you step up to the plate and do what

I need you to do, even though I protest? Theraplay allows parents to answer these questions for their children in the basic, nonverbal way that parents have used with their children from the beginning of time. Theraplay allows adoptive and foster parents to build attachment as it was meant to be built, in the moment-to-moment, face-to-face, playful and nurturing, structuring and engaging interactions of everyday life. Moments of "real meeting" have the power to transform lives forever.

Notes

1. We are not focusing on children adopted as newborns and raised by their adoptive families because those children have the opportunity to develop attachments through responsive caregiving just as biological children do, although we acknowledge that they have sustained a loss. Theraplay may be useful for children adopted as newborns if and when later typical issues emerge concerning loss, self-esteem, and identity (Reitz and Watson, 1992).
2. Jarratt (1994, pp. 7–11) discusses helpful ways to talk to children about loss, taking into account the child's stage of thinking.
3. Reitz and Watson, working from a family systems perspective, ask about the family rules concerning the adoption, and how they match other operating rules in the family; they examine the interaction among the family system dynamics of a particular family, its life stages, and adoption; and they encourage the clinician to understand which of four phases of the adoption process (uncertainty, apprehension, accommodation, integration) the family is in and what unfinished business from previous phases may exist (1992, p. 135).

   Grabe reports on the conclusions of a survey of adoptive parents and their experience of the therapy process: "The non-directive approach does not work with foster/adoptive issues, nor does an approach that excludes the family, that does not see the family as a resource, or opts for confidentiality. Much of the potential of a therapy session is lost if the family cannot continue to reinforce the issues during the next week" (1990, p. 39).
4. Hughes (1997, p. 32) comments, "The healthy sequence of union, exploration, shame and reunion has been replaced by neglect, self-minimizing, contempt/rejection, and isolation/splitting."

CHAPTER ELEVEN

Theraplay for Adolescents

William S. Fuller

"Dude!"

"Back up!"

"Whoa, whoa, whoa!"

"Hey, listen to Tony."

"Yeah, yeah, yeah. Try it!"

"Almost . . ."

A burst of boisterous laughter followed by victory shouts and an explosion of high fives around the room. Six teenage boys, ranging in age from fifteen to seventeen, have just completed a challenging task of creating a plastic pyramid with a simple "tool" that requires the teamwork, synchronization, agility, and good humor that makes up a cooperative social group. What was the task that created all this good feeling? The teens had to work together to build a multilevel pyramid of seven large plastic cups using only a rubber band with six strings attached. Each holding a string, they had to coordinate their action to stretch the rubber band and capture a large plastic cup, raise it, and place it where they wanted it to go. No hands allowed on the cup! Their plan: first four cups in a close circle, next three cups balanced on top of the first set, and finally one cup balanced on the top. As you can tell from the high fives and shared feelings of elation,

the exciting task of building the pyramid together had truly lifted them into a world of shared excitement and fun.

Rewind to three months earlier when this group was forming: words can barely describe the resistance, opposition, and negative energy that engulfed the room at the beginning of each session. None of the boys was willing to leave his comfort zone; let alone make eye contact, say a peer's name, play a game, or laugh. Each of the teens in the group was serving part of his mandated probation by attending weekly group therapy sessions. None of the teens could have imagined what the sessions were going to be like. Most of the group members reported that they had expected the meetings to be filled with talk: about how badly they had screwed up and about all the things they needed to do differently. Instead, the sessions were filled with activities that challenged and engaged them—activities that would actually change their view of themselves and their sense of competence and camaraderie.

In describing the challenge of working with adolescents, Mary Spickelmier and Brijin Gardner (2008, p. 5) say:

> Adolescence is a wild ride for everyone involved. It is filled with tumultuous friendships, power struggles with parents, preoccupation with social status at school, self-esteem issues, testing limits and rules, along with a menagerie of other difficulties acquired along life's journey. Providing therapy to teen-agers is a challenge, to say the least, but, believe it or not, adolescents want adults in their lives, especially adults who treat them differently than "other" grown-ups. Theraplay can provide great results with this difficult population if you have a dab of creativity, lots of patience and a generous understanding of what teenagers are experiencing.

Discouraged with other approaches that did not engage teens or lead to hoped-for change, a few therapists have been brave enough to try Theraplay with adolescents and creative enough to adapt Theraplay groups for this population resulting in important gains. Peggy Weber (1998) noted the following shifts after a school program of Group Theraplay with teens:

- Students and staff establish better rapport.
- Challenging students show a softer side.

- Students are more willing to listen to staff members.
- Students are more motivated to solve group problems.
- Students are more accepting of traditional mental health interventions, such as crisis intervention, mediation, and problem solving.
- Students show unexpected responsiveness and "blossoming" of personalities.

When we think of using Theraplay with adolescents, it is hard to imagine that all those "childish" games could appeal to an aloof thirteen-year-old, or an aggressive, embittered sixteen-year-old. Can an "in-your-face," destructive dropout be reengaged through well-designed, esteem-enhancing play of the kind we have been recommending? The above example of Theraplay with a group of boys in a juvenile offenders program makes it clear that it is possible to engage adolescents in playful activities that can change their attitudes toward themselves and others.

Although Theraplay must be significantly modified when dealing with adolescents, the experienced Theraplay therapist working with adolescents—whether in groups, in sessions with their parents, or in individual sessions—can reverse threatening behavior, restore relations between teens and their parents, and get the troubled teenager back on the right track. The group example above and the examples throughout this chapter, however, testify to its effectiveness. One former adolescent client, when revisiting her therapist years later, emphasized the importance of the direct, caring, physical interaction rather than the talk therapy that they had engaged in for their first twenty-five sessions:

> I remember every detail of every active thing you and I *ever* did together. I remember that first time when I came in frozen from the cold. Instead of our usual talking you took my hands in yours and warmed them up. Then you put lotion on them and made a print of my hands on blue paper. I was so startled. Nobody had ever done that for me before. And how you put lotion on my elbows and fed me bananas. And the day we tried on hats. You know, it's funny, I don't remember anything at all about the time when I was coming to see you and we just talked [personal communication].

In this chapter we look at the special challenges of working with adolescents, what Theraplay has to offer, and how this approach differs from work with younger clients. We then consider the more complex issues that arise and the variety of forms that Theraplay with adolescents can take.

UNDERSTANDING THE SPECIAL CHALLENGES IN WORKING WITH ADOLESCENTS

Every child moving into the teen years faces biological and psychological upheaval: complex brain reorganization, sexual development, changes in physical appearance, changes in relationships with parents, blows to self-esteem, exciting but often daunting challenges about the future. These changes produce characteristics that are very different from those we see in younger children.

Adolescents pose a unique challenge in therapy. Already mistrustful of adults, the adolescent is often resistant to engaging in the treatment process. Too often he comes into treatment because his parents or teachers think he needs help, not because *he* feels a need for it. He sees this as the adults' effort to make him shape up, rather than as an offer of help to deal with his own pain. As a result, the adolescent has a different agenda from that of his therapist or the other adults in his world. Frequently his goal is simply to get his parents off his back. Although there are exceptions, right from the beginning the young person may be resistant and even hostile.

Many adolescents no longer look to adults as authority figures. Those who were unable to benefit from an adult relationship in the past feel that engaging in one now is a waste of time. Those who do relate to adults prefer to treat them as peers rather than as respected authority figures, and adults are often eager to comply in this less challenging form of relating. Thus the therapist can no longer rely on his authority or size; he must instead use verbal skills, life experience, humor, or intellect to take charge of the situation.

Nor, for several reasons, can the therapist assume that the adult style of talking therapy will be effective. Although adolescents love to talk to peers, they are often uncomfortable talking to adults. In conventional "talk" therapies, many adolescents adopt a strategy of maintaining silence, or "clamming up." Adolescent therapists are familiar with the line, "I'll come, but I won't talk." When the

adolescent does talk, she may use words to keep her therapist at bay. Finally, the adolescent may not yet have the maturity to understand the complexity of her situation and therefore may find it difficult to admit to any confusion she feels.

For all of these reasons, therapy of any kind with adolescents can be difficult. You must be alert, creative, and resourceful in order to ensure successful treatment. You must also understand adolescents' developmental needs for autonomy, individuation, and the development of a sense of self. At the same time, however, you must address their need for connection, not only with peers, but also with adults. Given all these complex factors, Theraplay with adolescents is best done by experienced Theraplay therapists who understand adolescent development and current teen culture.

UNDERSTANDING WHAT THERAPLAY CAN OFFER

Rather than attempt to adapt adult talking therapy to adolescents, Theraplay offers an alternative method of treatment. It engages the troubled adolescent in an active process, one that is full of fun and surprises. It responds directly to the younger attachment needs underlying the adolescent's difficult behavior. The Theraplay therapist actively takes charge, providing the clear structure that adolescents so desperately need. The adolescent does not have to talk about his problems, reveal secret fantasies or wishes, or even be motivated to get help. The active, playful nature of Theraplay makes it possible to engage the silent teen and to avoid getting lost in a smoke screen of glib talk.

Theraplay with adolescents can be very effective in groups, as we see in the example above. The advantages of group work are twofold: first, it is a ready-made forum for working directly on social interaction and how to get along with peers; and second, after the initial reluctance, the young person will feel less self-conscious, because everyone in the group is joining in.

Theraplay can also be used with the adolescent individually or it can include his parents as well. Including parents in Theraplay treatment can add special power to work with adolescents, particularly when the issues are related to family interaction. By the time a child is in her teens, dysfunctional family patterns of distancing, arguing, and angry fighting are entrenched. Parents, having "tried everything,"

feel hopeless, angry, hurt, and often ready to give up. Theraplay can help parents regain their leadership role and provide clear rules and structure at home. It also helps parents understand and respond to their teenager's needs for calm support and nurture, for interactions that enhance self-esteem, and for just plain shared fun. In the following example, the whole family was asked to join an adolescent girl's treatment in order to address the problems of her isolation from the family group. We return later to discuss specific issues related to having parents in Theraplay sessions with their teens.

THERAPLAY IN PRACTICE

Adding Theraplay to Family Therapy Sessions

Angela, age fifteen, graduated from her familiar K–8 school and left her group of long time friends to begin high school. She had a learning disability and experienced difficulty adjusting to the new school, students, and programs. Angela lived with her mother, her stepfather, and her ten-year-old brother.

Treatment began as individual sessions with Angela to address her self-esteem and social adjustment issues. In order to develop their relationship, the therapist included a few Theraplay activities in each session. The therapist also checked in occasionally with Angela's mother to see how things were going at home and at school. After several sessions, the mother reported that Angela's attitude toward school was becoming more positive and that she was developing some new friendships. She was, however, concerned that Angela continued to spend most of her time in her bedroom alone and seldom interacted with her family. This prompted the therapist to bring the whole family together for some family Theraplay sessions. The goal was to provide a positive playful atmosphere in which the family could share some fun. The therapist discussed the plan with Angela. Because she had enjoyed the Theraplay activities in her earlier sessions, Angela readily agreed to try it.

The Theraplay activities chosen for this family were

1. Checkup (each participant spoke about recent positive and negative experiences in their life)
2. Beanbag Toss (as soon as one beanbag was in motion another was added, up to four beanbags)
3. Mirroring (copying each other's movements)
4. Hokey Pokey
5. Pass Around Silly Faces
6. Pass a Gentle Touch

At first Angela was hesitant, but as the session got started she gradually warmed up. The therapist, parents, and brother had a great deal of fun in the activities and this helped Angela to relax and enjoy them. During Checkup time, Angela shared some of her struggles at school and her successful attempt at performing a difficult passage on her flute.

In the mirroring activity each person took a turn creating an action that everyone had to copy. The family did a great job providing hilarious movements and sounds for everyone to copy. Angela's brother, being quite a ham, led the group in exaggerated hip hop and other dance movements. This boy's activity level and need to be noticed could be annoying at home, but in the Theraplay setting it helped to bring some lively fun into the activities. Angela started her turn by putting her hands up to her face self-consciously and seemed unsure of what to do. When everyone playfully copied that movement, she added other movements, ending with pretending to play her flute. Even though she appeared leery of acting as silly as her family members, she seemed to thoroughly enjoy being part of the group. Seeing her usually quiet, empathic therapist act silly seemed to impress her.

The rhythmic and playful movements of Hokey Pokey were enjoyable to this musical family. Angela did not express embarrassment but joined in quite readily as everyone danced in unison together. Passing a Gentle Touch around the circle

was a nurturing way to end the session and say good-bye. After the session was over, all agreed that they had a great time together and were willing to come again.

In the third family Theraplay session, the therapist added a time for talking about various concerns of the members. The final activity in this session was to give a compliment to the person on your right. When Angela's turn came, she turned to the therapist and said, "Thank you for the fun warm-up activities that help us feel safe to share with one another." Shortly after this session, the mother reported to the therapist that Angela was spending more time out of her room with the family. Six months later, during a follow-up phone call, the therapist learned that Angela was continuing to do well.

UNDERSTANDING HOW ADOLESCENT THERAPLAY DIFFERS FROM THERAPLAY WITH YOUNGER CHILDREN

When you work with adolescents, you must have self-confidence, perseverance, imagination, and a good sense of humor. You must also take into account the adolescent's physical size and intellectual and sexual development.

Adapting to Physical Size

The adolescent's greater height, weight, and strength call for activities in which taking charge does not depend on your being able to "take hold" physically. Rather, your tone of voice, certainty of movements, and commanding attitude must carry the message that you are capable of guiding the session in a safe, playful, and appropriate manner. In this way, you create both psychological and physical safety for the adolescent.

To accommodate a large teenager, you will need a larger room than for a small child. The large pillows that we recommend for younger children are also useful for adolescents and you can use many more of them. They can be used to support the adolescent as he sits facing you, they can be stacked for him to balance on, and they can be made into a huge pile to burrow under.

Responding to Greater Self-Consciousness and Verbal Sophistication

Because they are older and more intellectually mature, adolescents are more self-conscious, more defensive, and more verbally and personally challenging than younger clients. You need to be prepared to respond to their sophisticated verbal resistance with humor and confidence. To the accusation, "This is dumb," you can answer, "I know. But this is what they taught me in Psych 101 so we have to do it." Client and therapist thus can share a humorous way of "saving face." Teens are also prone to making personal statements such as, "Your breath smells" or "You're all sweaty. Get away." You will need to develop considerable self-confidence to protect yourself from such remarks. The adolescent's protest often seems to be a necessary precondition—first of his acceptance and then of his enjoyment. It is as though the adolescent needs to go on record as having denounced such childish carryings-on before he can settle down to participate in them.

Taking Sexual Development into Account

The adolescent's heightened sexual awareness precludes many of the Theraplay activities appropriate to younger children. No longer can you engage in such physically intimate activities as rubbing powder on backs, blowing on ears or on eyelids, or holding the young person on your lap while singing lullabies. These intimate interactions should be reserved for use by parents, if used at all. Yet there are still many fun, physical activities that are appropriate and that raise self-esteem and enhance growth. This chapter is full of ideas for activities that work well with adolescents.

Although you may sometimes need to take gender into account as you choose a therapist for a younger child with special issues, you must always give it special consideration when working with teens. If possible, most adolescents should have a therapist of their own sex. Occasionally there are cases where life experience may preclude a male treating a male or a female treating a female. A two-therapist team—a man and a woman—is ideal to make everyone comfortable. With two adults it is possible to manage activities that involve swinging, or lifting a large adolescent. Having parents in sessions also adds to the sense of safety for all.

Having two therapists, including parents in sessions, or working in groups reduces the possibility that the playful, physically intimate

Theraplay activities might be sexually stimulating or arouse sexual fantasies in the adolescent client. These alternatives also protect you from the possibility that outsiders, aware of the physical nature of Theraplay, might assume that the interaction was sexually provocative or inappropriate. It will also avoid the possibility that the young person herself, during an angry or resistant phase, might accuse you of inappropriate intimacy. As a protection against these misperceptions, all sessions should be videotaped. Having parents and an interpreting therapist observe sessions or take part in them is an additional safeguard against the false accusation of inappropriate touch.

The following case is an example of working with a highly sexualized adolescent. Although it might seem counterintuitive to use Theraplay with such a client, the example shows that it can be very helpful.

THERAPLAY IN PRACTICE

Using Theraplay with a Sexualized Adolescent

Sasha began Theraplay treatment at age thirteen when he entered Fairhaven, a residential treatment center that included Theraplay along with other approaches in working with troubled adolescents. He had been removed from his birth mother's care at the age of eighteen months because of neglect. For the next four and a half years he lived in an Eastern European orphanage where he suffered severe physical and sexual abuse. He was adopted at age six by parents who are dedicated to helping him heal. At age twelve he entered a residential treatment facility for juvenile sex offenders. The reasons for referral at that time included sexual acting out, difficulty accepting directives from authority figures, and frequent temper tantrums accompanied by physical aggression. His parents reported that he always pushed them away when they approached him with comfort or nurture. In the juvenile sex offender facility, he seemed to interpret all touch as sexual and repeatedly asked staff members if they wanted to have sex with him. After a year, he was transferred to Fairhaven. The referring therapist stated that Sasha was not

developing empathy for his victims and seemed unable to make progress. It was the opinion of several consultants to the case that Sasha was in need of treatment to address attachment and trauma issues before he could make progress in his treatment for his own sexual abuse and his sexual offenses.

In order to protect Sasha and all the adolescents in the therapeutic community, a strict safety plan was put in place to monitor his behavior at all times. As is the case for all the young people in the program, he was assigned an individual counselor, Judy, who was with him in the cottage five days a week from two to ten o'clock. She was a crucial figure in his regular weekly Theraplay sessions and became his most important attachment figure while at Fairhaven. His parents visited approximately once a month and participated in his treatment sessions during their visits.

Active, playful Theraplay was used almost exclusively during the early treatment sessions. As Sasha became more comfortable addressing his feelings, Dyadic Developmental Psychotherapy (Hughes, 2007) was added to help him explore his history of trauma and loss. Whenever he got stuck or became anxious while talking, Theraplay activities were used to help him regulate and feel more secure.

The overriding goal of Sasha's treatment at Fairhaven was to give him a reparative experience of positive, safe interactions and connection with others that would replace his history of victimization and victimizing of others. Using Theraplay with a young person who had severe trauma and sex-offending issues required multiple adaptations. It was critical at the very beginning of treatment to let Sasha know that David, his therapist (carefully chosen for his ability to be both empathic and firm), as well as all residential staff, were aware of his history and of his expectation that most people want to have sex with him. David explained to him in a matter-of-fact manner that when staff have physical contact with him it would not be for the purpose of sex but rather it would be to help him feel safe and well cared for. The staff would be helping him to learn the difference between touch

that was sexual and touch by a trusted caregiver that was appropriate, safe, and nurturing.

David and Judy, who were co-therapists in all the sessions, did not want Theraplay to be another experience for Sasha to sexualize. In his early sessions, therefore, they used playful, engaging activities such as Cotton Ball Hockey and Beanbag Catch that did not require much physical intimacy. In order to normalize closeness and to help regulate Sasha's excitement level, David and Judy often sat close to him and gave him a pat on the back or tousled his hair to convey their pleasure in being with him. They paid special attention to Sasha's level of anxiety in order to help regulate him before he lost control. Noticing that his foot was beginning to rock up and down, Judy would gently place her hand on his foot to help him calm down. It was assumed that Sasha would be least likely to sexualize the experience if more intimate nurturing activities, such as being cuddled and fed, were saved for sessions when his parents were present.

It soon became clear from his response to many Theraplay activities that Sasha was starved for appropriate touch and nurturance but until he began Theraplay treatment he had not been able to accept it. He had pushed away all the efforts that his very caring adoptive parents had made. In residential treatment settings, he had been caught in a vicious cycle: his sexual allegations toward treatment providers led them to withdraw from him; he then sought comfort from sexual experiences, which, in turn, led to more restrictions on any kind of touch. In Theraplay sessions, David and Judy helped his parents push past his superficial response to their efforts to get close. As he began to be more trusting, Sasha was able to accept his mother's efforts to nurture and comfort him. One day, as she held him on her lap (this required a big sofa and lots of pillows to make it comfortable), his body began to relax and he let out a little sigh of relief and began to cry genuine, heartfelt tears. It was clear that he finally felt safe in his mother's arms and able to accept her loving care.

David asked Sasha to keep a journal about any sexual fantasies that he had in order to share them with him. This

allowed Sasha to be totally honest about what he was thinking and feeling without being rejected and becoming once again "untouchable."

When parents were in the sessions, David used activities that are typical in parent-child Theraplay: having his parents feed him a snack with eye-to-eye gaze, using eye signals to guide activities, having him punch a newspaper and then throw the crumpled balls into his parents' open arms, having him mirror his parents' movements, playing Cotton Ball Hockey, asking him to distinguish between a touch with a cotton ball and a feather, using a soft brush as they pretended to paint his face, passing lotion touches around the circle, and blowing and popping bubbles. The healing power of these activities for Sasha came from the fact that they gave him concrete, memorable moments of being nurtured and taken care of by adults, primarily his parents. Such experiences had been totally missing from his life before he was adopted. Even though his adoptive parents had been eager to provide him with these experiences, they needed help to get past his resistance to accepting them. The team was working toward their goal of giving him a new experience of positive relationship to incorporate into his life story.

As sessions began to include more talk and exploration of his history, Theraplay activities were used as a way to help him regulate and reconnect after a particularly difficult session. Often Sasha talked about issues related to his deviant sexual fantasies that brought up shame and self-loathing and that, in his mind, would surely lead to rejection by his therapist, parents, and caregivers. A few Theraplay activities, such as pretend face painting and making powder handprints, allowed Sasha to end a session positively with a feeling of being special, safe, and valued. Theraplay provided a tangible way of showing Sasha, "You are not your behaviors. You have value as a human being no matter how unacceptable some of your thoughts and behaviors might be." Such acceptance is critical for all children with a history of abuse and neglect, but it was even more important for Sasha due to the fact that he had sexually abused his younger sibling. It was as though he had a

dual layer of shame. In his mind, his offense confirmed his deep feelings of being worthless and deserving to be abandoned. He had become what he feared most—an abuser. David, Judy, and his parents all had to be able to demonstrate unconditional care, love, and acceptance.

Throughout Sasha's stay at Fairhaven, David regularly consulted with the juvenile sex offender therapist who had worked with him originally. At David's request, the JSO therapist did a complete evaluation before Sasha was discharged from Fairhaven. He expressed amazement at the change in Sasha, "He is a totally different kid from the one that I referred to you." By the end of his stay at Fairhaven, Sasha was taken off of all psychotropic medications. Sasha continues to work on an outpatient basis with his JSO therapist. He reports that Sasha is doing well and maintaining the tremendous change.

Two years after he left Fairhaven, when Sasha was sixteen, his mother said, "I have a deep and satisfying relationship with Sasha that many parents will never have. It's something I had dreamed of but almost lost hope for. Sometimes I almost forget all the difficulties and the trauma of the past."

ADAPTING THE THERAPLAY DIMENSIONS FOR ADOLESCENTS

As for clients of any age, the Theraplay dimensions of structure, engagement, nurture, and challenge are used to tailor treatment to the needs of each individual adolescent. In the case of adolescents, your first priority is clear structure that ensures safety. Challenge is a particularly good way to intrigue and engage adolescents. Playfulness is essential throughout.

Using Play

Adolescents love to play and therefore it is very important that all activities be done in a playful, self-confident manner. You need

to have a good sense of humor and communicate confidence and comfort. Playfulness should be communicated not only in your selection of activities but also in your voice, stance, and gestures. You can also joke about yourself and freely admit your faults and blunders. For instance, you could joke about what a terrible arm wrestler you are, how wimpy and weak or how you goofed when you missed the basket. Adolescents love this and it enhances the bond between the two of you.

In the following example from a Theraplay session with Alex, you can see how play helped bring him out of angry withdrawal to engage in some lively fun.

THERAPLAY IN PRACTICE

Using Play to Engage an Angry Adolescent

Alex, fourteen years old, was brought for treatment by his adoptive parents because of his angry acting-out behavior. He entered his third Theraplay session in a highly resistant mood. He slouched on the pillows and made little initial response to the playful approaches of Gary, his therapist. Feeling a need to rouse him from his passivity and to bring some lightness to the scene, Gary staged a marshmallow fight. Positioning Alex across the room from his parents, who were observing the action from behind the video equipment, Gary said, "I'll bet you can't throw a marshmallow over the TV and hit Dad on the shoulder." Alex's first efforts were minimal. He barely reached the TV set. "Here, Dad, here's your supply of marshmallows; see who ends up with the most marshmallows on his side." As Dad entered the fray, Alex brightened up and joined the game, accompanied by whoops of laughter from Alex and his Dad and cheers from his mother and Gary. Soon the room was adrift with marshmallows. As they settled down, Alex and his Dad fed marshmallows to each other. This silly, playful activity had roused Alex from his sullen lethargy and made it possible for him and his Dad to share a joyful moment together.

Structuring

If they are to move successfully toward running their own lives, all adolescents need clear expectations and firm rules. You must always be responsible for guiding and regulating the action. Faced with a strong, self-assured therapist, the adolescent can model his own growing sense of self on that strength and self-assurance.

An adolescent from a family where the rules are few and inconsistently enforced is in great need of structure. An adolescent who is overscheduled or who has too-rigid internal rules needs spontaneity, flexibility, and fun. The timid adolescent may need to be encouraged to take more initiative.

Structuring activities with adolescents include making life-size body tracings or hand and footprints, making aluminum-foil prints, or plaster impressions of body parts, such as nose, head, ear, elbow, or knee. Structure is also provided by activities in which the adult directs the action. The adult can specify where to aim the Tic Tacs in a spitting contest, the water pistol, or the basketball, and he can decide which foot to move first in Three-Legged Walk. In addition to the activities themselves, structure is provided by giving signals for when to start an activity, stating clearly what the young person is to do, and making sure that the activity is carried out safely and in an orderly, calm manner.

THERAPLAY IN PRACTICE

Learning to Follow the Rules

Erin, an impulsive, defiant, fifteen-year-old girl, had difficulty following the family rules and accepting her parents' appropriate demands for compliance and follow-through on household chores and responsibilities. In the sixth session of her ten-session course of Theraplay treatment, her therapist set up an activity that would give Erin practice in following her mother's directions. It also gave her mother practice in clearly defining what she expected Erin to do.

Erin's mother was to give eye signals to indicate which direction they both should move as they stand facing each other. If she winked her left eye, both she and Erin must move to her left. If she winked her right eye, they must go to her right. Erin said, "That's stupid; anyone can do that." "Wait,"

her therapist said, "there's one more thing you have to do. Here's a big pillow. I'll put it between the two of you. Let's see if you can keep it from falling while you both keep your hands behind your back. You'll have to lean toward each other and watch very carefully when the signal changes." Erin accepted the challenge, and carefully watched for her mother's eye signals. When the activity became more complicated—two blinks mean two steps, head back means move back, and so forth—they struggled, and finally, to the accompaniment of much laughter, the pillow dropped to the floor. In a spirit of challenge and fun, Erin had an experience of following her mother's clear signals. Because there were no words, there was no opportunity for their typical legalistic arguments and delaying tactics.

Challenging

As you can see from the example, the challenge of supporting a pillow between them while she followed her mother's signals made it possible for Erin to participate. Challenging activities are always a good way of engaging an adolescent and we therefore discuss them before turning to the dimension of engagement. In the process of pitting her strength or skill against you or against a standard, the teenager loses her self-consciousness and can enter wholeheartedly into an activity. Challenges should never result in a put-down or a failure, nor should they in any way add to the already overburdened, striving teenager. The passive teenager with low self-esteem benefits tremendously from being challenged to succeed in activities that are fun. The essential ingredient is a supportive atmosphere in which she learns to enjoy the feeling of successful teamwork.

Challenging activities for the adolescent will be more sophisticated, as we saw in the very challenging pyramid-building activity in the group example at the beginning of the chapter. It will be up to your ingenuity to create interesting activities that challenge the teen. Challenging activities for adolescents include: Tug-of-War, Arm and Leg Wrestling, jumping to see how high he can reach, Tic Tac (or watermelon seed) spitting contest, and Pillow Balancing: How many can you balance on your head? How many pillows can you stand on and balance?

THERAPLAY IN PRACTICE

Challenging the Resistant Adolescent

Ken, a fifteen-year-old, was referred because of defiant behavior toward his mother. As an introduction to his first session, Ken's therapist challenged him to a wrestling match.

THERAPIST: Hi, Ken! I'm Bill. Wow! Those look like big muscles you have there. (checking his arms) *[Ken's therapist does not ask for permission or announce what they are going to do. Instead, there is immediate physical contact and positive body-image reference.]*

KEN: (pulls away) *[This is an appropriate reaction of a teenage boy toward a stranger who behaves so presumptuously.]*

THERAPIST: Bet you can't push me over. *[This paradoxical move is designed to turn Ken's negativism into cooperation. It is an assertive self-statement, offering his own self-confidence for identification.]*

KEN: (goes through the motions only) *[Still master of his own destiny. Not an inappropriate stance once it becomes truly his own rather than based, as it now is, on the defiance born of anxiety.]*

THERAPIST: Ah, I know you can push harder than that. I'm really strong so you've got to use all your power. [*The challenge grows.]*

KEN: (begins to push in earnest) *[He can no longer resist the challenge. In addition, his therapist is beginning to look like a fun, appealing person.]*

THERAPIST: Oh, you're not kidding. You really are powerful! *[Therapist praises Ken for the person he is, for his assets. It is clear that his therapist, unlike his mother, has neither a stake in Ken's being cooperative nor a need to be loved by him.]*

BOTH: (tussle vigorously and alternate winning)

This vigorous, challenging tussle begins the process of helping Ken feel better about himself while helping to impress on him who this adult is and how involved his therapist has become with him; Ken sees that he is viewed as a fun-loving person.

Engaging

Given his resistance to treatment, engaging the adolescent is perhaps the most difficult and most important task for the therapist. More than when working with a younger child, any activity that places the therapist close to the adolescent can feel intrusive. For example, just sitting close to a teenager, or touching his hand, may make him uneasy. But the closer you are, the more difficult it is for the teenager to shut you out from awareness. Humor, surprise, and paradox are all useful in disarming, and thus engaging, the resistant adolescent. The goal is to find ways to overcome the adolescent's defensive attempts to keep you at bay by making him experience your presence intensely and by forging an alliance that will be the basis of a new way of relating and feeling about himself.

The withdrawn, isolated, or obsessive-compulsive adolescent particularly needs to be surprised and engaged. The same is true for the adolescent who has clammed up in order to resist therapy. Surprises make it difficult for the adolescent to maintain his intellectual distance. The adolescent who comes from an intrusive family, however, needs somewhat more distance. But this does not preclude surprises or other engaging activities.

Many activities that are usually classified in other dimensions can engage the adolescent. Activities that require touch and physical closeness serve the function of making the teenager aware of your presence and thus begins the process of engaging him. The structuring activities of body tracing, measuring, weighing, and making aluminum-foil body molds all require touch and physical closeness and therefore can be seen as serving to engage as well as structure. Give-and-take activities, such as hand-clapping games, three-legged races, and coordinated two-person juggling acts, also require awareness and serve to foster engagement. Because they require awareness of the other person, many nurturing activities, such as dressing up with hats and face painting, also include an element of engagement.

THERAPLAY IN PRACTICE

Engaging the Reluctant Adolescent

As an example of how to engage the reluctant adolescent through surprise, humor, and physical touch, we continue

with Ken's first session. Immediately following the challenging wrestling match, his therapist takes his hand:

THERAPIST: You have big hands. Here, let's put some paint on them and see how many different colors we can make your fingers. (carefully covers Ken's hand with brightly colored finger paint) *[Identifies and describes body parts in ways that are positive yet not related to performance. Playfulness and caring are expressed through this activity.]*

KEN: (studying the process interestedly) This is dumb. *[Although he continues to save face, he is clearly beginning to enjoy himself.]*

THERAPIST: Wow! That is beautiful. (takes the painted hand and "walks" it up the paper hanging on the wall) *[Expresses enchantment and excitement like a mother discovering a new characteristic of her baby. Takes charge of an activity that he is certain is fun as well as novel and surprising.]*

KEN: God, this is so silly! What you doing all this for anyway? *[Still saving face while enjoying it. Shifts again to the man-to-man talk that is obviously his more familiar style, allowing him to keep control.]*

THERAPIST: I know it's kinda silly, but the nice thing about being here is that we can be as silly as we want and no one needs to know.

KEN: (laughs, then looks at his therapist with good eye contact) *[Finally lets down his defensive vigilance. Allows himself to interact with his therapist for the first time.]*

Nurturing

Many nurturing activities may seem more appropriate for young children than for adolescents, yet there is no age limit to the need to feel nurtured and valued. Adolescents, though they may be self-conscious about receiving nurture, are often especially needy. Evidence that teenagers need nurture can be seen in their poor self-image, their inability to relax, their poor hygiene, and their development of stress-related illnesses. Terrence Koller (1994, p. 172) writes, "Although not all adolescents need nurture as a primary focus,

it is always appropriate for helping the adolescent relax after a more active and lively Theraplay session."

Although adolescents may find it difficult to allow you to lotion their hands or feed them cookies, they will often accept such caretaking combined with another activity or a challenge. Though he protested verbally, Ken made no move to pull his hand away as Bill rubbed paint on it, and he was intrigued when the painted handprints marched up the wall. Both the rubbing of paint on his hands and the washing up were opportunities for gentle touch and caregiving. Feeding can be made part of a challenge such as "doughnut challenge," in which the goal is to see how many bites can be taken before breaking the doughnut ring (poised on the therapist's or a parent's finger). In seed-spitting contests, each feeds the other a chunk of watermelon and saves the seeds. Then they see who can spit the seeds farthest. A less competitive version of this game is to have one person spit a seed and the other try to get as close to it as possible. Tic Tacs serve the same purpose as watermelon seeds and are available all year long.

Examples of nurturing activities include: taking care of hurts, cuts, and bruises by applying lotion or Band-Aids; combing hair; polishing nails; applying lotion to dry hands; fanning after an energetic activity; offering several appealing choices of food; making powder footprints; trying on flattering hats; and making crepe paper bow ties, hats, and necklaces.

THERAPLAY IN PRACTICE

Finding Ways to Make Nurture Acceptable

Edward, an aloof thirteen-year-old, was brought by his parents for therapy because he was struggling with peer relationships at school. He had always been a bit isolated and had never allowed his mother to get close to him. One of the goals for treatment was to encourage more emotional closeness to his mother, as a way of helping him become more open to his own feelings and to those of others. Because it was hard for Edward to be emotionally close to his mother, James, his therapist, added a bit of challenge to the pretzel-feeding activity he had planned. Edward sat directly in front of his

mother while James placed pretzels, one at a time, on his head. When his mother gave the signal to duck his head, Edward was to aim the pretzel right into his mother's hands. When she caught it, she looked into Edward's eyes and popped it into her son's mouth. Edward rose to the challenge of the activity, accepting the feeding with no objections and chewing the pretzels with loud crunches. Mom was delighted to find her son accepting such closeness.

One final example demonstrates the kind of nurturing activities that a young teen can accept. Edward and Mom sat cross-legged, knee to knee, while Mom held a can of soda pop with two straws in it. The rule: no one could drink unless the other one was looking. This strategy promoted eye contact and associated it with the pleasure of drinking a delicious beverage. This activity cultivated the emotional closeness and comfort that feeding a young child can provide, but in a setting that was acceptable for a young teen.

HANDLING ADOLESCENT RESISTANCE

Adolescent treatment does not follow the sequence of phases typical of the younger child as described in Chapter Five. Instead, it often bypasses the initial tentative acceptance phase and jumps right into the resistance phase. There is usually no opportunity for the relationship to evolve slowly from lukewarm acceptance through negative rejection to active participation. When experiencing their painful ambivalence about closeness, adolescents can become resistant very quickly. Thus, their "negative phase" starts early and has a strength and a conviction that is likely to catch you off guard.

As we said, adolescents' highly developed verbal skills make them masters of argument, reasoning, and discussion. If you allow yourself to get caught up in discussing the treatment rationale and in listening to the client's arguments against it, much ground can be lost. From then on, you may find treatment interrupted at any point while the client calls for a restatement of the contract or for an answer to the question, "How's this supposed to do me any good?" Only when treatment can proceed without this kind of shifting in and out of playfulness can it be smooth, enjoyable, and free. You can also avoid

getting caught up in the adolescent's resistant maneuvers by planning fast-paced sessions that draw her into intriguing activities in spite of herself.

Although it is important to prepare parents to handle difficult behavior during a young child's resistant phase, such planning is even more important with adolescents. Their greater capacities for dangerous behavior, plus their greater skill at manipulation, make preparation especially important. Because the negative stage can begin immediately, you must build this warning into the intake process.

You must consider whether the adolescent is so panicked or out of control that it would not be safe to embark on Theraplay treatment at all. If you cannot keep everyone safe, then you should not engage in activities that might escalate out of control. Being attuned to the client and to your own responses can help you to pace the session. In this way, you can avoid overstimulation and situations where aggression might occur. The case example of Tom later in this chapter describes how one therapist handled a teen's tendency to dysregulation by providing moments of quiet to reduce his tension.

All the techniques for handling resistance that we discussed in Chapter Five apply as well to working with adolescents. It is, however, even more important not to get into a head-on collision with a large teenager.

PREPARING FOR ENDING TREATMENT

The concluding phase for adolescents also requires special consideration. Just as with younger children, you point out the adolescent's strengths and gains, and let him know in advance how many more sessions there will be before your final party. The experience of ending, however, may be more difficult for a teen than it is for younger children, who are being turned over to the security of their families. Though adolescents also have families, their struggle to achieve independence makes the anticipation of losing the close relationship with their therapist a greater threat. This is particularly true if therapy takes place without the parents. It may throw them into a depression that can be worrisome to you and to the parents. It is important to prepare both the adolescent and her parents for a temporary return to previous behavior. "Adolescents who had academic problems prior to Theraplay may stop doing homework. Withdrawn,

depressed adolescents may retreat to their rooms. Defiant adolescents may temporarily pick fights" (Koller, 1994, p. 174). If parents are well prepared for this eventuality, they can carry on where the therapist left off. This regression does not last long, because the adolescent's new pleasure in relating to others in a healthier way will soon take over to help him feel confident about the future.

DEALING WITH COUNTERTRANSFERENCE ISSUES WHEN WORKING WITH ADOLESCENTS

In Chapter Five we discussed the countertransference challenges that Theraplay presents to the therapist, noting that you must be especially aware of your own motivations and must provide yourself with many necessary safeguards. Theraplay with adolescents can be even more challenging. With a young child it is relatively easy to set limits, to challenge and engage him, and to assume the role of nurturing caregiver. With an adolescent client, there is more temptation to identify with the client's situation and to hold back out of "respect" for his more grown-up feelings.

Recognizing the Influence of Your Own Adolescence

Based on your own adolescent experience, you may find yourself identifying strongly with your client's rebelliousness and pain. On the one hand, though your empathy can be helpful to the adolescent, your own rebellious feelings may lead you to collude with him against his parents and make it difficult for you to set limits and make challenging demands. On the other hand, if you yourself were a very controlled adolescent and a good, obedient student, you may not understand how much your client needs to be relieved of the too-heavy demands of his daily life.

If you are a person who has difficulty allowing others to get close to you, you may find it harder to engage the resistant adolescent. If you were not well nurtured, you may find it difficult to nurture an adolescent who, like you, prefers to distance himself from closeness. Without proper self-monitoring you may find yourself agreeing (as you would never do with a small child) that she is too old for this baby stuff.

As we suggested in Chapter Five, regular consultations with colleagues or supervisors can help you keep your focus on the needs of the client rather than acting out of your own needs.

Paying Careful Attention to Your Responses

Perhaps the most challenging aspect of working with adolescents is dealing with their angry, aggressive behavior. Handling the anger of a small child is one thing; handling the anger of a large teenager is quite another. You must be aware of any tendency of your own to respond with anger or aggression.

Using Teamwork as a Safeguard

If, in spite of all your precautions, a session gets out of hand, you should discuss it with your co-therapist or a colleague after the session, and plan a strategy in which opportunities for angry acting out on either side cannot present themselves again. Some very good teams combine one active, physically strong leader with a supporting partner who is "maternal," soft spoken, and helpful. Optimum teamwork requires agreement on who will play which role, as well as what to do if a planned activity fails to work. An angry, belligerent client can only be treated effectively with Theraplay if his two therapists share a level of comfort that allows them to give each other open feedback. This provides a system of checks and balances that ensures that the therapists' responses will be therapeutic.

INCLUDING PARENTS IN THERAPLAY SESSIONS WITH ADOLESCENTS

Just as we recommend that parents be included, if at all possible, in treatment for young children, we also recommend including parents in the sessions for most adolescents. Following the usual intake interview, a diagnostic session using the adolescent form of the Marschak Interaction Method (MIM) can help determine the parents' strengths and the adolescent's needs; it will also lead to a decision about the appropriate level of parent involvement. Appendix A contains a list of recommended MIM tasks for adolescents.

Many adolescent behavior difficulties stem from both early and current problems with their parents. Often, by the time a family comes

for treatment, the battle lines are drawn. Parents are angry and stuck in an ineffectual pattern of nagging, complaining, and punishing. The adolescent expects only negative things to come from his parents and therefore shuts them out and distances himself. Many parents have given up trying to establish rules and set limits. Theraplay gives them a chance to practice being clear about what they want their teenager to do and following through on seeing that they do it. With the increase in successful structure must come an increase in empathy, nurture, and support for their teen. Theraplay provides parents with a model for positive appreciation, attuned responsiveness, and loving care.

Helping Parents Understand Their Adolescent

Often parents do not understand the complex mixture of feelings that generate the adolescent's confusing behavior; younger needs vie with strivings for independence. Parents need help to understand and respond appropriately to both impulses. The role of the interpreting therapist can be crucial here. He can give parents information about what they can expect during the adolescent years. He can encourage them to recall their own experiences when they were in their teens and thus give them insight into their child's feelings. Many parents also need guidance in setting appropriate rules and following through. The interpreting therapist can help with this. When parents begin to join the sessions, they can be guided to provide what adolescents need during these difficult years: the clear structure; the sensitive, attuned nurturing responses; and the playful, appreciative give-and-take.

Knowing When to Limit Parent Involvement

There are some circumstances in which parents should not be involved in sessions with their adolescent. Some adolescents become so self-conscious in front of their parents that they can't allow themselves to relax. In such a case, it is best to begin Theraplay without parental involvement. You may then be working alone with the adolescent and must be sure to videotape the sessions. You can explain at the start that parents will join the sessions later when it is time to work out some of the problems that occur between them. When the client is more comfortable, parents can be briefed about what is expected to happen in the session and can be given an

opportunity to role play their part in the interaction before joining the session.

As we discuss in Chapter Six, sometimes parents are unprepared to relate to their adolescent in an accepting and understanding manner. In that case, you should not include them in Theraplay sessions; they may need an extended period of preparation before they can join in. You or the interpreting therapist should meet with the parents alone to explore issues concerning how they relate to their adolescent, to educate them about his needs, and even to role play some of the activities with them. The goal would be to include parents in sessions with their adolescent as soon as both the parents and he are ready.

During the time when you are preparing the parents you can engage the teen in individual Theraplay. In addition, you may need to talk about and explore the feelings of loss of the "ideal" parent whom the adolescent may be grieving. It is also an opportunity to discuss whether there are other adults in his life who can meet the needs that his parents cannot meet. Though talk therapy can provide this opportunity, Theraplay can also be useful in this situation. Carefully selected, gently nurturing activities can create for the adolescent the missed experiences of childhood; this will help to support the grieving process.

Some adolescents, particularly older ones, need individual Theraplay sessions that do not include their parents. They may be at a stage when they need to focus more on developing their autonomy and on moving toward greater independence. In such cases, it may be inappropriate to include parents in treatment. Sessions should still aim to meet the younger needs of the client but a strong emphasis should be placed on supporting feelings of competence and autonomy.

When the teen is in residential or day treatment, parents may rarely or never be available for Theraplay sessions. In that case, if the therapist is on site, treatment should focus on establishing a relationship between the adolescent and a person from the residential community who interacts regularly with him and can take on the role of his special attachment figure. This was the case with Sasha. In most residential treatment centers, however, the only consistently available person will in fact be the therapist who then must assume this role.

When parents come for occasional visits, they should be included in sessions, as we saw with Sasha, along with the therapist and the staff member with whom the young person has formed a strong

relationship. The parents can then be helped to learn the new approach as preparation for the teen's return home. They should be gradually incorporated into an increasing number of activities, while the staff member gradually decreases his activity. This must be done carefully, so that the adolescent does not experience the staff member's withdrawal as abandonment.

The following case describes a lengthy course of Theraplay treatment with a fourteen-year-old boy and his adoptive parents. The boy was living in a residential treatment center but receiving outpatient Theraplay treatment. His parents were actively involved in treatment throughout and contributed a great deal to the good outcome of the work.

THERAPLAY IN PRACTICE

Using Theraplay to Prepare an Adolescent to Return Home from Residential Placement

Tom was fourteen when he began Theraplay treatment. He was removed from the care of his birth mother when he was two years old because her boyfriend was physically abusive to him. Over the next four years, Tom lived in seven different foster homes before being placed with his adoptive family. The adoption was finalized when he was seven years old.

Since his adoption, Tom had displayed significant emotional and behavioral difficulties. He had received psychological services at home, had been hospitalized on two occasions, and had been placed in a residential treatment center (RTC). He was moved to a second RTC due to physical aggression and lack of progress. Because there were no RTCs in his state that specialized in treating attachment and trauma difficulties, Tom's attachment-focused psychotherapy was conducted on an outpatient basis, beginning just as he made the transition to the second RTC. Tom's adoptive parents had been consistent in maintaining contact with Tom throughout his first residential placement and were willing to participate in the outpatient treatment. The goal was to prepare Tom to return home to his adoptive family.

At the time of the initial comprehensive psychological evaluation, separate clinical interviews were conducted with Tom and with his parents. Tom completed projective drawings and the Children's Apperception Test. The family interaction was observed using the Marschak Interaction Method. Tom's parents completed the Behavior Assessment System for Children, Second Edition (BASC-2) (Reynolds and Kamphaus, 2004) and the Randolph Attachment Disorder Questionnaire (RADQ) (Randolph, 1999). Tom's initial diagnoses were Reactive Attachment Disorder; Bipolar Disorder, Not Otherwise Specified; and Attention Deficit/Hyperactivity Disorder, Combined Type. The evaluation revealed that Tom had a very negative self-image, difficulty trusting adults, including his parents, and a sense that the world around him was a threatening place over which he had little control. All of these issues were thought to be related to his early trauma and attachment disruptions. Theraplay was chosen as the initial therapeutic modality. The trauma work would begin gradually as he gained enough trust and security with his therapist and his parents to face these difficult issues.

Tom was transported to weekly outpatient sessions, either by RTC staff or by his parents. The Theraplay therapist, Mary, began most of the Theraplay sessions with Tom alone, while his parents met with the interpreting therapist, Jane, who provided education, support, and information about parenting strategies. Jane helped his parents understand and practice some of the Theraplay activities used by Mary so that they could respond appropriately to Tom during the sessions as well as during home visits from the RTC. In most of the sessions, the parents and the interpreting therapist joined Tom and his therapist for part of the hour. The plan was that Tom and his parents would do the activities together at home in order to increase attachment. To allow this to occur more often, the therapists arranged for Tom to have more frequent home visits.

The treatment goals were both to help Tom form a more secure attachment relationship with his parents and to change

his view of himself and the world to a more positive one. The steps toward these goals would include helping him to accept nurture, to accept external structure, and to be more open to positive engagement. These goals would provide the foundation for Tom to make better choices; deal with negative emotions more effectively; learn to identify and express his feelings more appropriately, as well as to understand the feelings of others; and increase his accountability for his actions. The Theraplay plan included an initial focus on structure, utilizing challenge to increase his engagement. Nurturing activities would be introduced gradually with his parents to help with regulation. Tom had missed nurturing experiences early in his life which left him with feelings of shame about himself and a lack of trust in others. He needed to learn how to allow adults, particularly his parents, to take care of him and set appropriate limits for him. Playfulness was woven throughout the sessions.

Although it might be desirable to have a male-female team, Mary and Jane were the only attachment therapists available to take on the work. Tom was six inches taller than Mary, his Theraplay therapist, and outweighed her by approximately fifty pounds. Given the size differential, Tom's significantly poor self-regulation, and his history of physical aggression, the therapists decided that for the initial sessions, Theraplay activities needed to be carefully structured and relatively calm. Structured entrances and exits were planned and a beanbag chair was provided for Tom to sit in.

Mary also hoped to have Tom remove his shoes in order to decrease the chances of someone getting hurt. This was also viewed as a way to convey a message of comfort and relaxation. This was an issue that took several sessions to resolve. At first Tom was adamant that he was not going to allow his shoes to be taken off, saying that his feet were ugly and stinky. Even after Mary reassured him that it was entirely up to him to decide whether to take his shoes off, several times he held on to his shoes, as if he were afraid Mary would trick him while he was engaged in other activities. Trust was obviously an issue.

Initially, Tom was very wary and refused to engage in many activities. At times he was like an oppositional two-year-old who automatically says "No" to everything new. Sometimes Mary was able to move past his resistance with good humor and playfulness. Just showing Tom the bottle of bubbles and blowing a few his way was often enough to cause him to become more responsive. At other times his refusal had a very different quality. He would become verbally agitated and his body would become tense. If Mary didn't intervene immediately, this quickly turned into a flailing of his arms and legs that could escalate into physical aggression. In order to keep everyone safe, such episodes had to be avoided. Aside from the safety issue, it was not good for Tom to experience such dysregulation. By being sensitively attuned to his level of distress, Mary was able to prevent most episodes of this nature. She used a technique that allowed Tom to feel that he had some acceptable control of the situation and gave him time to settle down. She calmly gave him a choice, "We can either do the activity or we can wait quietly for the amount of time [she kept it short] the activity would take and then go on to the next game." She accepted either choice. In many cases, the lure of wanting to continue engaging with Mary in playful activities moved Tom beyond his resistance.

The major benefit of this approach was that it provided an opportunity for Tom to learn how to regulate himself. In the beginning it was Mary who identified his need for a moment of calming and who provided the quiet presence that helped avoid an eruption. Later after Mary and Tom had practiced some coping skills that he could use when he was upset, she encouraged him to use them—deep breathing or other self-calming techniques—during moments of distress when he was on his own at home and at the RTC.

When treatment began to include discussion of difficult issues—problems that had occurred at the RTC or during home visits, for example, or when it shifted to processing earlier experiences of trauma—Tom often needed moments of quiet when he could settle down and regulate his emotions.

By that point in treatment his parents had become a safe haven and he benefited from having them in the session with him.

Session One

Tom and his Theraplay therapist came into the session doing a three-legged walk: their two knees were tied together with crepe paper and they had to coordinate their steps in order to make it to the beanbag chair without breaking the tie. Tom chose not to take off his shoes during this session. Mary moved ahead with activities designed to get to know him better. Because of his very poor self-image, Tom found it difficult to allow himself to be focused on in this intent, positive manner. No matter what Mary found—freckles, healthy skin, or hurts—Tom was always reluctant and sometimes refused outright. As he became a bit more comfortable, his initial "No" to certain activities would turn into a reluctant acceptance. Searching for something that would capture his interest, Mary correctly guessed which was his strongest muscle—his right upper arm—and drew a picture on it with washable markers. Since it was close to Easter, her picture was an Easter egg. Tom immediately told her that he only liked pictures that included dragons or flames. So she added some flames as a decoration on the egg.

Mary initiated some balloon tossing activities, having them both remain seated in order to keep things calm. Tom rose to the challenge of counting how long they could keep the balloon in the air without letting it drop to the floor, as well as the challenge of increasingly higher numbers of claps between balloon taps. Next they did hand stacking games together. And finally, they played basketball using cotton balls. Mary would signal with winks and blinks for Tom to toss the cotton balls into her basket. When Tom's parents entered the room halfway through the session, he let them find three cotton balls hidden in his clothes: in a pocket, under the cuff of his jeans, and in the fold of his shirt sleeve. He willingly engaged in a repetition of some of the same activities with his parents that he had done with Mary. Surprisingly, for a boy this reluctant

to accept nurture, Tom allowed his parents to feed him snacks as part of a knock-knock game: when they touched his nose, he would open his "door" (mouth) and they would pop the snack in.

Session Two

As soon as Tom entered the room he said, "I'm not going to take my shoes off." Mary calmly said, "We won't take off your shoes unless you decide to. It's your choice." Because removing shoes was an important safety issue, Mary kept the decision open, "You don't need to decide now." He then engaged willingly with Mary in fast and slow scissors steps to reach the beanbag. During Checkup, he showed Mary a bruise and a scrape on his skin and allowed her to put lotion on or around them. Because he had shown interest in body drawings during his first session, Mary drew a lizard, something closer to his interest than the Easter egg, but not moving toward more violent subjects. Tom spontaneously announced that he wanted the therapist to teach his mother more games this week, so she could play them with him at home. After the next several activities went well, the therapist said, "Now is the time for you to choose whether you want to take off your shoes for the next game with bubbles." Without a word, Tom pulled off his shoes. He was self-conscious about his feet, however, and made many comments about how smelly they were. In order to make him feel more comfortable, Mary took her own shoes off as well. When his parents entered the session, Tom mentioned his smelly feet to his mother, and asked if she would spray his shoes, so his feet would smell better. This was a surprise coming from a teen with very poor hygiene.

Games during this session included Tom standing on his traced footprints while popping bubbles blown in his direction, catching a beanbag dropped from Mary's head, as well as breaking out of toilet paper wrapped around his wrists or ankles. All of the activities had prearranged signals, mostly eye blinks, but sometimes a verbal prompt of "One, two, three, go." Tom comfortably went through these activities a second

time with his parents when they joined the session. Tom's parents fed him snacks using reciprocal blinking signals. To end the session, they had a competition to see whether the co-therapist team could put Tom's shoes back on before Tom and his parents counted backwards from twenty-five to zero. The family won, and Tom was very excited about this.

Session Three

Tom and Mary entered the session holding hands and walked to the beanbag chair, using alternating tin man and scarecrow steps. He proudly announced that he and his parents had been able to keep a balloon in the air for as long as 137 taps. Mary was genuinely delighted and shared his excitement.

During these early sessions, Mary would express her appreciation in a matter-of-fact manner when she noticed traits that were important to Tom's progress, such as helpfulness, kindness, responsibility, and self-control. When Tom lifted his pant leg or sleeve to make it easier for Mary to check for hurts, she would say, "That was very helpful. Thank you." When he remained standing on his footprints for balloon games, she'd say, "That showed good self-control." In the beginning, Tom often reacted as if he either didn't hear the comment or was uncomfortable hearing something positive about himself. In spite of his apparent dismissal of the comments, he began to develop more awareness of his strengths. Within a short period of time, Tom was welcoming positive comments about his attributes.

Session Four

Once again Tom was reluctant to take off his shoes. Mary responded in a playful manner, "I won't put my toes up to your nose, if you won't put your toes up to my nose!" His laughter at this silliness helped him relax. When Mary challenged him to see whether he could get his socks and shoes off faster than she could, he won the race. During this session Mary began adding more nurturing touches to the snack

activities. Tom and his parents were asked to exchange Eskimo kisses. He didn't balk at this, which was a pleasant surprise to his parents. In future sessions, other kisses were used during snack activity, including butterfly kisses, finger kisses, and noisy raspberry kisses.

Session Five

During Checkup, when asked if he wanted to take his shoes off at the beginning of the session or later, he said that they could come off immediately. This trend continued for several sessions, as Tom and Mary raced to see who could take off shoes more quickly. After several sessions of racing, Tom began entering sessions and immediately taking off his shoes and socks just as Mary did. After that, the shoes were no longer an issue.

Tom's attitude toward having his shoes off parallels his progression from a pattern of general refusal, extremely poor self-concept, and shame to one of cooperation, cheerful engagement, and a more positive sense of self. His response to having his hurts attended to followed the same upbeat path. His mother said, "In the past Tom would never let me look at or touch anything that involved a hurt on his body. I'm really surprised at how comfortable he is now letting me put lotion on his scrapes and bruises."

Because of Tom's difficulties with self-regulation, Mary had moved slowly in allowing him to stand up during activities. During the second session he had been able to do activities standing on his traced footprints. Later he was able to stand on a specified square on the quilt on the floor. By the fifth session, Tom was ready for more active and challenging games without spiraling out of control. He participated in a carefully structured Simon Says activity, in which he followed Mary's directions and was able to move around the room freely. As he was able to meet the challenge, other activities were added. They used paper towel tubes as well as a variety of handmade and commercial small racquets to play balloon baseball, to tap out rhythms, and to play toss and catch. Any of these bats and

racquets could have been used in a physically aggressive manner, but Tom never used them inappropriately in sessions.

Session Six

Tom's early experiences of neglect and abuse had left him very negative about being touched. As he became more relaxed and more trusting, he became more open to the reparative experiences he so desperately needed. Mary included more nurturing activities in sessions in order to have him experience the loving care that he had missed as a baby. Tom's parents fed him snacks and gave him juice from a sippy cup while they encouraged loving eye contact. Many activities provided opportunities for his therapist and his parents to use gentle, caring touch that he could accept. For example, his parents would touch him in three places and he had to return the touch to them in the same places and with the same gentleness. They put lotion on his hurts or on special freckles, and drew pictures with markers on his arms. Gradually, Tom was able to relax and to receive physical affection from his parents. Later, he began to reciprocate. Positive nurturing experiences also helped Tom to be less aggressive; he showed increased self-control, as he did not want people he cared about to be hurt. His parents were taught a special "Twinkle" song about Tom. As they sang it to him for the first time, he seemed genuinely touched and became teary-eyed. Tom accepted hugs from his parents after the song.

Sessions Seven to Fourteen

By session seven, Tom asked that the pictures be wiped off before he left the session, as he did not want to break RTC rules, which included residents not being allowed to have drawings or words written on their body.

Mary had not been aware of this rule and apparently he had been washing them off in the bathroom before returning to the RTC. Mary commented on how responsible he was being by making this prosocial choice. His mother lovingly used wipes in session from then on to remove the pictures before he left the session.

After every activity, Tom and Mary would do high fives with one another to celebrate their shared pleasure in his success. As a result, Tom's reciprocity continued to increase. Mary and her co-therapist also taught the family a special family high five, and Tom began to initiate it spontaneously, particularly if the family team had won a game or a race against the Theraplay team. Mary and her co-therapist developed "nice try" high fives to be given to the losing team. When Tom was able to give and receive affection in sessions, Mary moved toward more reciprocity with snack activities also. Instead of Tom being the only one to be fed, he and his parents began feeding each other.

As Tom was accepting nurture from his parents more freely in session and during home visits, the therapist taught the family how to do a "three signal." A three signal is a set of three gentle touches in the same place on someone you are feeling close to. It then can be returned to the initiating family member. We discussed that the three signals meant "I love you," and so they could use this signal in places where Tom or his parents might feel uncomfortable expressing love more openly. This became a favorite of Tom's and was utilized in a variety of ways to consolidate his attachment with his parents. Even after a year and a half of treatment, three signals were still being used. Parents reported and the therapists observed that Tom was much more responsive to them and receptive to physical nurturance. When his case manager came to observe a session, she was extremely surprised and pleased to see Tom giving his parents a "see you later" hug when he entered the session with Mary. This became a weekly ritual for Tom, and he began to include the hug along with the high five.

While nurture continued to be an important therapeutic dimension, engagement was added, using activities such as hand or body mirroring, reciprocal facial expressions, rhythmic returns, and a focus on teamwork. Structuring activities were also continued, such as cotton ball blowing races, tapping a balloon back and forth with a specified body part, and toss and catch activities with soft balls or beanbags. All of these were structured by a specific "Go" signal. Tom's

parents began to notice that there were fewer control battles and that he was starting to seek them out for assistance and comfort.

Sessions Fifteen to Twenty-Five

By session fifteen, Tom was ready to move a bit beyond the typical Theraplay format to begin identifying and expressing basic feelings. Mary asked him to draw four faces on separate cards, each reflecting a feeling: happy, sad, mad, and scared. Tom would pick one of the cards and then, without showing it to Mary, put that expression on his face. Mary had to guess what the feeling was. Tom could gain points for telling about times when he had that feeling. And he could earn a bonus point for answering a follow-up question from Mary, for example, "How did you handle the feeling?" After Tom became more comfortable sharing his feelings, they expanded the number of feelings to include worried, surprised, lonely, stressed, proud, excited, loving, calm, and silly. When the parents entered the sessions, they were included in this activity in order to expand Tom's comfort with sharing his feelings and their awareness of his feelings.

During Checkups, Mary began asking Tom for information about what had happened during the week. This would often turn up troublesome issues, such as problems that had occurred at home or at the RTC, problems that needed to be discussed. In order to facilitate trust and communication between family members, Mary asked Tom to share these issues with his parents when they entered the session.

Involving Parents

During parent sessions, the co-therapist helped the parents understand the anxiety and fears underlying many of Tom's dysregulated and negative behaviors. She explained Hughes's PACE model of parenting (2007): playful, accepting, curious, and empathic. Tom's parents, particularly his mother, began advocating for his needs more effectively on home visits and at the RTC. In sessions, all three family members often sat

together on the sofa, holding hands or with their arms around each other, especially during feelings games or discussions about issues. Tom's trust in his parents had increased to the point that their presence in sessions helped him maintain better regulation when difficult material was being discussed. Even when sessions included more and more time for discussion, Mary maintained the structure of a Theraplay session to help Tom feel safe and secure in the routine and to have some fun in sessions. The sessions thus always included some type of playful entrance activity, as well as a special activity to prepare for his parents to join in. Tom was able to make fairly quick and appropriate choices about what signal to give for his parents to enter. He was given other basic choices, such as whether he wanted to do a balloon game or use other materials when there was free time set aside for fun activities. Reciprocal snack activities were also continued on a weekly basis between Tom and his parents.

Integrating Theraplay with Other Modalities

Once Tom's attachment was more positive and secure, other therapeutic services were added. Biofeedback sessions to help Tom with regulation were started during session eighteen. They were provided by a therapist who joined the therapeutic outpatient team. During Theraplay session twenty-two, Mary began discussing and developing coping strategies to enhance the biofeedback. His parents were told about Tom's coping strategies and, as a result, family coping skills were formulated so that they could practice these skills together. The list included deep breathing and visualization techniques. By session twenty-five, Eye Movement Desensitization and Reprocessing (EMDR) was added to the sessions in the same manner.

Difficulties in the Residential Setting

Although he made good progress in his Theraplay sessions, Tom continued to have difficulties at the RTC. It became clear that many of Tom's problems in that setting had to do with his

lack of trust and his sense that he was not safe there. This was in contrast to how he was beginning to feel in sessions and on visits at home. Tom was learning to identify and express his feelings appropriately with Mary and his parents, but he had extreme difficulty doing so with peers or staff at the RTC. Even though Mary tried to maintain good contact with his treatment team at the RTC, it was very difficult to do so. The RTC staff was unable to change their programming enough to help Tom feel safe in that environment. As a result, Tom made slow progress at the RTC. Their main contribution was continuing to monitor his medications.

After a year of therapy, Tom had made good progress with his family in sessions. His behavior during home visits had become more appropriate and no longer included any safety risks for himself or others. The treatment team began, therefore, to discuss either a step-down to a less structured placement or a return home.

Return Home

Tom was discharged to return home after sixty-four Theraplay sessions, spanning a period of one and a half years. Shortly before his discharge from the RTC, Tom's parents filled out a follow-up RADQ describing Tom's current functioning. The change in the scores indicated that significant gains had been made in areas such as appropriate eye contact, reciprocal physical affection, decreased need for control and arguing, appropriate remorse, decreased stealing and lying, improved cause-and-effect thinking, fewer food issues, and improved friendships. Both parents' responses to the BASC-2 indicated a general lessening of symptoms. They agreed that significant progress had occurred in conduct problems and adaptability.

In spite of these significant improvements, Tom continues to have emotional and behavioral difficulties in a variety of areas. He and his parents will continue with Mary and her co-therapist in outpatient psychotherapy, the immediate goal being to help them deal with the difficult adjustment of Tom's

returning home after three and a half years in residential treatment centers. The treatment team will also be moving into more direct therapeutic content to address early unresolved trauma.

Clearly, Theraplay was a helpful therapeutic modality for Tom and his parents. Due to attachment disruptions and early trauma, his emotional age was much younger than his chronological age of fourteen. Theraplay made it possible to address Tom's needs at an appropriate emotional level. The reparative experience that Theraplay provided led to a more positive self-concept for Tom and made it possible for him to develop a more secure attachment with his parents. His experience of a trusting reciprocal relationship with his therapist and his parents provided a foundation for making progress in other areas.

COMBINING THERAPLAY WITH OTHER MODALITIES

As we saw in Tom's case, it can be very helpful with adolescents to integrate Theraplay with therapies that include discussion of emotional issues. These approaches are well supported by the adolescent's greater ability to process and explore his experience. In the following two examples, Theraplay is used to engage the clients and to modulate the tension that might develop with unrelieved discussion of difficult issues.

THERAPLAY IN PRACTICE

Making a Connection Through Sports

Roger, thirteen, was brought in by his amicably divorced parents because he showed little interest in schoolwork and seemed unhappy much of the time—except, that is, when he was playing sports. He spent time at both parents' homes. He loved playing football and was on the school team. Due to

poor academic progress, he was soon to be moved to a self-contained special education program at his middle school and was feeling sad and discouraged by this. In an initial family interview, he said little, gave only occasional eye contact, and his mood seemed depressed. His parents appeared to have empathy for his situation and expressed concern. Mom was busy with her career, but made sure to spend time with Roger in the evenings. Dad connected to him by playing sports with him and coaching one of his teams. His school counselor reported that Roger usually did his homework, but struggled academically and was often discouraged. Psychological testing found Roger to be in the low average range of abilities.

The therapist, Chuck, surprised Roger by playing catch with a Nerf football as soon as he entered his first session. Roger clearly had expected a lecture. While tossing the ball, Chuck started a conversation about Roger's play on the team, his strengths and preferences for positions, as well as relationships with the other players and coaches—all of which were very positive. Next, Chuck introduced a variation of catch called "football tag." Chuck was the quarterback and Roger was the receiver. After catching the pass, Roger had to run to a designated spot (in this case, a beanbag chair) and tag it—before Chuck tagged him. This allowed a little bit of age-appropriate physical contact and plenty of room for reality-based positive feedback about Roger's skills. After a while, they sat on some pillows and talked about the school situation and his feelings about moving to the self-contained classroom. Having established some closeness through the playful games, Roger volunteered more about his concerns at school and his feelings about the challenges of academics. Chuck was then able to discuss strategies for managing frustration and seeking help when needed. It was clear from Roger's earlier talk about sports that he was very successful in getting help from his coaches when he wanted to be more effective at football. These were skills that he could use in the classroom. In order to lighten the mood and to end on an upbeat note, Chuck ended the session with a marshmallow fight. In this activity, Chuck and Roger each had a pillow to use

as a shield. Each got to make five free throws (the other could throw back) before moving to a free-for-all ("If you can get a marshmallow, you can throw it!"). The only requirement was that the two stay on their knees—a strategy that kept things a little more controlled and helped increase the challenge, especially in the small space of Chuck's office. To add to the drama, Chuck made sounds in sync with the throws: "Ouch!" "Whew!" "You parted my hair on that one." "Good shot." Afterward, they collected the used marshmallows and the therapist popped two fresh ones into Roger's mouth.

With the help of Theraplay activities to make a connection, have fun, and build on his strengths, Roger was able to move on to the next school year with more self-acceptance and a positive attitude. Academics continued to prove a challenge, but some additional instructional support from the school made it possible for him to succeed sufficiently to stay in his sports activities and, with traditional cognitively based therapeutic strategies, to maintain his social network.

THERAPLAY IN PRACTICE

Using Theraplay Strategically

The following is a situation where Theraplay is used strategically as part of a variety of systems-wide interventions. Charles, sixteen, was brought in by his parents because they were concerned that although he used to be a pretty happy kid, in the past year or so, he had been depressed and lackadaisical about school. He had only one friend. He had never done particularly well in school and had a mild verbal learning disability. An older sister, with whom Charles had been close, left the year before for duty in the Iraq War. In the initial interview with his mother, Jean, and stepfather, Graham, Charles said very little and avoided eye contact much of the time. Communications with Graham were especially

constricted. Charles had maintained a grocery store job for the past six months and did quite well in that setting. The therapist, Jose, decided to offer a mixture of individual and family therapy, and to use bits of Theraplay, as needed, to engage Charles. The individual work was to boost Charles's self-esteem and increase his capacity to verbalize his concerns. The family work was needed to improve communications with his parents. The plan was to have two individual sessions before beginning family sessions.

In the first individual session, Jose, a psychologist by training, did a brief Theraplay Checkup, measuring Charles's biceps and his smile, and then moved to a more verbal, non-Theraplay approach. He administered a Thematic Apperception Test (TAT) and gave Charles immediate feedback. In the TAT, the client identifies characters, thoughts, feelings, and outcomes that he perceives in a series of pictures. This can be done in a few minutes and a trained person can determine the results quickly. It makes it possible to identify, directly and authoritatively, some fairly deeply held concerns. Because the TAT is a subjective technique, Jose presented the results as "likely to be true, but you will need to tell me which of these ideas seems correct to you." In this way, Charles could choose whether to endorse what the therapist said might be true. Jose suggested that the TAT found Charles to be feeling helpless about important things in his life, including school and his sister's being sent to Iraq. Charles strongly affirmed these ideas, "That is exactly what I've been feeling!" A few other aspects of Charles's dynamics were proposed and discussed. In order to end the session on an upbeat note, Jose returned to Theraplay. Noting that Charles wore skateboard shoes to the session, he had Charles do a Pillow Balance. In this activity, Charles stood on a large pillow that had handles, setting his stance as if he were on a skateboard. The rules: (1) When Charles looks Jose in the eye, Jose will pull the pillow around the room. He will do his best to help Charles stay balanced on the pillow; and (2) when Charles looks away, the pillow stops. Charles is in full control. Jose added, "If you are going to fall, try to fall on me so you don't hit the floor." As the activity

started, Charles could hardly stop laughing in a full and genuine way. Jose exclaimed, "Wow! That was easy for you! You're really good at this!"

During the second session, Jose helped Charles develop his agenda for the follow-up family meeting, which was to have his parents respect his ability to be more independent. At his therapist's suggestion, he proposed that his parents allow him to invite some buddies over for an evening of video games and outside sports.

At this meeting, the family learned and practiced verbal communication skills, using both Charles's and the parents' concerns for content. The therapist encouraged the parents to think about Charles's developmental needs. For example, they needed to continue to build skills for more independence by recognizing his present capabilities—he was able to maintain a job by being on time, working hard, and respecting bosses. They needed to support his need to expand other skills, such as making more friends and organizing schoolwork more successfully. Finally, the therapist helped the family to air and clarify their feelings about Charles's sister being in the Iraq War.

The cases in this chapter outline the special challenges that you face when using Theraplay with adolescents. Because making a connection is so important and because adolescents are so good at avoiding connection you need more sophisticated ways of working with these clients. You will need a broader repertoire of activities, a better sense of humor, and more imagination and spontaneity than you do with younger children. "Talking" therapy requires adolescents to relate to their therapists on an adult-to-adult basis: verbally, cognitively, and with reference to past and future. Theraplay, on the other hand, is directed to those not-yet-grown-up needs of a younger person that presumably have remained unfulfilled.

Because therapy with adolescents may combine Theraplay with other modalities, you need to have excellent diagnostic and therapeutic skills. In spite of the challenges, a Theraplay session with an adolescent can be extremely gratifying when it is well-thought-out and well-directed, yet spontaneous and fun-filled.

CHAPTER TWELVE

Group Theraplay

Phyllis B. Rubin

Group Theraplay is a logical extension of individual Theraplay. The idea of using Theraplay with large groups of children originated with schoolteachers who recognized the value of individual Theraplay and wanted all of their children to reap the benefits of such an experience. Group Theraplay was fully described and illustrated by Phyllis Rubin and Jeanine Tregay (1989) in their book, *Play with Them: Theraplay Groups in the Classroom,* but its application has grown significantly in the twenty years since the book's publication. Not only has it been used in a wider variety of settings with children, but it has also been used with parent groups and even with seniors suffering from depression.

By its very nature, Group Theraplay can offer more people our unique approach to relationship building. It is not, however, a substitute for individual treatment. Group Theraplay can be an adjunct to individual treatment or it can stand alone. It offers the experience of spirited, playful, and caring interaction with a group of peers, supported by the therapist who acts simultaneously as coach, leader, and participant.

As in individual Theraplay, Group Theraplay aims to enhance self-esteem and to increase trust in others through concrete, personal,

and positive experiences. It also strives to increase the sense of connection and belonging among group members. It addresses underlying needs that are often disavowed or defended against, rather than those that are manifest. Just as in individual Theraplay, the group will need various degrees or combinations of structuring, engaging, nurturing, and challenging activities.

After summarizing the Group Theraplay approach, we give details about how to organize and structure your group. Finally, we describe the diverse groups for whom Group Theraplay has been effective.

We begin with a sample Theraplay group session, so that you will have a picture of the process. The session took place in a kindergarten classroom of twenty children. The classroom teacher, Sam, leads the group. His assistant teacher and two parents join him.

GROUP THERAPLAY IN PRACTICE

A Sample Session of an Ongoing Group

Sam begins the group's fourth session by saying, "Okay, boys and girls, let's all make a line, put your hands on each other's waist and here we go! Choo-choo-choo-choo!" and the line of adults and children chug to the rug, forming a circle as they go. Sam tells them when to stop and when to sit, saying, "Get ready, get set, all sit down!" Then, to the tune of "Goodnight Ladies," they sing a welcoming song, naming each participant and giving a handshake as they go: "Hello, Mary. Hello, Paul. Hello, Natasha. We're glad you're here today!" Then each person, beginning with Sam, "checks" the next person in the circle to find a special spot or a hurt to rub lotion on.

As they go around the circle, Sam notices that Bobby looks sad today and says to him, "Bobby, maybe you have an 'inside hurt.' Tell Suzanne [the child next to him] if you want some lotion or a hug." Bobby says he wants a hug, and after getting one, is able to check and nurture the next person with sensitivity and care. After all the children and adults have attended to and nurtured each other, the fun begins. Sam brings out a cotton ball and says, "I'm going to try to blow this

to Mary's elbow! Everybody tell me when to blow." The whole group says, "One, two, three, go!" and Sam blows but gets Mary's shoulder instead of her elbow. Everyone laughs, including Sam. "My goodness, I missed your wonderful elbow but I got your shoulder instead! Now Mary, it's your turn to blow it somewhere on Paul," and the game goes on.

Then one person is chosen to go under a sheet and guess which member of the group is saying, "Hi, friend." Next, pairs of children try walking together while balancing a balloon between their stomachs, foreheads, or shoulders. Finally, Sam has everyone sit in a circle once again. One by one, he faces each child with a treat and says something special about each one. "Bobby, I hope your inside hurt feels a little better now. Suzanne, you and Ted did a really good job of balancing that balloon between your foreheads."

As Sam acknowledges the children one by one, he feeds them each a cracker, looking right at them with a smile on his face and a twinkle in his eyes. Then Sam gives a cracker to each child. The children pair up, and on the count of "One, two, three, go!" they simultaneously feed the treat to each other and quietly listen to themselves all crunching at once. Finally, all join hands to sing, "Goodbye, Paul. Goodbye, Mary. Goodbye, Bobby. We're glad you came to play," until all the children have had their names called out. Sam tells them to wrap hands around each others' backs, and at the signal, "Get ready, get set, go!" to give each other a gentle squeeze to remember until the next time they play together. The Theraplay group is over.

UNDERSTANDING THE GROUP THERAPLAY FRAMEWORK

Theraplay groups like the one just described are organized around four group rules and two group rituals that frame the sessions and communicate the Theraplay messages of structure, engagement, nurture, and challenge. Sam would have laid the rules out clearly at the beginning of the first session and, when necessary, reinforced them in each session.

Group Theraplay Rules

Group Theraplay is guided by a simple set of rules that evolved out of the four Theraplay dimensions:

- No hurts.
- Stick together.
- Have fun.
- The leader is in charge (usually unspoken).

As the Theraplay group leader, you should communicate these rules through both actions and words. In contrast to the emphasis in many other types of groups, in a Theraplay group it is primarily what you do, rather than what you say, that creates the therapeutic group atmosphere and contributes both to the healing and to the enhancement of relationships.

NO HURTS. This rule communicates the nurturing dimension of Theraplay. Your words, your affect, and your actions will converge to communicate that giving or receiving a hurt is unpleasant and undesirable. Regardless of whether a participant denies that he or she was hurt, that the hurt does not really hurt, or expresses pleasure in or a lack of awareness of getting hurt, you should respond in the same caring manner.

Take all hurts seriously and attend to them by rubbing lotion around them, blowing on them, or responding in any of the myriad ways that a caring parent reacts to a child's pain. The one exception is that we do not kiss the hurt; we respect the boundary that differentiates parents from other helpers, and we leave kissing to the parent. Encourage the children to tell you when they are hurt, to alert others if they think someone else is hurt, and to take seriously both "inside" hurt feelings and "outside" injuries. Group members will learn to express the No Hurts rule directly through actions (for example by putting lotion on other hurt children) and through words (either by expressing their feelings or by verbally asserting their rights). The child who caused the hurt can be encouraged to make restitution by taking care of the hurt child, using lotion, offering a Band-Aid, or giving a hug. This may be easy for the child who caused a hurt by accident. The child who caused the hurt in anger may need time to get over his anger before he is ready to make amends.

Some group leaders offer a nurturing activity to the person who purposefully hurt a peer, assuming that the one who did the hurting must have had a hurt in order to give one away. Especially in the case of an accidental hurt, the one who gave the hurt needs nurturing to heal the bad feeling that comes from having injured another. If we think about the message of community that Theraplay groups want to convey, there can never be too much nurturing when any physical or emotional pain is involved. Some groups may even stop for all participants to apply lotion to each other when a hurt happens, because witnessing a hurt is a sad experience for everyone. When we nurture everyone, we are enacting the interconnectedness envisioned in the poem by John Donne: "No man is an island entire of itself; every man is a piece of the continent, a part of the main."

STICK TOGETHER. This rule communicates the structuring and persistently interactive message of Theraplay. Strive in your groups to have all participants engaged together in activities with no one left out for any reason. To this end, you should help children attend to what is happening around the circle and respond to the activity at hand. This develops the children's ability to focus on a joint experience, and wait for each other's turn, delay gratification, and learn vicariously.

In practice, however, this proves difficult in large groups or in groups where the children are very young, needy, frightened, or have difficulty trusting others. Thus, you must be flexible in following this rule. You may sometimes choose to allow a hesitant child to watch peers playing together while you look closely for cues that he might be ready to join in. This will prevent him from depriving others of the group experience, sabotaging the group, or being cast in the role of the problem child.

This flexibility is especially important when you are working with individuals who have been physically or sexually abused. Not only has the child's trust in adults been violated, but power has been used in an abusive manner, thus creating the wrong kind of structure. Because these children were unable to protect themselves from the bad things that happened to them, they need to have some sense of control over present experiences. For abused children, the physical closeness and touch that characterize Group Theraplay can be highly charged experiences. While not avoiding matter-of-fact, health-promoting touch (James, 1989), allow abused children to "say no" or to have more space than the typical closeness we create among

group members. For example, one group leader acknowledged, "Sometimes people may need more space. If you do, you can tell your closest adult that you need some space, and then you can sit right over there until you are ready to join us again." Later in that session, instead of misbehaving in order to leave the group, one child asked a group leader for space, sat out briefly, and returned quickly to the group. This prevented him from acting out in order to get the distance he periodically needed.

HAVE FUN. This rule communicates the engagement, challenge, and playfulness of Theraplay. Fun engages group members, lifts the burden of excessive or prematurely imposed responsibility, and relieves the pressure for conditional achievement. Group members can let their goal-oriented, competitive drives "take a vacation." Leaders enjoy participants, and participants are able to enjoy each other, without having to do something to deserve their shared pleasure other than just being themselves. You may, for example, send children to hide all over the room, and hear them giggling in anticipation as you look inside desks, backpacks, or pencil cups ("Bet Eddy's in here! No! Now where is he?"). Then you can "find" each child with an ever-increasing group of "found" children helping you. You may cover a group of kneeling preschool children with a large sheet (or balance a large piece of cardboard on the heads of older standing children), label them a turtle in its shell, and have them try to move around the room together, keeping the shell on their backs or heads. You can see how long the group can keep a beach ball or balloon up in the air. Or you can pass a balloon around the circle without using hands and then try to do it again with eyes closed as the balloon is transferred from person to person. Today's children are growing up in a society that often encourages being goal directed and competitive. Even in early childhood, children are increasingly stressed and worried. To counteract this, the fun, exuberance, and pure delight experienced in these games are precious and should be cultivated at every opportunity.

THE ADULT IS IN CHARGE. Perhaps even more than in individual Theraplay, you must provide clear structure and strong guidance for the group sessions. This means that you and your coleaders plan the activities and decide such things as when to start and stop, where participants will sit, and how to handle whatever occurs. When

presenting the activities, you should not ask permission: "Do you want to play pass-a-squeeze?" or "How about playing blindfold-walk, okay?" Be positive and clear: "It's time to sing our good-bye song." When a group is well established, it is appropriate to involve children in decisions, as you might in an adolescent or adult group. This is especially the case during the termination phase, when you may ask about favorite games they would like to have repeated.

To coordinate the group's activity, give cues that tell the children when to respond, such as "Ready, get set, go!" You may say, "Bobby, I think you are standing too close to Louie and he needs more space. Stand right here next to me." Taking charge also means that if your group gets overstimulated by an activity, you stop the game, introduce a calming activity, and create a new way to play by adding structure to increase the group's sense of safety.

As with individual Theraplay, you can, of course, take cues for your activities from the behaviors or needs of the children. One group, for example, after checking who was present and absent that day, realized it was an absent child's birthday. The group leader said, "Let's send a great big Happy Birthday to Donna so that she can hear it all the way to her house. On the count of one, two, three, let's yell, 'Happy Birthday!' " The room resounded with three of the loudest "Happy Birthday" yells ever.

Group Theraplay Rituals

Early in the development of Group Theraplay, two rituals emerged as anchors marking the beginning and ending of each group session. They are "Checkups" and "Food Share," each of which will come to have a powerful meaning to your group members, and thus should always be included in your plans.

CHECKUPS. One of the first activities in every session should be a Checkup of each child. This allows her to have a "moment in the spotlight" to be recognized, admired, and cared for without having to ask for it. Included in Checkups is the nurturing of physical or emotional hurts with lotion, cotton balls, hugs; you can also blow kisses or good feelings to the hurt person.

Group leaders have often found that the children whom they would least expect to accept this type of nurturing are the most eager participants, pulling up their shirt sleeves and pant legs and inviting

the leader to put lotion on their arms and legs. Whatever vehicle you use is likely to become a symbol of caring in your group environment, and children will apply it in related situations. If Group Theraplay is provided for a classroom of children, for example, the teacher will find that she needs to keep a bottle of lotion (or container of cotton balls) available in the room so that she and the children can readily nurture distressed peers outside the designated group time.

FOOD SHARE. At the end of each group session, regardless of the degree of success of that session or the individual behaviors of group members, everyone shares a treat. Being fed by another person and being able to accept a treat from another is the most basic of nurturing and trusting experiences. Healthy emotional development for every human being depends on being nurtured and on developing trust. During food share, the group members receiving the treat have the experience of feeling vulnerable and putting their trust in the other to take care of them. The capacity to give away a treat shows that the "giver" trusts that sufficient nurturing is readily available from sources that are either external (nurturing adults) or internal (self-comforting, self-regulating, and self-nourishing behaviors). During the initial stages of the group, the leaders do the feeding. As the group becomes more comfortable with closeness and as trust increases, the children can feed each other.

ORGANIZING YOUR GROUP

In setting up your group, you need to make a number of decisions. These include determining how big your group will be, what combinations of children will be included, who your coleaders will be, how long your sessions will last, and how frequently you will meet.

Designing the Group

Group Theraplay is appropriate to many different settings and age groups. Although Rubin and Tregay describe Group Theraplay for entire classes of children, there are times when you will need to construct smaller groups. One Theraplay therapist, for example, formed a small group chosen from both special education and regular education classrooms in her school. Teachers of small class groups can provide sessions for their own children, and periodically combine classes with another teacher for a larger, communal Theraplay experience. Groups can be constructed based on age, on issues and behaviors

displayed by participants, or on a desired balance among interactional styles. You might, for example, include both overactive and passive-withdrawn individuals in one group to create opportunities for "stretching" the relational styles of all participants.

Large groups of troubled children demand thoughtful organizing as well as high levels of coleader cooperation and communication. It may often be necessary to divide such a class into smaller groups. One option is to have two or three totally separate groups operating in the same room, each with its own leader and doing the same activities as simultaneously as possible.

An alternative is to divide the class into smaller groups that meet separately in a location outside the classroom. This would reduce the amount of distracting and potentially disorganizing stimuli during the session but would raise problems about how to arrange for group leaders. The teacher would need to leave the classroom twice to lead, or participate in, each group. Given that the children in the individual groups improve in self-esteem and social interaction, the groups might be able to merge at some point.

Another option is to form small groups around coleaders within a large group. This has been highly successful in preschool classrooms by using three to five coleaders with fifteen to twenty children. The groups convened as a whole, but Checkups, putting lotion on one another, and sharing treats were done in informal "break-out" groups, in which three or four children clustered around their leader. Each adult had a bag that contained lotion, treats, a small mirror, or a prop for the day's planned activity. The result was a noisy nurturing scene that was nonetheless effective. The greeting activity, at least one midsession activity, and the ending song were done with the whole group together.

The more distressed, agitated, and emotionally needy the children, the smaller the group should be. Highly defended and chronically traumatized children require as much containment as possible. For them, a large group with children in close proximity can be a threatening experience and can exacerbate rather than calm their fears.

Coleading

We recommend having a coleader, particularly if you are working with young or significantly troubled children. Having another set of eyes, ears, and hands is indispensable when you have children sitting close together on the floor without the benefit of structuring chairs

and desks. Rubin and Tregay (1989) give more detail about how to plan for and manage coleading a group.

Because good teamwork between group leaders is essential, you will either want to work with coleaders who are playful, accepting, and supportive of helping the children participate, or you will need to help them develop these capacities. Practicing Group Theraplay activities with them will give you a sense of how well your coleader can contribute to the "Theraplay atmosphere." If your coleader is not trained in mental-health issues, you will want to attend to any incompatibility or lack of coordination between group leaders, or any distancing, withdrawal, or acting out by a leader. The presence of any of these problems will increase the children's feelings of insecurity and tension, leading to anxious behavior within the group. You certainly will want to preserve time to plan, prepare, and troubleshoot before sessions, and to process afterward.

Length of Sessions

Sessions generally average thirty to forty-five minutes, but extra time is needed for assembling and dispersing your group. The length of sessions will depend in part on the group. You may need to shorten the sessions if the children are young, have short attention spans, or have more serious psychological difficulties. Similarly, when a group is particularly anxious or having difficulty settling down, a shorter session is likely to be more effective.

Frequency of Sessions

Groups can be custom scheduled and designed for different settings and needs, but to be fully effective, they should meet at least once a week. Some leaders schedule their groups two or three times a week. Obviously, the more frequently you meet, the sooner the group will develop cohesion. If you are a teacher, you may have more flexibility than a visiting group leader to decide when to initiate additional sessions as needed. One teacher routinely gathered her class around any distressed child and used this "crisis," with the child sitting in her lap, as an opportunity for a caring Group Theraplay experience.

In addition to such situation-oriented group sessions, a classroom teacher can incorporate Theraplay principles and activities into her everyday schedule. Just beginning the school day with a Checkup can have very positive results.

PLANNING GROUP SESSIONS

A well-planned session calls for different types of activities at the beginning, middle, and end. Where you are in the overall course of treatment also dictates the nature of the activities you choose within each session. In the middle phase of treatment, for example, the relational issues your group is dealing with dictate some of the activities you choose.

Planning the Sequence Within a Session

The Checkup and Food-Sharing rituals will anchor the beginning and ending of your session. Begin with one or two activities that welcome the children and acknowledge each child as an individual. The ending allows each child to be given something (food, a hug) and to be nurtured. After food share comes the ending song that binds the group together in a joyful communal experience.

Nurturing should never be withheld or made contingent on how well the group performed. Such a behavioral perspective is the antithesis of our attachment perspective. In attachment terms, the group is most likely to need nurturing when it is feeling most vulnerable (for example, when things have not gone so well during the session). You should view any "failure" as an opportunity for a caring experience rather than for criticism or unpleasant consequences.

For the middle of each session, choose activities that are lively and engaging and that reflect the stage or the issues of your group. We discuss this part of planning in more detail when we describe the middle stage of the overall treatment cycle.

Planning for the Phases During the Course of Treatment

We think of the group process as falling into three phases: a short beginning and get-acquainted phase; a middle phase (the length of which depends on how long your group will be continuing), during which the group can work on special relational issues that need to be dealt with; and a termination phase, during which the group prepares for the ending of sessions.

BEGINNING PHASE. During the beginning phase, which can last from three to five sessions, you should focus on activities that help children

get to know each other. You should introduce the group members to the rules, rituals, and atmosphere of the Theraplay group. It is during this stage that they learn how you expect them to "be with" each other and how you will "be with" them. You demonstrate your approach when, for example, you remain unruffled if the group does not play a game as you or they expected, or when you participate in activities with enthusiasm without worrying whether the group will "get it right." They learn the nonverbal meaning of the "No Hurts" rule when you stop an activity and lotion a hurt child, of "Stick Together" when you take the hand of a child who is "doing his own thing" and bring him back into the group, and of "Have Fun" when you initiate activities that are playful and cooperative rather than competitive.

In addition to learning these norms, group members will also be getting to know one another and increasing their comfort with eye contact, touch, and physical closeness. For the beginning phase, simple, well-structured, nonthreatening activities are best. In fact, for your first one or two sessions, you might want simply to sing a hello song, do Checkups, share food, and sing a good-bye song (without a middle activity). This strategy is particularly advisable if you are yourself learning how to lead a Theraplay group and this is your first group.

MIDDLE PHASE. Once children have become familiar with the group rules and are more comfortable with each other, you can choose activities that require more trust, self-control, and group cooperation than is possible during the beginning phase. Such activities might include Progressive Pass Around, Cotton Ball Touch, and Blanket Pass.[1]

During this phase, in contrast to the nurturing quality of the beginning and ending rituals, you can add other Theraplay dimensions to the mix. Exciting games (moving together in pairs while balancing a balloon between tummies or foreheads with no hands) and challenging games (one or two people leave the group while the group forms a tangle; they then try to untangle the group without breaking the handholds) serve to create a rhythm from low to high arousal and back again. Group members will learn not only that they can be excited together, but also that they can settle down together.

Focusing on Relational Issues. During the middle phase you can also choose activities that address an issue that the group or an individual

member is dealing with, such as increasing comfort with eye contact and touch or taking turns. Showing nurturing care of others and having fun together are two issues that should form the basis of activities throughout all sessions. You can also decide to use a session or an activity to meet the needs of one child if, for example, he has just suffered an illness, family disruption, loss, or trauma.

The following are some activities that relate to specific relational themes:

- **Eye contact** can be promoted through activities such as Cotton Ball Touch, magical Face Painting, and Beanbag Catch.
- **Touch and closeness** are fostered by games such as Pass-a-Squeeze, Magnets, and Weather Report.
- **Trust** can be developed by having children guide a blindfolded peer around the room.
- **Turn taking** can be developed gradually. At first you may want to do activities simultaneously ("everybody hold hands and jump together" or "be small or tall with your partners"). Slowly, you can add activities that require varying degrees of turn taking. You might divide the group into two teams, each imitating the other's claps, jumps, laughs, and so on, so that each child does not have to wait long to respond. You can gradually build up to activities that go around the circle, one by one.
- **Cooperation** is promoted through games like Blanket Ball (everyone holds on to the edge of the blanket and cooperates to make the ball roll to someone across the circle), Stack of Hands, giant Row, Row, Row Your Boat, Cooperative Musical Chairs (Orlick, 1978), and Partner Pull-Ups.
- **Respecting and appreciating individual differences** can be heightened by finding shapes or letters in hands, and by discovering whose noses or hands are warm and whose are cold.
- **Managing excitement** can be encouraged by using less structure, more movement, and more props. Games such as Motor Boat and Balloon Balance allow children to experience higher levels of excitement or arousal, which must then be followed by a return to calm activities such as Pass Around where everyone sits down in a circle and passes a gentle touch (handshake, pat on the back, tap on the nose, hug) around.

- **Facing challenge** is supported by games with a hint of competition or mock aggression, such as Cotton Ball Fight, Follow the Leader, Blindfold-friend-guess (the blindfolded child must guess who is sitting in front of him by gently touching her face and hair or listening to her voice). Games with an academic bent also offer challenges as group members write a letter, number, shape, word, or short message on another child's back.

Deciding Whether to Use Adult-Child, Partner, or Whole-Group Activities. You need to decide whether, during any given game or session, the children will be interacting with the group leader, a partner, or the group as a whole. With children under age five, with new groups, or with children who are developmentally delayed, it is often best to have the children interact primarily with a group leader until they become familiar and comfortable with the type of directness and intimacy that Theraplay interactions can entail. Gradually, you should support and encourage members to interact with one another. Whole-group activities avoid making individual children feel put "on the spot" and are often useful with older, more self-conscious children. Whole-group activities, however, tend to be more stimulating and can more easily get out of control.

TERMINATION PHASE. During the termination phase, you will need to gear your activities toward helping participants prepare for and accept the ending of the group. Just as in individual Theraplay, you should announce in advance that the group will be ending in a certain number of sessions and remind them each time of the remaining number of sessions. During this stage, some groups repeat their favorite games as a way of saying good-bye. You may want to plan time to create tangible memoirs for your group for each member to keep. These might include a group picture, special lists that describe the positive characteristics of each member, and a gift bag for each person containing a small bottle of lotion, cotton balls, stickers, or other meaningful symbols of their Group Theraplay experience.

INFORMING AND INCLUDING PARENTS

Because Group Theraplay is often a new experience for those involved, parents need information about it ahead of time. Not only do they need to be informed about what the Theraplay group will be like, but

they should be encouraged to visit or participate in your group and to incorporate Theraplay-like activities into their interactions with their children at home. In these ways, parents can play an important role in integrating the atmosphere of your group into the family.

Orienting Parents to the Theraplay Approach

Offer parents an orientation meeting before you have your first group session. At that time, you can tell them about the four group rules, describe Group Theraplay, and explain your goals. Parents need to understand what their children are talking about when they describe something that happened in the group. It is helpful to show a videotape of a group similar to yours. Take time for a live demonstration of Group Theraplay and invite the parents to participate. Hand Squeeze, Feather Guess, Cotton Ball Blow, Weather Report, and the usual treats and songs are nonthreatening activities that parents enjoy. The orientation meeting provides the opportunity for parents to ask questions and express concerns, and for you to convey your belief in the value of the caring touch that you will model with their children.

Giving Parents Practice

If you decide to include parents with their children in your group, it will be helpful to offer them a few practice sessions before they join their first group. Not only do you want them to be comfortable with touch, play, and nurturing, but you want them to get some of their own needs met before you expect them to be attentive and nurturing with their children. Parents will need to learn how to take charge, nurture, stick together, and have fun. You may want to put parents in pairs so that one parent can take the adult role and the other the child role while they practice taking charge, providing nurture, and having fun.

Including Parents in Group Theraplay

Parents can be included in groups in several ways. They can be issued an open invitation to observe the group and join as participants when they feel comfortable. Each can be the play partner of his own child, interacting one-on-one with his child and helping his child join whole-group activities when it is appropriate. Or they can

first observe their children from behind a one-way mirror while an interpreting therapist helps them understand what is going on in the group and prepares them to join in. The following examples illustrate these three ways of including parents in child groups.

THE OPEN-DOOR APPROACH. This approach invites parents to visit the classroom during group time. They can choose to watch or to join in with their children. If a child finds it difficult to have her parent watch rather than join in, you can encourage the parent to join or allow the child to sit with her parent. When parents do join in, you can make them equal members of the group, having them participate in the fun and receive the same care that you are giving their children. Or you may make each parent the partner of her own child, supporting the child's participation in the group. This arrangement will enable you to identify distressed, poorly attached child-parent pairs for whom treatment should be recommended. When a parent does participate, she should understand clearly that she is responsible only for her own child. It would not be appropriate for a parent to be given the responsibility of helping to structure another parent's child.

THE PLAY PARTNER APPROACH. A parent can be the partner of one or all the children in her family. In the following example, every child in the group has a parent present.

THERAPLAY IN PRACTICE

Adopted Children with Their Parents

In order to enhance the attachments between parents and their children, the one-parent, one-child model was used with a group of families who had adopted children as infants and toddlers from Eastern European orphanages (Bostrom, 1995). The children ranged in age from three to six years. Organized as a multifamily group, the focus was on attachment-fostering interactions between parent-child pairs. Meeting with the leader for thirty minutes after each group session, parents shared experiences of the previous week and asked questions, and the leader and parents exchanged observations of positive changes in the children.

In sessions, parents formed the containing outer circle of the group. Their children, forming the inner ring, were seated on pillows facing their parents. During initial sessions, the leader called out directions for each activity, and each dyad took a turn playing the game while the others watched. As everyone became more comfortable and capable, all the pairs did the activities simultaneously. The leader then acted as coach to further facilitate the emotional connection between each parent-child pair. Sessions began with parents putting lotion on their children, making handprints, and rocking their children. They ended with children cradled in their parents' arms for the "Twinkle" song. The children developed new language skills and they were also more connected to their parents through increased eye contact and "touchability." Their parents were more relaxed, were more comfortable with "silliness," and felt more competent.

With this group of adopted children, all activities remained between the dyads so as not to dilute the parent-child attachment that was being nurtured. If you use this model with other populations, you could bring everyone together for a whole-group playtime after the initial parent-child playtime. You might even use the same activity that they did as pairs and modify it so that all the group members can do it together. Such a format would allow families to join together, children to pair up, or children to group together while their parents watched and supported only as needed.

THE OBSERVATIONAL APPROACH. Being able to observe their children in a Theraplay group gives parents the opportunity to learn more about how their children interact as well as about how the group works before joining in. A school-based parent-child assessment and treatment model was developed for teen mothers and their children (Talen and Warfield, 1997). The parent-child component was part of a comprehensive "family health and wellness" program that provided primary health and mental health care to preschool children both within their community and among the children and their caregivers.

The teenaged mothers used their study hall breaks for fifteen- to twenty-minute observations of their children, who were participating

in a "healthy self-esteem group" within the Head Start program located in their parents' high school. To prepare for these visits, the children had had a few weeks of Group Theraplay before parents began visiting. Across three different observation times, the interpreting therapist pointed out each child's positive characteristics, helped the mothers understand age-appropriate behaviors, and modeled positive interactions. The parents readily joined in the group with their children for the final session. The group took on a joyful, caring atmosphere, with children sitting comfortably in the laps of their mothers. One mother spontaneously created a rap song to end the session. This, and the laughter and smiles that accompanied the games, attest to the success of this model.

The following is an example of Group Theraplay for children with internalizing problems (shy, withdrawn behavior) where the parents observed sessions before joining the children's group. It took place in China and was designed as a research study.

THERAPLAY IN PRACTICE

Group Theraplay with Children with Internalizing Problems

Because internalizing problems are on the rise in China, children aged two to four years who were at risk for internalizing problems, as measured on the Child Behavior Checklist (CBCL) (Achenbach, 1991), were included in a Theraplay group. In order to test the effectiveness of Group Theraplay, participants were matched with a control group of children on the wait list. Group sessions were held once a week for eight weeks, were forty minutes in length, and followed the recommended format of a beginning Checkup of each child, middle lively activities alternating with calming ones, and ending with the sharing of food and a song. Mothers observed the early sessions, were given feedback afterward, and were urged to practice the activities they had seen at home. In the last two sessions, the mothers joined the group. Posttest scores were significantly improved for the children who participated in Group Theraplay as compared with the scores of children in the control group. The children reported that they enjoyed the

sessions and particularly liked playing with their mothers. Balloon Balance and Cotton Ball Blow appeared to be the favorite games!

THE WHOLE FAMILY THERAPLAY APPROACH

The Theraplay Institute, in conjunction with Dr. Kyle Weir of California State University at Fresno, developed a format for using Theraplay with whole families. Typically we begin individual Theraplay with the parents and the one child who is having the most difficulty and bring the whole family in only at the end. In this treatment, we included the entire family from the beginning. The families targeted for this approach had at least one adopted child who was having difficulty. Two therapists worked with each family as a group. The sessions utilized the Theraplay group rules and followed the group format. Sessions could be very challenging because of the children's range in ages and variety of needs. Very young children needed to be free to move about the room but were included whenever possible in the activities. After the half-hour session, one therapist sat with the parents to one side of the room and talked about what had happened in the session, while the other therapist engaged the children in quiet play with toys.

In Whole Family Theraplay, parents interact directly with their children from the beginning rather than first observing the therapists working with their children. In this way the parents are empowered and supported in their role as the ones who organize their children's experience. Whole Family Theraplay therapists need to provide a very brief model of the approach, but then quickly move into a coaching and supporting role while the parents take the active role with their children.

Bringing the whole family into sessions from the beginning can be very helpful for families with several children, all of whom need help forming a cohesive and well-functioning unit.

SUNSHINE CIRCLES®

Because of the pressing need for teachers to build positive relationships between children and to create healthy classroom communities, The Theraplay Institute has developed Sunshine Circles (Schieffer,

2009), designed for teachers and other child-care providers to use for classroom management. Sunshine Circle leaders are not therapists and do not provide therapy, but by virtue of their focused training, they learn to guide children in activities that lead to greater respect for each other, more confidence, more connection to each other, and the ability to cooperate and solve problems. Sunshine Circles are consistent with social-emotional curricula for children and can help them develop frustration tolerance and the ability to ask for help from teachers or peers. Teachers who have led these groups for young children observe that there is more peer teaching and that the classroom runs more smoothly than before the initiation of Sunshine Circles.

USING GROUP THERAPLAY INFORMALLY

We turn now to describe ways of including Group Theraplay ideas in settings where it is not possible to organize a regular group.

All good teachers attend to the well-being and positive interactions among the children in their class. The following are two excellent examples of the kinds of supportive, social interactions that can be found in many education settings. One physical education teacher planned a cooperative game with the goal of the children working together, verbalizing feelings, and demonstrating concern for one another—a very different focus from her typical activities geared to competition and physical mastery. An art teacher made an outline of each child's head on a large piece of paper. Each profile was passed around the class so that every child could write on it something especially "likable" about that person. At the end, each child was able to take home a picture that contained contributions from the entire class.

It is possible to introduce such "Theraplay moments" into the atmosphere of any classroom. One teacher (Wiedow, personal communication, 1997), who cotaught two classes of first and second graders with a colleague, found an innovative way of providing a small Group Theraplay experience. Because of the numbers of children involved and the scarcity of time for a formal group, she offered the children the opportunity to be in a "Good Friends Group" instead of going to recess. Up to five children could choose to stay in for the group, and the teacher found she always had volunteers. Thus, all the children in her class, at some time or other, were able to have a Group Theraplay experience.

Most noteworthy, however, was how this teacher and her colleague integrated Checkups into the regular classroom setting. After lunch, when the children found it difficult to settle down from their active, outdoor play, the teacher and her colleague checked in with each child before beginning the afternoon lessons. As the children entered the room and sat at their desks, the two teachers, with bottles of lotion in hand, went from child to child, asking how they were feeling and if they had any hurts. By putting lotion around hurts and addressing any conflicts between children, the teachers helped the class settle down. Checkups provided a perfect transitional activity during which they took the time to attend to each child before asking the children to attend to their school agenda.

These applications in regular education classrooms show that the nurturing and playful aspects of Theraplay do not have to be limited to the formal Theraplay group or to the Theraplay facilitator. All children not only welcome but *need* nurturing attention in order to achieve a state of mind that is conducive to learning. This is perhaps more true today than ever before.

USING GROUP THERAPLAY WITH ADULTS

Group Theraplay has been used with the elderly in community outpatient settings, in nursing homes, and with Alzheimer's patients. In some settings it is possible to bring children and seniors together so that children can benefit from the attention of these surrogate grandparents, and the seniors can benefit from the joy of being in the presence of young children. Three examples follow that describe a group of seniors and primary school children in Germany, another for seniors in a nursing home in the United States, and the third for intellectually impaired adults in Western Australia.

THERAPLAY IN PRACTICE

A Group with Adults and Children

The group consisted of four adults and four children seated alternately around the circle. The opening activity for the first group session was to greet each other by touching the other person with a feather. This captured everyone's "funny bone"

and got them all giggling and laughing. Then came Checkups in the form of "quiet mail." Each person whispered the name of another participant into the ear of her neighbor. The neighbor had to say the whispered name, and the fun was whether the name would be correct or sound funny. Even though all the participants had name tags, the names did not always come out quite right because some of the young children couldn't read well and some of the elderly people couldn't hear well. But in the good-humored atmosphere of the group, everyone enjoyed the funny ways the names were said and no one felt offended. Next, everyone passed lotion from one hand to the next so that hurts could be cared for. But, uh-oh! Some lotion found its way to a nose or a cheek, increasing the fun and spontaneity. After the quiet Caring for Hurts activity, the children needed to move around, so the seniors blew bubbles for them to catch. They worked together so well that no bubble was left! Then the seniors took turns leading finger plays for the children. Next a small bag of chocolate candies was passed while the group sang a song. When the song ended the person holding the bag could take a chocolate piece. The song continued until everyone got some candy. The group ended with a good-bye song, followed by high fives between pairs. Both the seniors and the children benefited from this opportunity to share playful experiences together.

THERAPLAY IN PRACTICE

Group Theraplay in a Nursing Home

One of the primary problems for residents in nursing homes is the lack of nurturing touch. What little touch they get is purely functional: being helped from bed to wheelchair, being dressed, and being fed. Staff members are under pressure to serve a large number of residents and have very little time with

any one resident. Personal nurturing touch from a staff member is rare. It is no surprise that many residents receive far less nurturing touch than they did in their own homes. Being deprived of nurturing touch is one of many factors that contribute to the widespread depression among nursing home residents. In order to try to change this bleak picture and to provide some fun, Group Theraplay was introduced two to three times per week during the regularly scheduled activity time in a nursing home in Arkansas. Attendance was voluntary. The group met eight times and usually had between six to ten residents. The majority of the participants were women in their late seventies and eighties. Roughly half the group was seated in wheelchairs, and the rest were able to sit in regular chairs. The leader was assisted by the activity director who had no experience in Theraplay but was content to take the cues from the leader.

The groups centered on nurturing activities, such as putting lotion on one another, singing, and feeding each other. The group also participated in mildly challenging activities, such as bouncing a balloon around the group, popping bubbles, or passing a small beanbag to one another. For engagement, the leader walked around the room to various residents and played Peek-a-Boo, or sang the "Twinkle" song. Activities with more challenge were not used because most of the engaging and structuring activities were challenging enough for these elderly people.

The response of the participants in these groups was markedly positive. Sessions were filled with smiles and happy laughter, and many of the participants said how much they were enjoying themselves. Two participants cried when lotion was put on their hands. When asked to talk about the feelings behind the tears, they said how good the lotion felt and how nice it was to interact with their fellow residents in a fun, positive way. Staff reported that residents who attended the group seemed happier in their interactions outside of group. As staff began to hear about the group, many would stop by to observe. The leader then involved them in the group activities, thereby strengthening their bond with the residents.

There are inherent difficulties for the therapist in conducting Theraplay groups for the elderly. Many participants were confined to wheelchairs. This limited mobility and reduced the number and kind of activities that could be used. Because of this, more activities were repeated than would be the case in Group Theraplay with children. Some participants suffered from diminished cognitive capacity. Activities had to be kept simple, explained clearly, and demonstrated and practiced a number of times before residents could participate well. Fatigue was also a factor; groups could not last longer than thirty minutes. Because of these issues, the groups required a very high level of therapist energy and engagement. The many signs of increased energy and good spirits in the participants made it well worth the effort.

THERAPLAY IN PRACTICE

Increasing a Sense of Belonging in Cognitively Impaired Adults

A weekly Theraplay group was offered to cognitively impaired adults with the goal of improving their quality of life. As part of a project to teach Nonviolent Communication (NVC), the developers used Theraplay to increase self-awareness, emotional expression, and social interaction. Whereas structure was not emphasized, engagement helped the participants feel "seen" and "felt," nurturing helped them feel valued and worthy, and challenge led them to try new things with their bodies and their minds and to interact more with their peers. Other modalities were incorporated in these groups, including sensory integration activities, storytelling, dance, and relaxation. For those too impaired to benefit from the NVC training, Theraplay seemed to improve a range of behaviors. They made better eye contact, tolerated being close to others, accepted touch from others, expressed both negative and

positive feelings better, increased their activity level, and were able to control socially problematic behaviors. The power of these groups was demonstrated in the achievements of these individuals. One man, formerly unresponsive when in a group and only able to pace with chin on chest, could, after the Theraplay group experience, look at others and initiate interactions. A second man, previously severely depressed, was able to let others get to know him. A third man, also extremely negative about his life, became active in organizations as a group leader and peer advocate. All participants reported an increased sense of belonging, in contrast to the depression and isolation they experienced prior to the group.

Group Theraplay provides a means for sharing the benefits of the Theraplay approach with a wider number of people. We have given only a few examples of how Group Theraplay and its variations can be applied in many contexts and with different populations. It continues to be exciting to see its effectiveness with children, adults, families, and classrooms.

Note

1. For more ideas on group activities, refer to the following books: *Play with Them* (Rubin and Tregay, 1989), *Fun to Grow On* (Morin, 1999), the two *Cooperative Sports and Games* books (Orlick, 1978, 1982), and *Baby Games* (Martin, 1998). See Appendix B: Theraplay Activities for explanations of many of the activities mentioned in this chapter.

APPENDIX A

Marschak Interaction Method: Recommended Basic List of Tasks

3 YEARS AND OLDER

1. Adult and child each take one squeaky animal. Make the two animals play together.
2. Adult and child each take paper and pencil. Adult draws quick picture, encourages child to copy. OR: Adult builds a block structure. Then says to child, "Build one just like it with your blocks" (sets of five or eight blocks depending on developmental age).
3. Adult and child each take one bottle of lotion. Apply lotion to each other. OR: Adult combs child's hair and asks child to comb adult's hair.
4. Adult tells child about when child was a baby, beginning, "When you were a little baby." OR: If the child is adopted or in foster care, "When you came to live with us . . ."
5. Adult teaches child something child doesn't know.
6. Adult leaves room for one minute without child.
7. Play a game that is familiar to both of you.
8. Adult and child put hats on each other.
9. Adult and child feed each other (small snacks).

Additional Considerations

When two activities are listed, for example, using lotion and combing hair, use one for each parent.

Add a younger task such as Patty-Cake to assess child's and adult's comfort with younger activities.

For children ages nine to twelve, add activities with more challenge and physical activity, such as bean blowing, thumb wrestling, and closing eyes and recalling items in room.

PRENATAL

1. Draw a picture of you and your baby #1.
2. Talk and play with your baby.
3. Tell baby about when she or he is a grown up.
4. Communicate something to your baby without using words, then say it in words.
5. Tell your baby the story beginning, "When you were brand new."
6. Tell baby what you think have been his or her most stressful times.
7. Tell baby how you try to reduce his or her stress.
8. Sing to your baby.
9. Teach your baby something.
10. Prepare your baby for childbirth.
11. Tell your baby about the happiest times you've had together.
12. Draw a picture of you and your baby #2.
13. Tell your baby about his or her father or mother.
14. Tell your baby about the people she or he will meet.

INFANT

1. Take your baby on your lap. Talk and play with your baby.
2. Tell your baby the story beginning, "When you were brand new."
3. Tell your baby what you think have been his or her most stressful times and how you try to reduce his or her stress.

4. Sing to your baby.
5. Tell what your baby wants right now.
6. Bounce your baby on your knees and blow on his or her tummy.
7. Adult leaves the room for one minute without child.
8. Tell what you think your baby was doing while you were gone.
9. Teach your baby something.
10. Tell your baby about the happiest times you've had together.
11. Tell your baby about when he or she is a grown up.
12. Tell your baby about his or her father or mother.
13. Play Peek-a-Boo with your baby.
14. Feed your baby.
15. Dance with your baby.

TODDLER

1. Adult takes one squeaky animal, gives other to child, make the two animals play together.
2. Adult builds a block structure. Then says to child, "Build one just like it with your blocks" (sets of three blocks).
3. Adult puts lotion or powder on child.
4. Adult holds child's hands still for the count of twenty.
5. Adult tells child about when child was a baby, beginning, "When you were a little baby." OR: "When you came to live with us . . ."
6. Adult rings bell where child cannot see it.
7. Adult leaves the room for one minute without child.
8. Adult and child play Patty-Cake.
9. Adult teaches child something child doesn't know.
10. Adult feeds child.

ADOLESCENT

1. Adult takes one action figure or squeaky animal, gives other to teen. Make the two figures play together.

2. Teach the teen something he or she does not know.
3. Tell each other's fortunes.
4. Put lotion each other. OR: Comb each other's hair.
5. Play a familiar game together.
6. Leave the room for one minute without the teen.
7. Play three rounds of thumb wrestling.
8. Adult asks teen to describe a day in his or her life ten years from now.
9. Try hats on each other.
10. Feed each other (small snacks).

APPENDIX B

Theraplay Activities by Dimension

In this revised list, activities within each dimension are listed alphabetically within each of three age levels:

- *Young:* Chronologically or developmentally young; for example, one to three years
- *All:* All ages with appropriate modifications up or down
- *Older:* Chronologically or developmentally older; for example, eight to fifteen years

A few activities at the end of each dimension are especially suitable for use with a group of three or more participants, for example, when parents enter the session or when more than one child is present. Depending on the way an activity is carried out, it may fit more than one dimension, for example, hand-clapping games are both engaging and structuring. Many games enjoyed by young children throughout the world (not listed here) can also be adapted and used in sessions with children of all ages. Activities for very young children must be within their physical ability and must make sense to them. Simple activities can be adapted to make them more challenging or more interesting to older children. In order to encourage give-and-take

and extend the child's attention span, you or the parents can take turns with the child and vary the activity whenever possible.

STRUCTURE

The purpose of structuring activities is to organize and regulate the child's experience. The adult sets limits, defines body boundaries, keeps the child safe, and helps to complete sequences of activities.

A word about signals: Using signals for when to start will increase the structure in any activity. Start with simple signals, such as "One, Two, Three, Go" or "Ready, Set, Go"; advance to more complicated signals, such as listening for a selected word in a series, or watching for a visual signal, such as a wink or other facial movement. Signals should not be used for every activity as they can slow down the pace or become too predictable and they may take away from the lighthearted tone you want at a particular moment,

Young

BEANBAG GAME. Place a beanbag or soft toy on your own head, put your hands under the child's outstretched hands, give a signal and drop the beanbag into the child's hands by tilting your head toward the child. Take turns. Variations: For a child who cannot catch well, take his hands in yours and bring all four hands together to catch the beanbag. You can also open your hands to let the beanbag fall through.

JUMP INTO MY ARMS. Have child stand on pillows or sofa. Give a signal for the child to jump into your arms.

PATTY-CAKE. Hold child's hands and lead her through the activity. "Patty-cake, patty-cake, Baker's man / Bake me a cake as fast as you can / Roll it and pat it and mark it with a [child's initial] / And toss it in the oven for [child's name] and me!" You can use feet as well. This is also an engaging activity.

PLAY DOH SQUEEZE OR PRINTS. Place a ball of Play Doh between the child's hands. Place your hands on the outside of the child's hands and, while looking directly in the her eyes, say "Sqeeeeeeze!" as you firmly press your hands and hers into the Play Doh. This firm pressure can help organize a dysregulated child. You can also use Play Doh to make finger, hand, and footprints.

POP THE BUBBLE. Blow a bubble and catch it on the wand. Have child pop the bubble with a particular body part, for example, finger, toe, elbow, shoulder or ear. This is a structured way of playing with bubbles. Bubbles readily capture the interest of young children and can be used as an engaging activity either in this structured form or in a manner that invites more spontaneity (for example, by having the child pop all the bubbles as quickly as he can).

All Ages

COTTON BALL BLOW. You and the child hold a scarf or long piece of cloth between you. Place a cotton ball at one end of the scarf and blow it back and forth to the child. An alternative is to place the cotton ball in your cupped hands and blow the ball into the child's hands. Another alternative is to fold up the long sides of a piece of foil (as long as the child's arm or leg) and blow the cotton ball back and forth on the foil tray.

COTTON BALL HOCKEY. Lie on the floor on your tummies (or sit with a pillow between you). Blow cotton balls back and forth trying to get the cotton ball under your partner's arms or off the edge of the pillow. Or you can cooperate and both blow hard enough to keep the ball in the middle. You can make it less competitive but increase the complexity by specifying how many blows can be used to get the ball across the pillow—one blow is easy, but two or three are harder to control.

DRAWING AROUND HANDS, FEET, OR BODIES. Make a picture of the child's hand or foot by drawing it on a piece of paper. Be sure to check on the child's reaction by looking at his face periodically. Full body drawings require the child to lie still for some time and are therefore more challenging and may make the child feel vulnerable; wait to do this until later in treatment when trust has been established. Be sure to maintain verbal contact with the child as you draw; for example, "I'm coming to your ankle; I'm coming to the tickle spot under your arm."

MEASURING. Measure the child's height, length of arms, legs, feet, hands, and so forth. Keep a record for later comparisons. Use a measuring tape, yarn, or ribbon. Measure surprising things, such as the child's smile, the length of his ears, the circumference of his head, or how high he can jump. You can use fruit tape for measuring, then

tear off the length and feed it to the child. "This is just the size of your smile." You thus combine structure with nurture.

MIRRORING. Face the child, move your arms, face, or other body parts and ask child to move in the same way. For a very active child you can use slow motion or vary the tempo. Take turns being the leader.

PEANUT BUTTER AND JELLY. Say "peanut butter" and have child say "jelly" in just the same way. Repeat five to ten times varying loudness and intonation. Adapt the pair of words to the customs of the country; for example, "fish" and "chips" in Great Britain.

STACK OF HANDS. Put your hand palm down in front of child, have the child put his hand on top; alternate hands to make a stack. Take turns moving the hand on the bottom to the top. You can also move from top to bottom. This can be made more complicated by going fast or in slow motion. Putting lotion on hands first makes for a slippery stack and adds an element of nurture. You can stack feet, forearms, folded arms, and fingers; if a child is wary of touch, stack hands with one to two inches of space between each hand or finger.

Older

EYE SIGNALS. Hold hands and stand facing each other. Use eye signals to indicate direction and number of steps to take, for example, when you wink your left eye two times, both you and the child take two side steps to your left. If winking is difficult, tilt the head or purse the lips to the left and right. To make it more challenging, you can add signals for forward and backward movement as well (head back for backward, head forward for forward). You can hold a balloon or a pillow between you by leaning close to each other as you move.

RED LIGHT, GREEN LIGHT. Ask child to do something, such as run, jump, move arms. Green light means go, red light means stop.

THREE-LEGGED WALK. Stand beside the child. Tie your two adjacent legs together with a scarf or ribbon. With arms around each other's waist, walk across the room. You should be responsible for coordinating the movement. For example, you can say "inside, outside" to indicate which foot to use. You can add obstacles (pillows, chairs) to make this more challenging.

TOILET-PAPER-BUST-OUT. Wrap child's legs, arms, or whole body with toilet paper, paper towels, or crepe paper. To let a hesitant child know what is in store, have her hold her arms together in front of her body and wrap them first. On a signal, have child break out of wrapping.

When Parents Enter or When There Are Three or More Participants

Young

RUN TO MOMMY OR DADDY UNDER THE BLANKET. Child sits on one parent's lap facing the other parent with a small blanket lying on the floor between them. On a signal, both parents lift the blanket and the child runs or crawls under the blanket into the arms of the other parent.

All Ages

FOLLOW THE LEADER. All participants stand and form a line holding on to the waist of the person in front of them. The first person chooses a particular way to move and all others copy. The leader goes to the back of the line and the new leader demonstrates a different way to move around the room. This can also be done sitting in a circle and moving only arms, head, and shoulders.

FUNNY WAYS TO CROSS THE ROOM. One adult and the child stand at one end of mat (or play space); other adult stands at other end of mat. Second adult directs child to come toward her in a certain way, for example, hopping, tiptoeing, crawling, or walking backward. Child is greeted with a hug or special greeting on arrival. The first adult then calls her to come back in a specified way. Adult and child can come across mat together if child cannot manage alone. With older children, each participant can choose a funny way to cross the room that everyone must try, for example, crab walk, elephant walk, or scooting.

HOKEY POKEY. Everyone stands in a circle and sings: "You put your right foot in / You put your right foot out / You put your right foot in / And you shake it all about / You do the Hokey Pokey / And you turn yourself around / That's what it's all about / Hokey Pokey!" Arms, heads, whole bodies can be put in to the middle of the circle and shaken. When you do the Hokey Pokey, you dance in whatever way you like, arms in air, with playful, energetic gestures.

MOTOR BOAT. Holding hands, everyone walks around in a circle, chanting "Motor boat, motor boat, go so slow / Motor boat, motor boat, go so fast / Motor boat, motor boat, step on the gas!" Gradually increase the speed until it is very fast. Suddenly "put on the brakes!" and start over with the slow tempo. This can also be done with the child and therapist alone.

RING-AROUND-A-ROSY. Hold hands and walk around in a circle chanting, "Ring-around-a-rosy / A pocket full of posies / Ashes, ashes, we all fall down." All fall down at the end.

Older

"MOTHER, MAY I?" Parent gives instructions to the child to do something, for example, "Take three giant steps toward me." Child must say "Mother, may I?" before responding to the command. If the child forgets, she must return to the starting line. The goal is to have the child come to her parent and get a hug on arrival.

SIMON SAYS. This is similar to "Mother, May I?" but with the added challenge that the child must watch out for commands that do not have "Simon Says" as part of the phrase. Thus when the game is going rapidly, the leader can suddenly omit to say "Simon Says," and the unwary participant may do the action without thinking. If a player makes this mistake, it is his turn to be leader.

ZOOM-ERK-SPLASH. Everyone sits or stands in a circle. The word "zoom" is passed around the circle quickly. When one person stops the action by saying "erk," the "zoom" reverses and is sent back the way it came. When the zoom-erk gets stuck in one part of the circle, the person receiving the erk puts his hands together in a diving movement and point his hands to someone across the circle, saying "splash." The person splashed passes a zoom to the person next to her.

ENGAGEMENT

The purpose of engaging activities is to connect with the child in a playful, positive way, to focus intently on the child, and to encourage her to enjoy new experiences. At all times it is important to attend to the level of the child's arousal and to modulate it when needed.

Young

BEEP AND HONK. Press child's nose and say "Beep!" then press chin and say "Honk!" Guide child to touch your nose and chin. Make appropriate beeps and honks, as you are touched. Child may be able to supply noises also.

HELLO, GOODBYE. Child sits in parent's lap face-to-face. Parent supports child's back with his hands and says "Hello" and then dips the child backwards while saying "Goodbye." Parent then brings the child back up and says "Hello." This can be done standing, as well with the child's legs around the parent's waist. In this position the downward dip puts the child's face farther out of view of her parent.

KNOCK ON THE DOOR. This is a simple baby activity. There are many variations in different cultures. "Knock on the door" (tap on the child's forehead); "Peep in" (peek at child's eyes); "Lift up the latch" (gently push up child's nose); and "Walk in!" (pretend to walk fingers into child's open mouth or pop a piece of food in).

PEEK-A-BOO. Hold child's hands (or feet) together in front of your face. Peek around or separate the hands (or feet) to "find" the child. A lovely variation is to use a sheer scarf to hide your face or the child's, then pull it off to discover each other.

POP CHEEKS. Inflate your cheeks with air and help child to pop them with his hands or feet. Child inflates cheeks and you pop them in turn.

POPCORN TOES. As you take the child's shoes off, ask if she has popcorn, peanuts, grapes, and so forth, inside her shoe. Then take the shoe off and discover wonderful toes.

PUSH-ME-OVER, LAND-ON-MY KNEES. Kneel in front of standing child (so that child comes to your eye level) or sit in front of sitting child. Hold child's hands. On a signal, have child push you. As you fall back pull child onto your knees and "fly" the child smoothly or bounce child up and down.

STICKER MATCH. Put a colorful sticker on the child and have the child put stickers on you or his parent in just the same place until both are decorated in the same way. After the stickers are applied, child and parent touch matching stickers together, for example, nose to nose, elbow to elbow, before removing them.

STICKY NOSE. Put a colorful sticker on your own nose. Ask child to take it off. Or stick a cotton ball on your nose with lotion. Have child blow it off.

THIS IS THE WAY THE BABY RIDES. Adult holds child on knees and bounces the child, varying the pace as she moves from baby, to lady, to gentleman, to farmer. Another version of this activity is "Trot, trot to Boston, Trot, trot to Lynn, Trot, trot to Boston, All fall in!" Let the child gently "fall" off adult's lap at the end.

THIS LITTLE PIG WENT TO MARKET. Wiggle each toe as you chant, "This little pig went to market / This little pig stayed home / This little pig had roast beef / This little pig had none / This little pig cried 'Wee, wee, wee,' all the way home." Change details to fit the particular child, for example, "this little pig likes pizza." As you say "all the way home," walk your fingers up the child's arm in a playful way rather than tickling his tummy. With an easily dysregulated child use firm pressure and a calm approach.

WIGGLE TOES. Feel for wiggle toes through the child's shoes as a part of greeting and Checkup. Remove the shoes to discover the toes.

All Ages

BEEP AND HONK VARIATION. Make a special noise when you touch a specific face or body part, for example, elephant trumpeting when you touch a knee. Try to remember which noise goes with the part when you do a series of touches.

BLOW ME OVER. Sit facing the child and, holding hands (you can cradle a younger child in your lap), have child "blow you over." Fall back as the child blows. Once the child understands the game, you can blow her over.

CHECKUPS. Check body parts, such as nose, chin, ears, cheeks, fingers, toes, knees to see if they are warm or cold, hard or soft, wiggly or quiet, and so on. Count freckles, toes, fingers, and knuckles. Check strong muscles and high jumps.

FOIL PRINTS. Shape a piece of aluminum foil around the child's elbow, hand, foot, face, ear, or other body part. It helps to place a pillow under the foil and have the child press her hand or foot into the soft surface to get impressions of the fingers and toes. Parent may be called in to guess which print goes with which body part. This is also structuring since it defines body shapes and boundaries.

HIDE AND FIND. Hide a cotton ball (wrapped candy, a touch of lotion or powder) somewhere on the child (in a cuff or folded sleeve, under the collar, behind the ear). An older child can hide the cotton ball on himself. If parent or another adult is available, she can find the cotton ball, if not, you can find it. Young children will want to show where the hidden object is. Help parents accept this as the child's eager involvement in the game.

PIGGY-BACK/HORSEY-BACK RIDE. Help the child get onto your back. Jog around the room with the child on your back. Child can give signals, "Whoa!" and "Giddyap!" The strength of your back determines how old the child can be for this game. All children enjoy it.

PUSH-ME-OVER, PULL-ME-UP. Sit on the floor in front of child. Place child's palms against yours, or put child's feet against your shoulders. On a signal, have child push you over. Fall back in an exaggerated way. Stretch out your hands so that child can pull you back up.

ROW, ROW, ROW YOUR BOAT. Sing the familiar song, adding the child's name at the end ("Erin's such a dream"). Small children can be held in your lap. Older children can sit facing you. Clasping forearms rather than hands makes this feel more secure and connected. If another adult is available, child can be seated between you as if in a boat as you row back and forth. The tempo can be varied from fast to slow and back again to practice regulation. You also can rock from side to side. The second, more exciting verse concludes, "If you see a crocodile, don't forget to scream." Then both scream loudly.

Older

COUNTING FINGERS AND KNUCKLES. Count from one to five on one hand and then starting with ten on the other hand count down to six. Say with a puzzled look, "Five and six makes eleven. Do you have eleven fingers?" Older children will enjoy the joke, younger ones won't get it. You can also count all the knuckles on both hands. Children are often surprised to learn that they have twenty-eight knuckles.

CREATE A SPECIAL HANDSHAKE. Make up a special handshake together, taking turns adding new gestures, for example, high five, clasp hands, wiggle fingers, and so on. This can be cumulative over several sessions and can be your beginning or ending ritual. It can be used to good advantage when parents join the session.

HAND-CLAPPING GAMES. Children of all ages enjoy these games and many have a good repertoire of rhymes and rhythms. You should have a few chants that you know well, for example, "Miss Mary Mack" or "A Sailor Went to Sea." You can vary the complexity of the rhythmic pattern and the chant depending on the skill of the child. Always make sure that you first rehearse the clapping pattern slowly so that you can easily get into a satisfying pattern once you add the rhyme.

When Parents Enter or When There Are Three or More Participants

BLANKET PASS. Everyone sits (or stands) in a circle and holds on to the edge of a small blanket, sheet, or parachute. Each person takes a turn choosing who they want to pass a soft ball to across the blanket. Everyone must cooperate in lifting or lowering their part of the blanket to make sure that the ball gets to the right person. A variation is to pass the ball around the edge of the circle.

HIDE AND SEEK. Hide with the child under a blanket or under pillows and ask parents or other adult to find you both. Hiding with the child is important, because it gives you the opportunity to help the child contain the excitement generated by being alone and anticipating the surprise of being found. Parents should be coached

to make appreciative comments about their child as they look for him and to find him quickly if he is very young and impatient. A big hug is in order once the child is found.

HIDE NOTES OR OTHER OBJECTS ON THE CHILD FOR PARENTS TO FIND. One adult hides and the other finds, for example, notes directing the finder to do something with the child ("Pop Sara's cheeks"); or, find a cotton ball and give a soft touch, or find food and feed it to the child.

MAGNETS. Everyone stands in a wide, loose circle. Each time the leader gives the cue, everyone comes closer and closer until they are touching side-by-side.

MATCH THE BEANBAGS. Give the parent and child five beanbags each. The parent balances a beanbag on the child's body (on the head, shoulder, knee, in the crook of an arm) and the child places a beanbag on the same place on the parent; they take turns dumping the beanbags from the same body part into each other's hands.

PASSING FUNNY FACES. Each person in the circle makes a funny face which is passed in turn to the next person around the circle. Each has a turn to create a funny face.

PROGRESSIVE PASS AROUND. Sitting in a circle, one person passes a gentle touch to the next person (such as a nose beep, or pat on the back). The second person passes that touch to the third person plus one of her own. Each person adds a new touch. Everyone helps each other recall the sequence of touches. If a child is wary of touch, this may be done first by doing the touches only on oneself.

WHOSE TOES DID I TOUCH? Everyone sits in a circle with feet all entwined under a blanket. The person who is "it" touches the lumpy blanket and has to guess whose toes she has touched.

NURTURE

The purpose of nurturing activities is to reinforce the message that the child is worthy of care and that adults will provide care without the child having to ask. Nurturing activities help to calm and regulate the anxious child and enhance feelings of self-worth.

Young

COTTON BALL SOOTHE. Have child relax on pillows or in your arms. You, or a parent, gently stroke the child's face, arms, or hands with a cotton ball. You can quietly describe the features that you are outlining: rosy cheeks, smiling mouth, upturned nose.

FEEDING. Cradle the child in your arms while feeding pudding, applesauce, or juice.

LULLABY. Cradle the child in your arms in such a way that eye contact can be maintained. Sing your favorite lullaby or any quiet, soothing song. Add details about the particular child to the traditional words.

All Ages

CARING FOR HURTS. As part of the general checkup for the child's special qualities, notice and care for scratches, bruises, hurts, or "boo-boos." Put lotion on or around the hurt, touch with cotton ball, or blow a kiss. Check for healing in the next session. Do not announce, "Let's see how many hurts you have."

COTTON BALL OR FEATHER GUESS. First demonstrate by touching the child's hand with a cotton ball and a feather; ask the child to notice the difference between the two sensations. Then have child close her eyes and tell where you have touched her and whether you did it with a cotton ball or a feather. This adds challenge to a nurturing activity. If the child is not comfortable closing her eyes, have her look away.

COTTON BALL TOUCH. First have child hold out hand and demonstrate a gentle touch on one finger, and have her point to or tell you which finger you touched. Then have child close eyes (or turn her head if closing eyes bothers the child). Touch child gently with cotton ball. Have child open eyes and indicate where she was touched.

DECORATE CHILD. Make rings, necklaces, bracelets with Play Doh, crazy foam, crepe paper streamers, or aluminum foil.

FACE PAINTING. Paint flowers and hearts on cheeks or make the child up like a princess or a prince. Mustaches and beards are interesting for boys and their fathers. A variation on this is to use a soft dry brush

and pretend to paint the child's face, describing her wonderful cheeks, her lovely eyebrows, and so forth as you gently brush each part.

FEATHER MATCH. Prepare two sets of five feathers; if they are colored, have the sets match. The parent or therapist decorates the child with one feather (in the child's hair, tucked into a sleeve, between fingers) and the child places a feather on the adult in the same place. Admire each other.

FEEDING. Have small snack and drink available for all sessions; never insist that a child eat. Take child on lap or face seated child. Feed the child, listening for crunches, noticing whether child likes the snack and when he is ready for more. Encourage eye contact. You can add to the interest of the feeding by having two or three kinds of snack—raisins, nuts, crackers. Have the child close his eyes and guess which snack it is. If the child refuses to let you feed him at first, allow him to feed himself but make yourself a part of the activity, for example, by commenting on how long he chews, how loud his chews are, or what you notice about him that lets you know he likes the food.

LOTION OR POWDER PRINTS. Apply lotion or powder to the child's hand or foot and make a print on paper, the floor mat, a pillow, your dark clothing, or on a mirror. If you make a lotion print on dark construction paper, you can shake powder on it and then blow or shake it off to enhance the picture (take care to keep the powder away from the child's face). You can also make a pile of powder on a piece of paper and have the child rub his hand or foot in it to make the print.

LOTIONING OR POWDERING. Put lotion or powder on child's arms, hands, legs, or feet. You can sing a personalized song as you do this, "Oh lotion, oh lotion on Sarah's feet / It feels so good, it feels so sweet. Oh lotion, oh lotion on Sarah's hand / It feels so good, it feels so grand." Attend to the child's sensory needs by using firm pressure, or choosing powder rather than lotion for the child who has tactile sensitivity.

PAINT PRINTS. Rub finger paint on child's hand or foot, using one color or creating a pattern with several colors. It is best to do one hand or foot at a time. Press the painted hand or foot onto paper to make a print. After prints are made with paint, gently wash, dry, and powder the hand or foot.

POWDER PALM. Sprinkle some powder in the child's palm and partially rub it in so that the lines on the palm stand out; notice shapes and letters. Also rub into parent's palm; look for differences and similarities between the child's and the parent's palms.

PREPARING PIZZA, TACOS, HOT DOGS, OR COOKIE DOUGH. Have the child lie on pillows on his tummy. Knead his back while describing how delicious the cookie or pizza, taco, or hot dog is going to be. Firmly put the appropriate condiments on the pizza or cookie dough.

SLIPPERY, SLIPPERY, SLIP. This is a lotioning activity with an added element of surprise (as well as giving an opportunity to apply firm pressure to the child's body). First rub lotion on the child's arm or leg. Then holding firmly well up his arm or leg, say "slippery, slippery, slip" and pull toward you, falling backward with an exaggerated motion as the slippery arm or leg escapes. An alternative is to see how quickly the child can pull her hand out from between your two slippery hands and squeeze it back into your clasped hands.

SOFT AND FLOPPY. Have the child lie on floor and help him get "all soft and floppy." Gently jiggle each arm and leg and let it flop to the floor. If child has difficulty getting floppy, have him get "stiff like a board" and then let go to be "soft like a noodle." Once the child is relaxed, ask him to wiggle just one part of his body: his tummy, his tongue, his big toe, and so forth.

"TWINKLE" SONG. Adapt the words of "Twinkle, twinkle, little star," to the special characteristics of the child. "What a special boy you are / Dark brown hair, and soft, soft cheeks / Bright brown eyes from which you peek / Twinkle, twinkle little star / What a special boy you are." Touch the parts you refer to as you sing.

Older

DOUGHNUT OR PRETZEL CHALLENGE. Put a doughnut or pretzel on your finger. See how many bites the child can take before breaking the circle.

MANICURE OR PEDICURE. Soak the child's feet or hands in warm water. Using lotion, massage her feet or hands. Paint the child's toes or fingernails using a variety of colors or letting the child choose the color she wants. Make sure that the child is comfortable having the nail polish remain when she leaves the room. If not, take it off.

POWDER TRAIL. Place a small pile of powder on newspaper on the floor. Have the child put his feet into the powder so that they are liberally covered with powder. Have the child walk on the dark mat leaving footprints as he goes. This can be used as a lead-in to having the parents come into session to find the child who is hidden at the end of the trail of footprints.

TEMPORARY TATTOOS. Apply tattoos or, using washable body paints, draw designs on the child's arms, face, or hands.

TRACE MESSAGES. Using your finger, trace shapes or simple positive messages on the child's back for her to decipher.

When Parents Enter or When There Are Three or More Participants

Young

SHOE AND SOCK RACE. Adults race to put kisses on feet and then put child's shoes back on before the kiss flies away. Ask parents to see whether the kisses are still there and add new ones when the child goes to bed at night.

SPECIAL KISSES. *Butterfly Kiss:* Parent places her cheek against the child's cheek and flutters her eyelashes so that the child feels the brush of her eyelashes. *Elephant Kiss:* Hold both fists in front of your mouth (like a pretend trumpet), keep one fist by your mouth as you make a kissing noise. Move the other fist toward the child's cheek, completing the kissing noise with a flourish as you touch his cheek. *Eskimo Kiss:* Parent and child rub noses.

Note: the therapist describes the special kisses above or may demonstrate with a gesture; the therapist makes clear that real kisses are special signs of affection to be shared only by parents and children.

All Ages

BLANKET SWING. Spread a blanket on the floor and have the child lie down in the middle. The adults gather up the corners and give a gentle swing while singing a song. At the end bring him down for a "soft landing." Position parents so that they can see the child's face. If the child is fearful of being lifted off the floor, let her remain in contact with the floor as you gently rotate the blanket around in a circle.

FACE PAINTING. Using washable body paints, parents decorate their child's face with small designs. Older boys with their fathers enjoy making mustaches and beards on each other. The removing of the paint is an opportunity for more nurturing.

FANNING. After a vigorous activity, one adult or both parents rest with child in their arms, and the other adult fans with a large pillow, a fan, or newspaper. Watch how everyone's hair blows.

PASS A SQUEEZE OR TOUCH AROUND. Pass a squeeze, a gentle touch, a dab of lotion, or a fresh touch of powder from person to person around the circle.

WEATHER REPORT. Everyone in the circle turns to the right and puts his hands on the back of the person in front of him. The leader describes the weather and each person rubs the back of the next person to match the weather. For example, it's a warm sunny day: make a large warm circle. The wind is beginning to blow: swoop hands lightly across the back making a swishing noise. Thunder: use the sides of your hands to pound gently on the back. Rain: make light finger taps. Lightning: make a big zig-zag across the back.

CHALLENGE

The purpose of challenging activities is to encourage the child to take age appropriate risks in order to foster feelings of competence and mastery. These activities are most often done cooperatively with the parent or therapist. Challenge activities also allow a child to accept structure, engagement, and nurture that they might resist in more direct forms.

Young

CRAWLING RACE. You and the child crawl on your knees as fast as you can around a stack of pillows. Try to catch the other's feet. Switch direction.

All Ages

BALANCE ON PILLOWS, JUMP OFF. Help child balance on pillows, starting with one and adding more as long as the child can easily manage. While the child is gaining her balance, hold her around the rib cage—rather than holding her hands. This steadies her and reduces the child's impulse to jump up and down. Once the child is balanced, you can remove your hands and let her experience the feeling of balancing on her own. Then tell her to "jump into my arms (or down to the floor) when I give the signal."

BALLOON TENNIS. Keep balloon in the air using specified body parts; for example, heads, hands, no hands, shoulders. If you choose feet, everyone lies on the floor and keeps the balloon in the air by kicking it gently. To create more structure and focus, choose a goal for how long you can keep it in the air, for example "Let's see if we can count to twenty."

BUBBLE TENNIS. Blow bubbles high in the air between you and the child. Choose one bubble and blow it back and forth between you until it pops.

COOPERATIVE COTTON BALL RACE. You and child get on hands and knees at one end of room. Take turns blowing a cotton ball (or a Ping-Pong ball) to the other side of the room. You can try to better your time on repeated trials. A competitive version would be for each to have his own cotton ball and see who can get it across the room first. Parent and child can be teamed up against the therapist team.

FEATHER BLOW. You and the child each hold a small pillow in front of you. Blow a feather from your pillow toward the child's pillow. Child must catch it on her pillow and blow it back.

KARATE CHOP. Hold a length of toilet paper or paper streamer in front of the child and have her chop it in half when you give a signal.

MAGIC CARPET RIDE. Have child sit on a large pillow or small blanket, holding firmly to the edge. When the child looks at you, pull him around the room. When he breaks eye contact, stop. This works well on a slippery surface, such as a wood or vinyl floor.

MEASURING. Measure the child's height against a wall and mark it in some way, then measure when she stands on tiptoes and when she jumps up and touches the wall as high as possible. Measure various lengths of jumps on the floor as well.

NEWSPAPER PUNCH, BASKET TOSS. Stretch a single sheet of newspaper tautly in front of child. Have child punch through the sheet when given a signal. You must hold the newspaper so firmly that it makes a satisfying pop when the child punches it. Make sure that you hold the paper so that the punch does not hit your chest. To extend the activity, you can add a second or third sheet of paper, have child use the other hand, and vary the signals. For the basket toss crush the torn newspaper into balls. Have child toss a ball into the basket you make with your arms.

PICK UP COTTON BALLS OR OTHER SMALL OBJECTS WITH YOUR TOES. Start with one or two and increase the number. Once the cotton balls have been picked up, you can add tossing them across the room. You can make this more challenging by having the child hop around the room with the cotton ball between his toes.

PILLOW PUSH. Place a large pillow between you and the child. Have child push against pillow trying to push you over.

SEED-SPITTING CONTEST. Feed the child chunks of watermelon or orange or tangerine with seeds. You should eat some, too. Both save your seeds. Have the child spit her seed as far as she can. Try to spit your seed as close to hers as possible. Tic Tacs, beans, or other small objects can be used as well.

Older

BALANCING ACTIVITIES. Child lies on back on the floor with feet up in air. Place one pillow on child's feet and help her balance it. Add additional pillows one at a time as long as the child is successful. Balance books, beanbags, pillows, or hats on child's head and have her walk across the room.

BALLOON BALANCE. Hold a balloon between you and the child (for example, between foreheads, shoulders, elbows, or hips) and move across the room without dropping or popping the balloon. See if you can do this without using hands.

PARTNER PULL-UP. Sit on the floor holding hands and facing each other with toes together. On a signal, pull up together to a standing position. A variation is to have the partners sitting back to back with arms interlocked. On the signal, they both push up to a standing position. For these activities to work the partners need to be close in size.

STRAIGHT FACE CHALLENGE. Child has to keep a straight face while you try to make him laugh either by gently touching him (avoid sensitive spots or prolonged tickling) or by making funny faces.

THUMB, ARM, OR LEG WRESTLING. Adult guides activity, giving starting signals and ensuring safety.

WHEELBARROW. Have child put her hands on floor. Stand behind her and clasp her firmly by the ankles or just above the knees. Child "walks" on her hands. This is hard work for the child so you should stop as soon as it becomes too tiring.

When Parents Enter or When There Are Three or More Participants

Young

WIGGLE IN AND OUT. Child wiggles out of one adult's encircling arms and into the other's arms. This is best with small children and is useful when the child is already wiggling and wanting to get out of your arms.

All Ages

COTTON BALL, MARSHMALLOW, OR NEWSPAPER BALL FIGHT. Divide into two teams. Using cotton balls, marshmallows, or newspaper balls, each team throws the balls at the other team trying to get rid of all balls on their side. Players may set up a "shield" with pillows and throw from behind it.

COTTON BALL OR PING-PONG BLOW. Everyone lies on tummies on the floor. Someone starts the game by naming a person across the circle to whom he intends to blow the cotton ball or Ping-Pong ball. That person names someone else and the ball is blown back and forth across the circle.

KEEP BALLOON IN THE AIR. When there are more people this activity can become quite exciting. You can organize it by taking turns around the circle or by counting how many times the group can keep the balloon in the air before it hits the ground.

SHOE AND SOCK RACE. Adults race to see who can put the child's shoes and socks back on first.

TUG-OF-WAR. Divide into teams, for example, child and parents versus therapists. Each team holds on to the ends of a scarf, a blanket, or a soft rope and tries to pull the other team to their side. Make sure that the child has a good grip and that there is nothing to bump into if one team falls.

TUNNELS. Child crawls through a tunnel made of pillows or of kneeling adults to meet you or his parent at the end.

Older

COOPERATIVE CARRYING. Tie four to six strings or ribbons approximately thirty-six inches in length to a medium or large rubber band, with equal spacing between the knots. Four to six people each hold one string (or two or three people can each hold two strings) and work together to pick up a paper cup or empty water bottle by pulling the rubber band wide enough to drop it around the object. Once the group captures the object, they can carry the object to an appointed place. For more difficulty, stack objects on top of each other. The number of strings can be adjusted to fit the size of the group.

COOPERATIVE RACE. There are many ways to organize a cooperative race, for example, taking turns blowing Ping-Pong balls across the room, or kicking balloons. This can be done as a parent-child team against the therapists or timed to see how quickly the goal can be reached.

TANGLE. Everyone stands in a circle. One person crosses her arms and takes the hand of someone across the circle, that person crosses his arms and takes the hand of another person across the circle until everyone is holding hands, deliberately creating a tangle of hands. Participants then untangle without breaking the handholds. It is likely that some people will be facing in and some out when the circle is untangled. It adds to the fun to put lotion on everyone's hands first. Another alternative is to have two participants stand to one side and close their eyes while the tangle is being created. They then direct the process of untangling.

References

Abidin, R. R. *Parenting Stress Index: Professional Manual* (3rd ed.). Odessa, FL: Psychological Assessment Resources, 1995.

Achenbach, T. M. *Integrative Guide to the 1991 CBCL/4–18, YSR, and TRF Profiles.* Burlington: University of Vermont, 1991a.

Achenbach, T. M. *Manual for the Child Behavior Checklist/4–18 and 1991 Profile.* Burlington: University of Vermont, 1991b.

Achenbach, T. M., & Rescorla, L. A. *Manual for the ASEBA School-Age Forms & Profiles.* Burlington: University of Vermont, Research Center for Children, Youth, and Families, 2001.

Ainsworth, M.D.S. *Infancy in Uganda: Infant Care and the Growth of Attachment.* Baltimore, MD: Johns Hopkins Press, 1967.

Ainsworth, M.D.S., Blehar, M. C., Waters, E., and Wall, S. *Patterns of Attachment: A Psychological Study of the Strange Situation.* Hillsdale, NJ: Erlbaum, 1978.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Association, 2000.

Association for Play Therapy. "Paper on Touch: Clinical, Professional & Ethical Issues," 2009. Available from www.a4pt.org/download.cfm?ID=9971.

Association for Treatment and Training in the Attachment of Children. "ATTACh White Paper on Coercion in Treatment." April 2007. Available from www.attach.org/whitepaper.pdf.

Ayers, A. J. *Sensory Integration and Learning Disorders.* Los Angeles: Western Psychological Services, 1971.

Ayers, A. J. *Sensory Integration and the Child.* Los Angeles: Western Psychological Services, 1979.

Ayers, A. J., Robins, J., and McAfee, S. *Sensory Integration and the Child: Understanding Hidden Sensory Challenges* (25th Anniversary ed.). Los Angeles: Western Psychological Services, 2005.

Barnard, K. E., and Brazelton, T. B. *Touch: The Foundation of Experience.* Madison, CT: International Universities Press, 1990.

Baumrind, D. "The Influence of Parenting Style on Adolescent Competence and Substance Use." *Journal of Early Adolescence*, 1991, *11*(1), 56–95.

Beebe, B. "Brief Mother-Infant Treatment: Psychoanalytically Informed Video Feedback." *Infant Mental Health Journal*, 2003, *24*(1), 24–52.

Booth, P., Christensen, G., and Lindaman, S. *Marschak Interaction Method: A Structured Observational Technique to Assess the Quality and Nature of the Parent-Child Relationship (Pre-school and School Age)* (rev. ed.). Chicago: The Theraplay Institute, 2005.

Booth, P., and Koller, T. J. "Training Parents of Failure-to-Attach Children." In J. M. Briesmeister and C. E. Schaefer (eds.), *Handbook of Parent Training: Training Parents as Co-Therapists for Children's Behavior Problems* (2nd ed.). New York: Wiley, 1998.

Bostrom, J. "Fostering Attachment in Post-Institutionalized Adopted Children Using Group Theraplay." *The Theraplay Institute Newsletter*, Fall 1995, pp. 7–8.

Bowlby, J. *Attachment and Loss, Vol. 1: Attachment.* New York: Basic Books, 1969.

Bowlby, J. *Attachment and Loss, Vol. 2: Separation Anxiety and Anger.* London: Hogarth Press, 1973.

Bowlby, J. *A Secure Base: Parent-Child Attachment and Healthy Human Development.* New York: Basic Books, 1988.

Bradley, S. J. *Affect Regulation and the Development of Psychopathology.* New York: Guilford Press, 2003.

Brazelton, T. B. "Touch as a Touchstone: Summary of the Round Table." In K. E. Barnard and T. B. Brazelton (eds.), *Touch: The Foundation of Experience.* Madison, CT: International Universities Press, 1990.

Brazelton, T. B. *Touchpoints: Birth to Three.* New York: Perseus, 1992.

Brody, V. A. "Developmental Play: A Relationship-Focused Program for Children." *Journal of Child Welfare*, 1978, *57*(9), 591–599.

Brody, V. A. *The Dialogue of Touch: Developmental Play Therapy.* Treasure Island, FL: Developmental Play Training Associates, 1993.

Brodzinsky, D. M., Schecter, M. D., and Henig, R. M. *Being Adopted: The Lifelong Search for Self.* New York: Anchor Books, 1992.

Brown, S. *Play: How It Shapes the Brain, Opens the Imagination and Invigorates the Soul.* New York: Avery, 2009.

Bruner, J. "Vygotsky's Zone of Proximal Development: The Hidden Agenda." In B. Rogoff and J. Wertsch (eds.), *Children's Learning and the Zone of Proximal Development.* San Francisco: Jossey-Bass, 1984.

Bundy-Myrow, S. "Group Theraplay for Children with Autism and Pervasive Developmental Disorder." In E. Munns (ed.), *Theraplay Innovations in Attachment-Enhancing Play Therapy.* Northvale, NJ: Jason Aronson, 2000.

Bundy-Myrow, S. "Theraplay for Children with Self-Regulation Problems." In C. Schaefer, J. McCormick, and A. Ohnogi (eds.), *International Handbook of Play Therapy: Advances in Assessment, Theory, Research and Practice.* Northvale, NJ: Jason Aronson, 2005.

Busch, A. L., and Lieberman, A. F. "Attachment and Trauma: An Integrated Approach to Treating Young Children Exposed to Family Violence." In D. Oppenheim, and D. F. Goldsmith (eds.) *Attachment Theory in Clinical Work with Children.* New York: Guilford Press, 2007.

Cohen, P., and Beebe, B. "Video Feedback with a Depressed Mother and Her Infant: A Collaborative Individual Psychoanalytic and Mother-Infant Treatment." *Journal of Infant, Child and Adolescent Psychotherapy*, 2002, *2*(3), 1–55.

Coleman, R. "Integrating Theraplay with Multi-Modal Treatment for Children with Severe Autism Spectrum Disorders." Paper presented at the Fourth International Theraplay Conference, Chicago, July 2009.

Constantino, J. N., and Gruber, C. P. *Social Responsiveness Scale.* Los Angeles: Western Psychological Press, 2005.

Cook, A., Blaustein, M., Spinazzola, J., and van der Kolk, B. (eds.). *Complex Trauma in Children and Adolescents. White Paper from the National Child Traumatic Stress Network,* 2003. Available from www.nctsnet.org/nctsn_assets/pdfs/edu_materials/ComplexTrauma_All.pdf.

Cox, J. L., Holden, J. M., and Sagovsky, R. "Detection of Postnatal Depression: Development of the 10-Item Edinburgh Postnatal Depression Scale." *British Journal of Psychiatry*, 1987, *150*, 782–786.

DeGangi, G. *Pediatric Disorders of Regulation in Affect and Behavior: A Therapist's Guide to Assessment and Treatment.* New York: Academic Press, 2000.

DeGangi, G., Breinbauer, C., Roosevelt, J., Porges, S., and Greenspan, S. "Prediction of Childhood Problems at Three Years in Children Experiencing Disorders of Regulation During Infancy." *Infant Mental Health Journal*, 2000, *21*(3), 156–175.

DesLauriers, A. *The Experience of Reality in Childhood Schizophrenia.* Monograph Series on Schizophrenia, No. 6. New York: International Universities Press, 1962.

DesLauriers, A., and Carlson, C. F. *Your Child Is Asleep— Early Infantile Autism: Etiology, Treatment, and Parental Influences.* Homewood, IL: Dorsey Press, 1969.

Diego, M., Field, T., Hernandez-Rief, M., et al. "Aggressive Adolescents Benefit from Massage Therapy." *Adolescence*, 2002, *37*, 597–607.

Doepfner, M., Berner, W., Flechtner, H., Lehmkuhl, G., and Steinhausen H.-C. *Psychopathologisches Befund-System für Kinder und Jugendliche (CASCAP-D)* [German version of the Clinical Assessment Scale for Child and Adolescent Psychopathology (CASCAP)]. Göttingen: Hogrefe. Verlag für Psychologie, 1999.

Dozier, M. "Attachment-Based Treatment for Vulnerable Children." *Attachment and Human Development*, 2003, *5*(3), 253–257.

Dozier, M., Dozier, D., and Manni, M. "Attachment and Biobehavioral Catch-Up: The ABCs of Helping Infants in Foster Care Cope with Early Adversity." *Zero to Three*, April-May 2002, pp. 7–13.

Dunn, W. *The Sensory Profile Manual.* San Antonio, TX: The Psychological Corporation, 1999.

Fahlberg, V. I. *A Child's Journey Through Placement.* Indianapolis, IN: Perspectives Press, 1991.

Fanslow, C. A. "Touch and the Elderly." In K. E. Barnard and T. B. Brazelton (eds.), *Touch: The Foundation of Experience.* Madison, CT: International Universities Press, 1990.

Field, T. "Infant Gaze Aversion and Heart Rate During Face-to-Face Interactions." *Infant Behavior and Development*, 1981, *4*, 307–315.

Field, T. "Infant Massage Therapy." In T. Field (ed.), *Touch in Early Development.* Mahwah, NJ: Erlbaum, 1995.

Field, T., Quintino, O., Hernandez-Reif, M., and Koslovsky, G. "Adolescents with Attention Deficit Hyperactivity Disorder Benefit from Massage Therapy." *Adolescence*, 1998, *33*, 103–108.

Fisher S., and Kelly, V. "The Fear-Driven Brain: A Regulation Model for Attachment Disorders." Presented at the conference of the Association for the Training and Treatment of Attachment Disorders in Children (ATTACh), Providence, RI, 2007.

Fonagy, P., Gergely, G., Jurist, E. L., and Target, M. *Affect Regulation, Mentalization, and the Development of the Self.* New York: Other Press, 2002.

Franklin, J., Moore, E., Howard, A., Purvis, K., Cross, D., and Lindaman, S. "An Evaluation of Theraplay Using a Sample of Children Diagnosed with Pervasive Developmental Disorder (PDD) or Mild to Moderate Autism." Poster presentation at the American Psychological Association Conference, 2007.

Frost, L., and Bondy, A. *PECS Training Manual* (2nd ed.). Newark, DE: Pyramid Consultants, 2002.

George, C., Kaplan, N., and Main, M. *The Berkeley Adult Attachment Interview*. Unpublished protocol, University of California, Berkeley, 1985. Available from www.psychology.sunysb.edu/attachment/measures/content/aai_interview.pdf.

Gerhardt, S. *Why Love Matters: How Affection Shapes a Baby's Brain.* New York: Routledge, 2004.

Gilliam, J. E. *Gilliam Autism Rating Scale* (2nd ed.). Austin, TX: Pro-Ed., 2006.

Goldsmith, D. F. "Challenging Children's Negative Internal Working Models: Utilizing Attachment-Based Treatment Strategies in a Therapeutic Preschool." In D. Oppenheim and D. F. Goldsmith (eds.), *Attachment Theory in Clinical Work with Children.* New York: Guilford Press, 2007.

Goodyear-Brown, P. "Theraplay Approaches for Children with Autism Spectrum Disorders." In E. Munns (ed.), *Applications of Family and Group Theraplay.* New York: Jason Aronson, 2009.

Grabe, P. V. "The Therapy." In P. V. Grabe (ed.), *Adoption Resources for Mental Health Professionals.* New Brunswick, NJ: Transaction Publishers, 1990.

Grandin, T. *Thinking in Pictures and Other Reports from My Life with Autism.* New York: Vintage Books, 1995.

Grandin, T., and Scariano, M. *Emergence: Labeled Autistic.* Novato, CA: Arena, 1986.

Gray, D. D. *Attaching in Adoption: Practical Tools for Today's Parents.* Indianapolis, IN: Perspective Press, 2002.

Greenspan, S. I., and Wieder, S. "An Integrated Developmental Approach to Interventions for Young Children with Severe Difficulties in Relating and Communicating." *Zero to Three*, 1997, *17*(5), 5–18.

Greenspan, S. I., and Wieder, S. *Engaging Autism: Using the Floortime Approach to Help Children Relate, Communicate, and Think.* Cambridge, MA: Da Capo Press, 2006a.

Greenspan, S. I., and Wieder, S. *Infant and Early Childhood Mental Health: A Comprehensive Developmental Approach to Assessment and*

Intervention. Washington, DC: American Psychiatric Publishing, 2006b.

Grossmann, K. E., Grossmann, K., and Waters, E. *Attachment from Infancy to Adulthood: The Major Longitudinal Studies.* New York: Guilford Press, 2005.

Grotberg, E. H. "The International Resilience Project: Findings from the Research and the Effectiveness of Interventions." In B. Bain et al. (eds.), *Psychology and Education in the 21st Century: Proceedings of the 54th Annual Convention of the International Council of Psychologists.* Edmonton, AB: IC Press, 1997.

Harlow, H. F. "The Nature of Love." *American Psychologist*, 1958, *13*, 673–685.

Hart, S. *Brain, Attachment, Personality: An Introduction to Neuroaffective Development.* London: Karnac Books, 2008.

Hart, S., Field, T., Hernandez-Rief, M., et al. "Anorexia Symptoms Are Reduced by Massage Therapy." *Eating Disorders*, 2001, *9*, 289–299.

Hoffman, K. "Understanding Attachment: The Circle of Security Approach," Power Point Presentation, Chicago, 2008.

Hong, J. "Effects of Group Theraplay on Self-Esteem and Interpersonal Relations for Abused Children." Presentation at Sookmyung Women's University, Seoul, South Korea, 2004.

Hopkins-Best, M. *Toddler Adoption: The Weaver's Craft.* Indianapolis, IN: Perspectives Press, 1997.

Hughes, D. *Facilitating Developmental Attachment: The Road to Emotional Recovery and Behavioral Change in Foster and Adopted Children.* Northvale, NJ: Jason Aronson, 1997.

Hughes, D. *Building the Bonds of Attachment: Awakening Love in Deeply Troubled Children* (2nd ed.). New York: Jason Aronson, 2006.

Hughes, D. *Attachment-Focused Family Therapy.* New York: Norton, 2007.

Interdisciplinary Council on Developmental and Learning Disorders. *Diagnostic Manual for Infancy and Early Childhood* (ICDL-DMIC). Bethesda, MD: ICDL, 2005.

James, B. *Treating Traumatized Children: New Insights and Creative Interventions.* Lexington, MA: Lexington Books, 1989.

Jarratt, C. J. *Helping Children Cope with Separation and Loss.* Boston: The Harvard Common Press, 1994.

Jernberg, A. M. "Theraplay Technique." In C. E. Schaefer (ed.), *Therapeutic Use of Child's Play.* New York: Jason Aronson, 1976.

Jernberg, A. M. *Theraplay: A New Treatment Using Structured Play for Problem Children and Their Families.* San Francisco: Jossey-Bass, 1979.

Jernberg, A. M. "Theraplay: Child Therapy for Attachment Fostering." *Psychotherapy*, 1984, *21*(1), 39–47.

Jernberg, A. M. "Training Parents of Failure-to-Attach Children." In C. E. Schaefer and J. M. Briesmeister (eds.), *Handbook of Parent Training: Parents as Co-Therapists for Children's Behaviour Problems.* New York: Wiley, 1989.

Jernberg, A. M. "Attachment Enhancing for Adopted Children." In P. V. Grabe (ed.), *Adoption Resources for Mental Health Professionals.* New Brunswick, NJ: Transaction Publishers, 1990.

Jernberg, A. M., Hurst, T., and Lyman, C. *Here I Am.*16mm film. Wilmette: The Theraplay Institute, 1969.

Jernberg, A. M., Hurst, T., and Lyman, C. *There He Goes.* 16mm film. Wilmette: The Theraplay Institute, 1975.

Keck, G. C., and Kupecky, R. M. *Adopting the Hurt Child: Hope for Families with Special-Needs Kids. A Guide for Parents and Professionals.* Colorado Springs, CO: Pinion Press, 1995.

Klaus, M. H., Kennell, J. H., Plumb, N., and Zuehlke, S. "Human Maternal Behavior at the First Contact with Her Young." *Pediatrics*, 1970, *46*, 187–192.

Klin, A., Lin, D. J., Gorrindo, P., Ramsay, G., and Jones, W. "Two-Year-Olds with Autism Orient to Non-Social Contingencies Rather Than Biological Motion." *Nature* online publication, March 29, 2009. www.nature.com/nature/journal/v459/n7244/full/nature07868.html.

Kohut, H. *The Analysis of the Self.* New York: International Universities Press, 1971.

Kohut, H. *The Restoration of the Self.* New York: International Universities Press, 1977.

Kohut, H. *How Does Analysis Cure?* A. Goldberg (ed.). Chicago: University of Chicago Press, 1984.

Koller, T. J. "Older Child Adoptions: A New Developmental Intervention Program." Paper presented at the Annual Meeting of the American Psychological Association, Los Angeles, 1981.

Koller, T. J. "Adolescent Theraplay." In K. J. O'Connor and C. E. Schaefer (eds.), *Handbook of Play Therapy, Vol. 2: Advances and Innovations.* New York: Wiley, 1994.

Kupperman, P., Bligh, S., and Goodban, M. "Activating Articulation Skills Through Theraplay." *Journal of Speech and Hearing Disorders*, 1980, *45*, 540–548.

Kranowitz, C. S. *The Out-of-Sync Child.* New York: Berkley Publishing Group, 1998.

Kranowitz, C. S. *The Out-of-Sync Child Has Fun.* New York: Berkley Publishing Group, 2003.

Kwon, E. "The Effect of Group Theraplay on the Development of Preschoolers' Emotional Intelligence Quotient." Presentation at Sookmyung Women's University, Seoul, South Korea, 2004.

Laakso, M. "Parent Session in Theraplay: A Way to Consolidate Therapeutic Alliance and Joint Focus." In E. Munns (ed.), *Applications of Family and Group Theraplay.* New York: Jason Aronson, 2009.

Lacher, D. B., Nichols, T., and May, J. C. *Connecting with Kids Through Stories: Using Narratives to Facilitate Attachment in Adopted Children.* London: Jessica Kingsley, 2005.

LeDoux, J. *The Emotional Brain: The Mysterious Underpinnings of Emotional Life.* New York: Simon & Schuster, 1998.

Lender, D. "What's Behind These Theraplay Activities: A Window into Attachment." *The Theraplay Institute Newsletter*, Summer 2006.

Leslie, E., and Mignon, N. "Group Theraplay for Parents in a Public Housing Program." *The Theraplay Institute Newsletter*, Fall 1995, pp. 6–7.

Lovaas, O. I. *The Autistic Child: Language Development Through Behavior Modification.* New York: Irvington/Halsted/Wiley, 1977.

Mahan, M. G. "Theraplay as an Intervention with Previously Institutionalized Twins Having Attachment Difficulties." Unpublished doctoral dissertation, the Chicago School of Professional Psychology, 1999.

Main, M. "Parental Aversion to Infant-Initiated Contact Is Correlated with the Parent's Own Rejection During Childhood: The Effects of Experience on Signals of Security with Respect to Attachment." In K. E. Barnard and T. B. Brazelton (eds.), *Touch: the Foundation of Experience.* Madison, CT: International Universities Press, 1990.

Main, M., and Goldwin, R. "Predicting Rejection of Her Infant from Mother's Representation of Her Own Experience: Implications for the Abused-Abusing Intergenerational Cycle." *Journal of Child Abuse and Neglect*, 1984, *8*(2), 203–217.

Main, M., and Hesse, E. "Parents' Unresolved Traumatic Experiences Are Related to Infant Disorganized Attachment Status: Is Frightened and/or Frightening Parental Behavior the Linking Mechanism?" In M. T. Greenberg, D. Cicchetti, and E. M. Cummings (eds.), *Attachment in the Preschool Years: Theory, Research, and Intervention.* Chicago: University of Chicago Press, 1990.

Main, M., and Hesse, E. "Lack of Resolution in Mourning in Adulthood and Its Relationship to Infant Disorganization: Some Speculations Regarding the Causal Mechanisms." In M. T. Greenberg, D. Cicchetti, and E. M. Cummings (eds.), *Attachment in the Preschool Years: Theory, Research, and Intervention.* Chicago: University of Chicago Press, 1990.

Mäkelä, J. "What Makes Theraplay Effective: Insights From Developmental Sciences." *The Theraplay Institute Newsletter*, Fall-Winter 2003.

Mäkelä, J. "Kosketuksen merkitys lapsen kehityksessä" (The Importance of Touch in the Development of Children). *Finnish Medical Journal*, 2005, *60*,1543–1549. English summary available from The Theraplay Institute. www.laakarilehti.fi/e/summary.html?opcode=show/news_id=2668/news_db=web_lehti2006/type=4.

Mäkelä, J., Salo, S., and Lassenius-Panula. L. "The Effectiveness of Theraplay— Finnish Study." Research Plan, 2006.

Mäkelä, J., and Vierikko, I. *From Heart to Heart: Interactive Therapy for Children in Care. Report on the Theraplay Project in SOS Children's Villages in Finland 2001–2004.* Published by the SOS Children's Village, Finland, 2004.

Marschak, M. "A Method for Evaluating Child-Parent Interaction Under Controlled Conditions." *Journal of Genetic Psychology*, 1960, *97*, 3–22.

Marschak, M. "Imitation and Participation in Normal and Disturbed Young Boys in Interaction with Their Parents." *Journal of Clinical Psychology*, 1967, *23*(4), 421–427.

Marschak, M., and Call, J. "Observing the Disturbed Child and His Parents: Class Demonstrations for Medical Students." *Journal of the American Academy of Child Psychiatry*, 1966, *5*, 686–692.

Martin, E. *Baby Games.* Philadelphia: Running Press, 1998.

Maurice, C. (ed.). *Behavioral Intervention for Young Children with Autism.* Austin, TX: Pro-Ed, 1996.

Meyer, L. A., and Wardrop, J. L. "Research on Theraplay." Paper presented at the Second International Conference on Theraplay, Chicago, 2005.

Montagu, A. *Touching: The Human Significance of the Skin.* New York: Columbia University Press, 1971.

Morgan, C. E. "Theraplay: An Evaluation of the Effect of Short-Term Structured Play on Self-Confidence, Self-Esteem, Trust, and Self-Control." Unpublished manuscript: The York Centre for Children, Youth, and Families; Ontario, Canada, 1989.

Morin, V. *Fun to Grow On.* Chicago: Magnolia Street Publications, 1999.

Moses, K. "The Impact of Childhood Disability: The Parent's Struggle." *Ways*, 1987, pp. 7–10.

Muratori, F. "Early Indicators of Autism Spectrum Disorders." *Zero to Three*, 2008, *28*(4), 18–24.

Myrow, D. L. "In Touch with Theraplay." *The Theraplay Institute Newsletter*, Fall 1997, *9*, 1–4.

Neisworth, J. T., Bagnato, S. J., Salvia, J., and Hunt, F. *Temperament and Atypical Behavior Scale: Early Childhood Indicators of Developmental Dysfunction.* Baltimore, MD: Brookes, 1999.

Oppenheim, D., Dolev, S., Koren-Karie, N., Sher-Censor, E., Yirmiya, N., and Salomon, S. "Parental Resolution of the Child's Diagnosis and the Parent-Child Relationship." In D. Oppenheim and D. F. Goldsmith (eds.), *Attachment Theory in Clinical Work with Children.* New York: Guilford Press, 2007.

Oppenheim, D., and Goldsmith, D. F. (eds.). *Attachment Theory in Clinical Work with Children.* New York: Guilford Press, 2007.

Oppenheim, D., Koren-Karie, N., Dolev, S., and Yirmiya, N. "Secure Attachment in Children with Autism Spectrum Disorder: The Role of Maternal Insightfulness." *Zero to Three*, 2008, *28*(4), 25–39.

Orlick, T. *The Cooperative Sports and Games Book.* New York: Pantheon Books, 1978.

Orlick, T. *The Second Cooperative Sports and Games Book.* New York: Pantheon Books, 1982.

Panksepp, J. "Can Play Diminish ADHD and Facilitate the Construction of the Social Brain?" *Journal Academy of Child and Adolescent Psychiatry*, 2007, *16*(2), 5–14.

Parker-Pope, T. "Recess Found to Improve Behavior." *New York Times*, Feb. 3, 2009, p. D6.

Perry, B. D. *The Effects of Traumatic Events on Children: Material for Parents.* CIVITAS Child Trauma Programs, Department of Psychiatry and Behavioral Science, Baylor College of Medicine, Houston, TX, 1994. Available from www.bcm.tmc.edu/civitas/publica/effect.html.

Perry, B. D. "Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children: The Neurosequential Model of Therapeutics." In N. B. Webb (ed.), *Working with Traumatized Youth in Child Welfare.* New York: Guilford Press, 2006.

Perry, B. D., and Szalavitz, M. *The Boy Who Was Raised as a Dog and Other Stories from a Child Psychiatrist's Notebook: What Traumatized Children Can Teach Us About Loss, Love, and Healing.* New York: Basic Books, 2007.

Porges, S. W. "The Infant's Sixth Sense: Awareness and Regulation of Bodily Processes." *Zero to Three*, 1993, *14*(2), 12–16.

Powell, B., Cooper, G., Hoffman, K., and Marvin, R. "The Circle of Security Project: A Case Study— 'It Hurts to Give That Which You Did Not Receive.' " In D. Oppenheim and D. F. Goldsmith (eds.). *Attachment Theory in Clinical Work with Children.* New York: Guilford Press, 2007.

Prizant, B., and Wetherby, A. "Enhancing Communication: From Theory to Practice." In G. Dawson (ed.), *Autism: New Perspectives on Diagnosis, Nature, and Treatment.* New York: Guilford Press, 1989.

Randolph, E. *Randolph Attachment Disorder Questionnaire*. Evergreen, CO: The Attachment Center Press, 1999.

Reynolds, C. R., and Kamphaus, R. W. *Behavior Assessment System for Children* (2nd ed.) (BASC-2). Bloomington, MN: Pearson Assessments, 2004.

Reitz, M., and Watson, K. W. *Adoption and the Family System.* New York: Guilford Press, 1992.

Rubin, P., Lender, D., and Mroz Miller, J. "Theraplay and Dyadic Developmental Psychotherapy." In E. Munns (ed.), *Applications of Family and Group Theraplay.* Lanham, MD: Jason Aronson, 2009.

Rubin, P., and Tregay, J. *Play with Them— Theraplay Groups in the Classroom: A Technique for Professionals Who Work with Children.* Springfield, IL: Charles C. Thomas, 1989.

Schieffer, K. *Sunshine Circles Manual*. Wilmette, IL: The Theraplay Institute, 2009.

Schore, A. N. *Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development*. Hillside, NJ: Erlbaum, 1994.

Schore, A. N. "Attachment and the Regulation of the Right Brain." *Attachment and Human Development*, 2000, *2*(1), 23–47.

Schore, A. N. "Effects of a Secure Attachment Relationship on Right Brain Development, Affect Regulation and Infant Mental Health." *Infant Mental Health Journal*, 2001a, *22*(1–2), 7–66.

Schore, A. N. "The Effects of Early Relational Trauma on Right Brain Development, Affect Regulation, and Infant Mental Health." *Infant Mental Health Journal*, 2001b, *22*(1–2), 201–269.

Schore, A. N. "Attachment, Affect Regulation, and the Developing Right Brain: Linking Developmental Neuroscience to Pediatrics. *Pediatrics in Review*, 2005, *26*, 204–217.

Schore, J. R., and Schore, A. N. "Modern Attachment Theory: The Central Role of Affect Regulation in Development and Treatment." *Clinical Social Work Journal*, 2008, *36*, 9–20.

Searcy, K. L., Stahmer, A., and Cary, C. "Empowering Parents of Children with Developmental Disabilities." Presented at the California Speech, Language, and Hearing Association Conference, Monterey, CA, March 2008.

Shahmoon-Shanok, R. "Giving Back Future's Promise: Working Resourcefully with Parents of Children Who Have Severe Disorders of Relating and Communicating." *Zero to Three*, 1997, *17*(5), 37–48.

Shapiro, F. *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures.* New York: Guilford Press, 1995.

Siegel, D. J. *The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are.* New York: Guilford Press, 2001.

Siegel, D. J. "An Interpersonal Neurobiology Approach to Psychotherapy." *Psychiatric Annals*, 2006, *36*(4), 248–256.

Siegel, D. J., and Hartzell, M. *Parenting from the Inside Out.* New York: Jeremy P. Tarcher/Putnam, 2003.

Siu, A. "Theraplay for Elementary School Children with Internalizing Problems: The Hong Kong Experience." Poster presentation at the International Theraplay Conference, 2007.

Siu, A. "Group Theraplay for Preschool Children with Autism in Hong Kong." Submitted for publication in *The Theraplay Institute Newsletter*, 2009a.

Siu, A. "Theraplay in the Chinese World: An Intervention Program for Hong Kong Children with Internalizing Problems." *International Journal of Play Therapy*, 2009b, *18*(1), 1–12.

Slade, A. "Keeping the Baby in Mind: A Critical Factor in Perinatal Mental Health." *Zero to Three*, 2002, *22*(6), 10–16.

Slade, A., Belsky, J., Aber, J., and Phelps, J. "Maternal Representations of Their Relationship with Their Toddlers: Links to Adult Attachment

and Observed Mothering." *Developmental Psychology*, 1999, *35*, 611–619.

Spickelmier, M., and Gardner, B. "Theraplay with Adolescents." *The Theraplay Institute Newsletter*, Winter 2008.

Spitz, R. A. "Hospitalism: An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood." *Psychoanalytic Study of the Child*, 1945, *1*, 53–74.

Spitz, R. A. *Grief: A Peril in Infancy.* 1947. Film. Available from Penn State Audiovisual Services, University Park, PA.

Spitz, R. A. "The Effect of Personality Disturbances in the Mother on the Well-Being of Her Infant." In J. E. Anthony and T. Benedek (eds.), *Parenthood.* Boston: Little, Brown, 1970.

Sroufe, L. A. "A Developmental Perspective on Day Care." *Early Research Quarterly*, 1988, *3*, 283–291.

Sroufe, L. A., Egeland, B., Carlson, E., and Collins, W. A. "Placing Early Attachment Experiences in Developmental Context: The Minnesota Longitudinal Study." In K. E. Grossmann, K. Grossmann, and Waters, E. (eds.), *Attachment from Infancy to Adulthood: The Major Longitudinal Studies.* New York: Guilford Press, 2005.

Stern, D. N. "The Goal and Structure of Mother-Infant Play." *Journal of the American Academy of Child Psychiatry*, 1974, *13*(3), 402–421.

Stern, D. N. *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology.* New York: Basic Books, 1985.

Stern, D. N. *The Motherhood Constellation: A Unified View of Parent-Infant Psychotherapy*. New York: Basic Books, 1995.

Stern, D. N. Plenary Lecture at the Sixth World Congress on Infant Mental Health, Tampere, Finland, 1996.

Strauss, P. "Theraplay & EMDR: Integrating Trauma Work and Child's Play." *The Theraplay Institute Newsletter*, Winter 2009.

Sunderland, M. *The Science of Parenting: Practical Guidance on Sleep, Crying, Play, and Building Emotional Well-Being for Life.* New York: Dorling Kindersley, 2006.

Talen, M. R., and Warfield, J. R. "Guidelines for Family Wellness Checkups in Primary Health Care Services." In L. VandeCreek, S. Knapp, and T. L. Jackson (eds.), *Innovations in Clinical Practice: A Source Book*, Vol. 15. Sarasota, FL: Professional Resource Exchange, 1997.

Thomas, A., and Chess, S. *Temperament and Development.* New York: Brunner/Mazel, 1977.

Trevarthen, C. "Development of Early Social Interactions and the Affective Regulation of Brain Growth." In C. von Euler, H. Fossberg, and H. Lagercrantz (eds.), *Neurobiology of Early Infant Behaviour. Wenner-Gren Center International Symposium Series, Vol. 55*. New York: Stockton Press, 1989.

Trevarthen, C., and Aitken, K. J. "Infant Intersubjectivity: Research, Theory, and Clinical Applications." *Journal of Child Psychology and Psychiatry*, 2001, *42*(1), 3–48.

Tronick, E. Z. "Touch in Mother-Infant Interaction." In T. Field (ed.), *Touch in Early Development.* Mahwah, NJ: Erlbaum, 1995.

Tronick, E. Z., Bruschweiler-Stern, N., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Nahum, J. P., Sandre, L., and Stern, D. N. "Dyadically Expanded States of Consciousness and the Process of Therapeutic Change." *Infant Mental Health Journal*, 1998, *19*(3), 290–299.

Tronick, E. Z., Ricks, M., and Cohn, J. F. "Maternal and Infant Affective Exchange: Patterns of Adaptation." In T. Field and A. Fogel (eds.), *Emotion and Early Interaction.* Hillsdale, NJ: Erlbaum, 1982.

van der Kolk, B. "Developmental Trauma Disorder: Towards a Rational Diagnosis for Children with Complex Trauma Histories." *Psychiatric Annals*, 2005, pp. 401–408.

van der Kolk, B., and Saporta, J. "The Biological Response to Psychic Trauma: Mechanisms and Treatment of Intrusion and Numbing." *Anxiety Research*, 1991, *4*, 199–212.

Weber, P. "Theraplay Groups for Adolescents with Emotional Problems." *The Theraplay Institute Newsletter*, Summer 1998.

Weininger, O. *Time-in Parenting.* Toronto, Ontario, Canada: Rinascente Books, 2002.

Weiss, S. J. "Parental Touching: Correlates of a Child's Body Concept and Body Sentiment." In K. E. Barnard and T. B. Brazelton (eds.), *Touch: the Foundation of Experience.* Madison, CT: International Universities Press, 1990.

Weitzman, E. "The Hanen Program for Early Childhood Educators: Inservice Training for Child Care Providers on How to Facilitate Children's Social, Language, and Literacy Development." *Infant-Toddler Intervention: The Transdisciplinary Journal*, 1994, *4*(3), 173–202.

Wettig, H. *Die Wirkung von Theraplay auf Klein und Vorschulkinder mit klinisch bedeutsamen Verhaltensstoerungen, Aufmerksamkeitsdefiziten mit und ohne Hyperaktivitaet und mit rezeptiven Sprachstoerungen.* ("The Effectiveness of Theraplay for Toddler and Preschool

Children Diagnosed with Clinically Significant Conduct Disorders, Attention Deficit Disorders with or Without Hyperactivity, ADHD or ADD, and Receptive Language Disorders"). Doctoral dissertation. University of Heidelberg, Germany, 2007.

Wettig, H., and Franke, U. "Evaluation of the Effectiveness of Theraplay in Germany: Two Empirical Studies with Repeated Measurements Carried Out in Actual Therapy Situations." PowerPoint Presentation in Theraplay Institute Archives: Chicago, 2004.

Williams, D. *Autism— An Inside-Out Approach: An Innovative Look at the Mechanics of "Autism" and Its Developmental "Cousins."* Bristol, PA: Kingsley, 1988.

Williams, D. *Nobody, Nowhere: The Extraordinary Autobiography of an Autistic.* New York: Random House, 1993.

Williams, D. L. "What Neuroscience Has Taught Us About Autism." *Zero to Three*, 2008, *28*(4), 11–17.

Williamson, G. G., and Anzalone, M. "Sensory Integration: A Key Component of the Evaluation and Treatment of Young Children with Severe Difficulties in Relating and Communicating." *Zero to Three*, 1997, *17*(5), 29–36.

Wilson-Gamble, S. "Approaching Significance: International Conference Signs of Autism in Infants: Recognition and Early Intervention." *ILAIMH News*, Summer 2006, pp. 4–5.

Winnicott, D. W. *Collected Papers: Through Paediatrics to Psychoanalysis*. London: Tavistock, 1958.

Winnicott, D. W. *The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development.* London: Hogarth Press, 1965.

Winnicott, D. W. *Playing and Reality*. London: Tavistock, 1971.

Winnicott, D. W. *Babies and Their Mothers.* New York: Addison-Wesley, 1987.

Wylie, M. S. "The Limits of Talk: Bessel van der Kolk Wants to Transform the Treatment of Trauma." *Psychotherapy Networker*, January–February 2004. Available at www.psychotherapynetworker.org/jf04.htm.

Zeanah, C. H., and Benoit, D. "Clinical Applications of a Parent Perception Interview in Infant Mental Health." *Child and Adolescent Psychiatric Clinics of North America*, 1995, *4*, 539–554.

Zero to Three. *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.* (rev. ed.). Washington, DC: Zero to Three, 2005.

Publications About Theraplay and the Marschak Interaction Method (MIM)

The following is a comprehensive list of publications about Theraplay and the MIM that were available at the time of printing.

Adamitis, C. "Theraplay with the Elderly: A Case Study." *The Theraplay Institute Newsletter*, Spring 1982, pp. 1–3.

Adamitis, C. "Theraplay with an Older Adult: Marge." *The Theraplay Institute Newsletter*, Winter 1985–86, pp. 2–4.

Adamson, W. C. "Theraplay: A New Treatment Using Structured Play for Problem Children and Their Families" [Book review]. *Journal of Marital and Family Therapy*, 1981, *7*(3), 406–407.

Allert, A. "Temperament and Early Parent-Child Interactions: Changes from Infancy to Toddlerhood." Unpublished doctoral dissertation, Illinois Institute of Technology, 1982.

Ammen, S., and York, L. "The Many Measures of Attachment." Unpublished manuscript, California School for Professional Psychology-Fresno, 1994.

Asikainen, V. "Vuorovaikutusleikkiryhmä osana perheiden päihdekuntoutusta Tervalammen kartanon perheyhteisössä" (Interaction Group Involved in Rehabilitation with Families with Alcohol Problems in Tervalampi Manor House). Unpublished competence study, Diaconia Polytechnic/Helsinki Unit, Finland, 2007.

Atkinson, N. J. "Theraplay Used in a Multi-Cultural Environment." In E. Munns (ed.), *Applications of Family and Group Theraplay.* New York: Jason Aronson, 2009.

Azoulay, D., Ali, J., Lawrence, H., and Munns, E. "Strengthening the Bond Between a Mother and Her Child: A Case Study of Family Therapy." *Playground*, Spring 1994, pp. 5–11.

Backman, T. L. "Examining Parent-Child Relationships in Forensic Attachment Assessments: A Construct Validity Investigation of the Marschak Interaction Method Rating System." Unpublished doctoral dissertation, Alliant International University, Fresno, 2002.

Baur-Grove, G. "Erklären- Begreifen. Einsichten in Wissensvermittlung bei Vorschulkindern durch die H-MIM" (Explaining-Understanding: How Parents Teach Their Preschool Children. Research Using the H-MIM). *Schwierige Kinder-verstehen und helfen*, 2004, *32*, 4–7.

Bekker, Y. C. "Family Theraplay for Toddlers: An Educational Psychological Perspective." Unpublished masters thesis, University of Pretoria, South Africa, 1993.

Bennett, L. R., Shiner, S. K., and Ryan, S. "Using Theraplay in Shelter Settings with Mothers and Children Who Have Experienced Violence in the Home." *Journal of Psychosocial Nursing & Mental Health Service*, 2006, *44*(10), 38–47.

Bernt, C. "Theraplay as Intervention for Failure-to-Thrive Infants and Their Parents." Unpublished doctoral dissertation, Chicago School of Professional Psychology, 1990.

Bernt, C. "Theraplay with Failure-to-Thrive Children and Their Mothers." *The Theraplay Institute Newsletter*, Fall 1992, pp. 1–3.

Black, M., Freeman, B. J., Montgomery, J. "Systematic Observation of Play Behavior in Autistic Children." *Journal of Autism and Childhood Schizophrenia*, 1975, *5*(4), 363–371.

Bligh, S. B. "Theraplay: Facilitating Communication in Language-Delayed Children." In J. Andrews and M. Burns (eds.), *Selected Papers in Language and Phonology, Vol. 2: Language Remediation*. Evanston, Ill.: Institute for Continuing Education, 1977.

Blunden, C. "An Attachment Programme for Related, Single-Parent Foster Mothers and Foster Children." Unpublished doctoral dissertation, University of Pretoria, South Africa, 2005.

Bojanowski, J. J. "Discriminating Between Pre- Versus Post-Theraplay Treatment Marschak Interaction Methods Using the Marschak Interaction Method Rating System." Unpublished doctoral dissertation, Alliant International University, Fresno, 2005.

Booth, P. "Forming an Attachment with an Adopted Toddler Using the Theraplay Approach." *The Signal: The Newsletter of the World Association for Infant Mental Health*, 2000, *8*(3), 1–19.

Booth, P. "Theraplay—und wie es begann. Teil 1" (Theraplay—How It Began. Part 1). *Schwierige Kinder—verstehen und helfen*, 2003, *31*, 25–29.

Booth, P. "Theraplay—und wie es begann. Teil 2" (Theraplay—How It Began. Part 2). *Schwierige Kinder-verstehen und helfen*, 2004, *32*, 23–27.

Booth, P. "Die derzeit besten Theraplay Techniken" (Current Best Theraplay Practice). *Schwierige Kinder-verstehen und helfen*, 2007, *43*, 18–23.

Booth, P., Christensen, G., and Lindaman, S. *Marschak Interaction Method: A Structured Observational Technique to Assess the Quality and Nature of the Parent-Child Relationship (Preschool and School Age)* (rev. ed.). Chicago: The Theraplay Institute, 2005.

Booth, P., and Koller, T. J. "Training Parents of Failure-to-Attach Children." In J. M. Briesmeister and C. E. Schaefer (eds.), *Handbook of Parent Training: Parents as Co-Therapists for Children's Behavior Problems* (2nd ed.). New York: Wiley, 1998.

Booth, P., and Lindaman, S. "Theraplay for Enhancing Attachment in Adopted Children." In H. G. Kaduson and C. E. Schaefer (eds.), *Short-Term Play Therapy for Children*. New York: Guilford Press, 2000a.

Booth, P., and Lindaman, S. "The Theraplay Model: Forming an Attachment with a Toddler Adopted from an Institution." Paper presented at the Seventh Congress of the World Association for Infant Mental Health. *Infant Mental Health Journal*, 2000b, *21*(4–5), 179.

Booth, P., and O'Hara, D. "Using Theraplay to Interrupt a Three-Generation Pattern of Inadequate Parenting." In C. W. LeCroy and J. Daley (eds.), *Case Studies in Child, Adolescent, and Family Treatment*. Belmont, CA: Thomson/Brooks/Cole, 2005.

Bostrom, J. "A Preschool Curriculum Based on Theraplay." *The Theraplay Institute Newsletter*, Fall 1995a, pp. 3–4.

Bostrom, J. "Fostering Attachment in Post-Institutionalized Adopted Children Using Group Theraplay." *The Theraplay Institute Newsletter*, Fall 1995b, pp. 7–8.

Bouwman, M. M. "Theraplay with the Hyperkinetic Child" [Afrikaans Text]. Unpublished master's thesis, University of Pretoria, South Africa, 1984.

Bovingdon, T., and Fabian, K. "Relinquishment Visits: Saying Goodbye Is an Unnatural Process." In E. Munns (ed.), *Applications of Family and Group Theraplay*. New York: Jason Aronson, 2009.

Brand, H. "Die Bindungstheorie in ihrer möglichen Bedeutung für Theraplay" (Attachment Theory and Its Possible Meaning for Theraplay). *Schwierige Kinder-verstehen und helfen*, 2000, *20*, 14–17.

Brand, H. "Theraplay with Adults." *The Theraplay Institute Newsletter*, Spring 2004.

Brand, H., and Franke, U. "Tim auf der Suche nach sich selbst. Ein Pflegekind bei Theraplay" (Tim in Search of Himself: A Foster Child in Theraplay). *Schwierige Kinder-verstehen und helfen*, 2005, *35*, 24–30.

Brennan, C. "Theraplay in a Residential Setting." *The Theraplay Institute Newsletter*, Summer 1998.

Bressler, C. "Theraplay und die taktil-kinästhetische Stimulation nach Kesper" (Theraplay and Tactile-Kinesthetic Stimulation According to Kesper). *Schwierige Kinder-verstehen und helfen*, 2008, *44*, 22–23.

Breuer, J., and Munns, E. "Theraplay with a Toddler and His Parents." *Playground*, Spring 1994, pp. 7–8.

Briegel, W., Wettig, H., and Franke, U. "Evaluation der Wirkung von Theraplay bei Klein- und Vorschulkindern mit rezeptiver Sprachstoerung und komorbider Stoerung des Interaktionsverhaltens - eine erste Laengsschnittstudie" (Evaluation of the Effectiveness of Theraplay with Toddler and Preschool Children Suffering from Receptive Language Disorders in Comorbidity with Social Interaction Disorder—A First Longitudinal Study). Poster presented to the 29th Congress of the German Society of Child and Adolescent Psychiatry, Psychosomatic Medicine, and Psychotherapy, Heidelberg, 2005.

Brooke, S. L. "Critical Review of Play Therapy Assessments." *International Journal of Play Therapy*, 2004, *13*, 119–142.

Buckwalter, K. "Warum Theraplay wirksam ist" (Why Theraplay Is Effective). *Schwierige Kinder-verstehen und helfen*, 2003, *30*, 13–14.

Buckwalter, K. D., and Finlay, A. L. "Theraplay: The Powerful Catalyst in Residential Treatment." In E. Munns (ed.), *Applications of Family and Group Theraplay*. New York: Jason Aronson, 2009.

Bundy-Myrow, S. "Group Theraplay for Children with PDD." *The Theraplay Institute Newsletter*, Spring 1994, p. 9.

Bundy-Myrow, S., and Lindaman, S. L. "Theraplay for Children with Autistic Spectrum Disorders." *The Theraplay Institute Newsletter*, Winter 1999/2000.

Bundy-Myrow, S. "Group Theraplay for Children with Autism and Pervasive Developmental Disorder." In E. Munns (ed.), *Theraplay: Innovations in Attachment-Enhancing Play Therapy*. Northvale, NJ: Jason Aronson, 2000.

Bundy-Myrow, S. "Theraplay for Children with Self-Regulation Problems." In C. E. Schaefer, J. McCormick, and A. Ohnogi (eds.), *International Handbook of Play Therapy: Advances in Assessment, Theory, Research, and Practice*. Northvale, NJ: Jason Aronson, 2005.

Bundy-Myrow, S., and Booth, P. B. "Theraplay: Supporting Attachment Relationships." In K. J. O'Connor and L. D. Braverman (eds.), *Play Therapy Theory and Practice: Comparing Theories and Techniques* (2nd ed.). New York: Wiley, 2009.

Bunge, D. M. "An Analytical Exposition of the Interactional Dynamics Occurring Between Parents and Their Learning Disabled Child, Utilising the M.I.M." Unpublished master's thesis, University of Pretoria, South Africa, 1991.

Burger, U. "Daniel hat sein eigenes Tempo: Theraplay bei einem entwicklungsverzögerten Kind" (Daniel Has His Own Tempo: Theraplay with a Developmentally Delayed Child). *Theraplay Journal*, 1997, *14*, 14–20.

Call, J., and Marschak, M. "Styles and Games in Infancy." *Journal of the American Academy of Child Psychiatry*, 1966, *5*(2), 193–210.

Chaloner, C. M. "600 Theraplay Groups in Head Start Classrooms." *The Theraplay Institute Newsletter*, Winter 2006.

Chaloner, W. B. "One Therapist's Journey as a Head Start Mental Health Consultant Integrating Child-Centered with Sensory/Theraplay-Based Approaches to Play Therapy with At-Risk Children." *The Theraplay Institute Newsletter*, Fall 2006.

Chambers, C. L. "Group Theraplay with Children Impacted by HIV." *The Theraplay Institute Newsletter*, Fall 1995, pp. 5–6.

Clark, P. A. "The Theraplay Preschool Assessment and Treatment Manual: Preparing Mental Health Professionals to Use Structured Play to Remediate Experience-Derived Relationship Disturbances in Three- to Five-Year-Old Children and Their Caregivers." Unpublished doctoral dissertation, Adler School of Professional Psychology, 1997.

Coetzee, A. M. "'Theraplay' Founded Within the Orthopedagogical Context" [Afrikaans text]. Unpublished master's thesis, University of Pretoria, South Africa, 1987.

Copar, C. J. "Die Behandlung eines autistischen Kindes mit Theraplay" (Theraplay Treatment of an Autistic Child). *Schwierige Kinder-verstehen und helfen*, 2008, *46*, 4–10.

Crume, J. "Theraplay: Skills for the Timid Adoptive Parent to Deal with Her Very Active Three-Year-Old." *The Theraplay Institute Newsletter*, Fall 1996, pp. 2–4.

Curtis, J. "Children Exposed to Parental Violence: Group Work and Individual Therapy." Unpublished master's thesis, University of Manitoba, Canada, 2005.

De Wet, W. "Theraplay with the Deaf Child." Unpublished doctoral dissertation, University of Pretoria, South Africa, 1993.

DesLauriers, A. "Play, Symbols, and the Development of Language." In M. Rutter and E. Schopler (eds.), *Autism*. New York: Plenum, 1978.

DiPasquale, L. "The Dysregulated Child in Theraplay." In E. Munns (ed.), *Applications of Family and Group Theraplay*. New York: Jason Aronson, 2009.

Doel, M. *Experiencing Social Work: Learning from Service Users*. Los Angeles: Sage, 2008.

Drewes, A. "Asiatische Familien bei Theraplay: Kulturelle Unterschiede verstehen" (Using Theraplay with Asian Families: Understanding Cultural Differences). *Schwierige Kinder-verstehen und helfen*, 2006, *39*, 17–19.

Dunn, N. "The Usability of Theraplay as a Technique for Therapy with Children with Enuresis" [Afrikaans Text]. Unpublished master's thesis, University of Pretoria, South Africa, 1987.

Eddins-Folensbee, F. F. "Theraplay: Innovations in Attachment-Enhancing Play Therapy" [Book review]. *Journal of the American Academy of Child and Adolescent Psychiatry*, 2001, *40*(8), 984–986.

Edinborough, H. I. "The Use of Theraplay to Improve the Mother and Child Relationship: A Family Group Intervention." Unpublished master's thesis, University of Manitoba, Canada, 2005.

Eloff, I., and Moen, M. "An Analysis of Mother-Child Interaction Patterns in Prison." *Early Child Development and Care*, 2003, *173*(6), 711–720.

Erasmus, S. H. "Theraplay with Pre-School Deaf Children Exhibiting Separation Anxiety" [Afrikaans Text]. Unpublished master's thesis, University of Pretoria, South Africa, 1984.

Erickson, M. T. "Review of Play with Them—Theraplay Groups in the Classroom: A Technique for Professionals Who Work with Children" [Book Review]. *PsycCRITIQUES*, 1990, *35*(12), 1174.

Eyles, S., Boada, M., and Munns, C. "Theraplay with Overtly and Passively Resistant Children." In E. Munns (ed.), *Applications of Family and Group Theraplay.* New York: Jason Aronson, 2009.

Fesperman, L., and Lindaman, S. L. "Theraplay Reaches Difficult to Engage Children in Foster Care." *Zero to Three,* 1999, *19*(3), 34–35.

Finnell, N. "Adoption and Attachment." *The Theraplay Institute Newsletter*, Fall 1996, pp. 1–2.

Finnell, N. "Theraplay in einem Heim für Adoptions-und Pflegekinder" (Theraplay in a Home for Adopted and Foster Children). *Schwierige Kinder-verstehen und helfen*, 2006, *37*, 4–5.

Fitzka, K. "Ich falle aufwärts: Theraplay am Anfang" (My Mistakes Help Me Move Forward: Theraplay in the Beginning). *Theraplay Journal*, 1995, *11*, 26–27.

Fitzka, K. "Theraplay mit einem sexuell missbrauchten Mädchen" (Theraplay with a Sexually Abused Girl). *Theraplay Journal*, 1997, *14*, 4–10.

Fitzka, K. "über das Einbeziehen der Füße in die Therapie" (About the Importance of Dealing with Children's Feet in Theraplay). *Schwierige Kinder-verstehen und helfen*, 2000, *21*, 24–26.

Franke, U. "Theraplay: eine direktive kommunikative Spieltherapie" (Theraplay: A Directive Communicative Playtherapy). *Praxis der Kinderpsychologie und Kinderpsychiatrie*, 1990a, *39*, 12–17.

Franke, U. "Theraplay und seine Wirkung auf das Kommunikations-verhalten" (Theraplay and Its Effect on Communication). In G. Grohnfeldt (ed.), *Handbuch der Sprachtherapie* (Handbook of Speech Therapy), Band 2. Berlin: Edition Marhold, 1990b.

Franke, U. "Theraplay." Gesellschaft zur Förderung des Festhaltens (ed.), *I. Internationaler Kongress "Festhalten" in Regensburg* (Society for the Advancement of Holding Therapy: The First International Congress of Holding Therapy), 1991a, pp. 427–440.

Franke, U. "Die Theraplay Ko-Therapeutin" (The Theraplay Co-Therapist). *Theraplay Journal*, 1991b, *3*, 15–17.

Franke, U. "Die sensorische Wahrnehmung" (Sensory Perception). *Theraplay Journal*, 1991c, *6*, 4–7.

Franke, U. "Aufmerksamkeit" (Attention: An Aim in Theraplay Sessions). *Theraplay Journal*, 1992a, *6*, 20–25.

Franke, U. "Naschraten" (Guessing the Taste). *Theraplay Journal*, 1992b, *6*, 8–14.

Franke, U. "Warum wirkt Theraplay?" (Why Does Theraplay Work?). *Theraplay Journal*, 1992c, *6*, 14–15.

Franke, U. "Theraplay: eine Hilfe für schwierige Kinder und ihre Eltern" (Theraplay: Help for Difficult Children and Their Parents). In W. Leixnering und F. Wurst (eds.), *Krise als Chance*. Wien: Tagungsband, 1993a.

Franke, U. "Unterschiede zwischen Theraplay in den USA und in Deutschland" (Differences Between Theraplay in the United States and Germany). *Theraplay Journal*, 1993b, *7*, 4–8.

Franke, U. "Theraplay bei spracherwerbsgestörten Kindern" (Theraplay with Language Disordered Children). In H. Grimm, and F. Weinert (eds.), *Intervention bei sprachgeststörten Kindern* (Intervention with Language Disordered Children). Stuttgart: G. Fischer, 1994a.

Franke, U. "Zehn Grundannahmen und die therapeutischen Schlussfolgerungen" (Ten Basic Hypotheses About Theraplay and Their Therapeutic Conclusions). *Theraplay Journal*, 1994b, *8*, 6–15.

Franke, U. "Ergotherapie und Theraplay" (Occupational Therapy and Theraplay). *Theraplay Journal*, 1995, *11*, 16–21.

Franke, U. "Alexander der grosse Schweiger: Theraplay bei Mutismus" (Alexander the Great Mute: Theraplay with Mutism). *L.O.G.O.S. interdisziplinär*, 1996a, *4*(1), 20–29.

Franke, U. "Magdalena, ein nichtsprechendes wahrnehmungsgestörtes Kind" (Magdalena, a Non-Speaking Perceptually Handicapped Child). *Theraplay Journal*, 1996b, *12*, 4–15.

Franke, U. "Theraplay Handlungsanalysen" (Micro-Analysis of Some Procedures in Theraplay Sessions). *Theraplay Journal*, 1998a, *15*, 20–24.

Franke, U. "Theraplay: Welche Rolle spielen die Eltern?" (Theraplay: What Role Do Parents Play?). *Theraplay Journal*, 1998b, *15*, 4–13.

Franke, U. "Theraplay fuer die logopaedische Therapie" (Theraplay for the logopedic thereapy). *Forum Logopaedie*, 1998c, *6*, 13–17.

Franke, U. "Struktur der praktischen Theraplay Supervision" (The Structure of Theraplay Supervision). *Theraplay Journal*, 1998d, pp. 22–25.

Franke, U. "Theraplay mit einem behinderten Kind: Anja" (Theraplay with a Handicapped Girl, Anja). *Theraplay Journal*, 1998e, pp. 4–13.

Franke, U. "Die Geschichte eines Jungen zwischen "Kann-nicht" und "Will-nicht" (The Story of a Boy Standing Between Can Not and Will Not). *Schwierige Kinder-verstehen und helfen*, 1999a, *17*, 14–21.

Franke, U. "Was ist Theraplay?" (What Is Theraplay?). *Schwierige Kinder-verstehen und helfen* 1999b, *17*, 22–23.

Franke, U. "Inhalt und Struktur einer Theraplay-Stunde" (Content and Structure of a Theraplay Session). *Schwierige Kinder-verstehen und helfen*, 1999c, *18*, 14–18.

Franke, U. "Felix-Ein kleiner hyperaktiver Junge bei Theraplay" (Felix: A Young Hyperactive Boy in Theraplay Treatment). *Schwierige Kinder-verstehen und helfen*, 1999d, *19*, 8–15.

Franke, U. "Berührung und Aggression-Studien decken Zusammenhänge auf" (Touch and Aggression: Research Shows Inverse Relationships). *Schwierige Kinder-verstehen und helfen*, 2001a, *24*, 18–19.

Franke, U. "Erfahrungen mit intensiver Theraplay-Therapie" (Experiences with Intensive Theraplay Treatment). *Schwierige Kinder-verstehen und helfen*, 2001b, *25*, 25–27.

Franke, U. "Anna-über das mutige Wachsen in eine neue Identität" (Anna-Her Courageous Growth into a New Identity). *Schwierige Kinder-verstehen und helfen,* 2002a, *26*, 4–12.

Franke, U. "Jacqueline, eine Theraplay-Geschichte" (Jacqueline, a Theraplay Story). *Schwierige Kinder-verstehen und helfen*, 2002b, *27*, 4–9.

Franke, U. "Dennis. Ein autistisches Kind entdeckt die Emotionen über die Sprache" (Dennis. An Autistic Child Discovers His Emotions Through Language). *Schwierige Kinder-verstehen und helfen*, 2002c, *28*, 4–13.

Franke, U. "Eltern-Fragen an eine Theraplay Therapeutin" (Questions Parents Ask a Theraplay Therapist). *Schwierige Kinder-verstehen und helfen*, 2002d, *28*, 22–23.

Franke, U. "Milena, ein bindungsgestörtes Kind auf seiner Suche nach Sicherheit" (Milena: An Attachment Disordered Child's Search for Safety). *Schwierige Kinder-verstehen und helfen*, 2003a, *30*, 4–12.

Franke, U. "Wie eine Theraplay-Therapeutin ein scheues Kind verändert" (How a Theraplay Therapist Can Change a Shy Child). *Schwierige Kinder-verstehen und helfen*, 2003b, *31*, 4–7.

Franke, U. "Mama macht mit. Kind und Mutter in der Theraplay Stunde" (Mother Joins In: Child and Mother in a Theraplay Session). *Schwierige Kinder-verstehen und helfen*, 2005a, *35*, 11–15.

Franke, U. "Philipp wacht auf. Ein autistisches Kind findet Freude an der Interaktion" (Philipp Wakes Up: An Autistic Child Finds Joy in Interaction). *Schwierige Kinder-verstehen und helfen*, 2005b, *37*, 4–8.

Franke, U. "Therapieziele bei autistischen Kindern und wie man sie erreicht" (Therapeutic Goals for Autistic Children and How You Can Achieve Them). *Schwierige Kinder-verstehen und helfen*, 2006a, *37*, 9–11.

Franke, U. "Andreas, ein Vorschulkind mit der Diagnose Hochbegabung bei Theraplay" (Andreas, a Gifted Preschool Child with Theraplay). *Schwierige Kinder-verstehen und helfen*, 2006b, *38*, 20–27.

Franke, U. "Thomas findet zur Sprache. Theraplay bei Kindern mit Sprachentwicklungsverzögerung" (Thomas Finds Language. Theraplay with Language Delayed Children). *Schwierige Kinder-verstehen und helfen*, 2007a, *41*, 4–11.

Franke, U. "über das Sprachverständnis, seine Untersuchung und Behandlung mit Theraplay" (About Language Comprehension: Its Assessment and Treatment with Theraplay). *Schwierige Kinder-verstehen und helfen*, 2007b, *41*, 18–22.

Franke, U. "Was so alles passiert an einem Theraplay-Tag. Einblicke in den Praxisalltag" (What Happens in a Theraplay Day? A Look into the Practice). *Schwierige Kinder-verstehen und helfen*, 2008, *44*, 4–9.

Franke, U. "Theraplay in Germany." In E. Munns (ed.), *Applications of Family and Group Theraplay.* New York: Jason Aronson, 2009.

Fuhrmann, E. "ABC—wir Freunde sind OK. Gruppen-Theraplay in einer Institution" (ABC—We're Friends and We're OK: Group Theraplay in an Institution). *Schwierige Kinder-verstehen und helfen*, 2000, *22*, 21–25.

Fuhrmann, E. "Gruppen-Theraplay mit Senioren und Kindern im Alter von 3–6 Jahren" (Group Theraplay with Senior Citizens and Children Age 3–6). *Schwierige Kinder-verstehen und helfen*, 2008, *45*, 14–15.

Fuller, W. S. "Theraplay as a Treatment for Autism in a School-Based Day Treatment Setting." *Continuum, the Journal of the American Association for Partial Hospitalization*, 1995, *2*(2), 89–93.

Fuller, W. S., and Booth, P. "Touch with Abused Children." *The Theraplay Institute Newsletter*, 1997, *9*, 4–7.

Fux, G. "Die Anwendungsmöglichkeiten und die Grenzen des Theraplay Konzeptes in der Logopädie" (The Possibilities and Limits of Using Theraplay for Speech-Language Pathology). Unpublished thesis for the Heilpädagogiches Seminar, Institut Freiburg, 1991.

Gardner, B., and Spickelmier, M. "Theraplay with Adolescents." *The Theraplay Institute Newsletter*, Winter 2008.

Gardner, B., and Spickelmier, M. "Working with Adolescents." In E. Munns (ed.), *Applications of Family and Group Theraplay.* New York: Jason Aronson, 2009.

Gerretsen, M. "Theraplay: A Therapeutic Intervention for Children and Their Caregivers." Unpublished master's thesis, University of Manitoba, Canada, 2003.

Gillmeister, A. "über das Entdecken des anderen Ohrs. Theraplay mit geistig behinderten Kindern" (Discovering the Other Ear: Theraplay with Mentally Retarded Children). *Schwierige Kinder-verstehen und helfen*, 2001, *25*, 16–18.

Giskes, H. "Eine familiäre Konfliktsituation, dann eine 5 in der Schule und Martin ist ausgeflippt" (A Conflict in the Family, A Low Mark at School and Martin Freaks Out). *Schwierige Kinder-verstehen und helfen*, 2003, *30*, 15–19.

Giskes, H. "So etwas machen Sie mit einer Elfjährigen!" Theraplay mit einer Hochbegabten" ("You Do This with an Eleven-Year-Old!" Theraplay with an Intellectually Gifted Girl). *Schwierige Kinder-verstehen und helfen*, 2005, *36*, 4–7.

Giskes, H. "Vater und Sohn finden zueinander durch Theraplay" (Father and Son Come Together Through Theraplay). *Schwierige Kinder-verstehen und helfen*, 2007, *43*, 7–9.

Golden, B. R. "How Theraplay Facilitates Healthy Narcissism." *Journal of Child and Adolescent Psychotherapy*, 1986, *3*(2), 99–104.

González, C. M. "La Actividad Lúdica Como Instrumento de Intervención en el Autismo Infantil. La Técnica Theraplay" (Active Play as an Instrument of Intervention with an Autistic Child: The Theraplay Technique). *Revista de Educación Especial* (Review of Special Education), 1988, p. 3.

Goodyear-Brown, P. "Theraplay Approaches for Children with Autism Spectrum Disorders." In E. Munns (ed.), *Applications of Family and Group Theraplay.* New York: Jason Aronson, 2009.

Görg, D. "Patricks 15. Theraplay-Stunde" (Patrick's 15th Theraplay Session). *Schwierige Kinder-verstehen und helfen*, 1999, *18*, 27.

Gougeon, M. L. "Group Work with Women and Children Impacted by Family Violence." Unpublished master's thesis, University of Manitoba, Canada, 2002.

Govender, G. "Teacher-Pupil Relationship of the Hyperactive Junior Primary School Child." Unpublished master's thesis, University of Pretoria, South Africa, 1995.

Greeves, A. "Theraplay with Deaf Children and Hearing Parents." *The Theraplay Institute Newsletter*, Winter 2008.

Groschke, D. "Theraplay: A New Treatment Using Structured Play for Problem Children and Their Families" [Book review]. *Praxis der Kinderpsychologie und Kinderpsychiatrie* (Practice of Child Psychology and Child Psychiatry), 1988, *37*(8), 315–316.

Haaman, T., and Immonen, T. "Vuorovaikutusleikki" (Interaction Play). Unpublished master's thesis, Helsinki University, Finland, 2003.

Händel-Rüdinger, M. "Isabell." *Theraplay Journal*, 1992, *5*, 12–13.

Händel-Rüdinger, M. "Verena: Theraplay mit einem Kleinkind" (Verena: Theraplay with a Young Child). *Theraplay Journal*, 1995, *11*, 22–25.

Händel-Rüdinger, M., und Franke, U. "Was lernt Jens wie in der Therapie?" (What Did Jens Learn in Therapy?). *L.O.G.O.S. interdisziplinär*, 1993, *1*(2), 97–101.

Hellinen, E. "Theraplay: vaikuttavuus lapsiperheen arkeen ja vuorovaikutukseen" (Theraplay: Effect on Ordinary Life and Interactions in Families with Infants). Unpublished candidate thesis, Tampere University, Finland, 2008.

Hitchcock, D. L. "A Construct Validity Study of the Marschak Interaction Method Rating System with Adolescent Mother-Child Dyads." Unpublished doctoral dissertation, Alliant International University, Fresno, 2002.

Hitchcock, D. L., Ammen, S., O'Connor, K., and Backman, T. L. "Validating the Marschak Interaction Method Rating System with Adolescent Mother-Child Dyads." *International Journal of Play Therapy*, 2008, *17*, 24–38.

Hölzel, L. "Entwicklung eines Auswertungsverfahrens im Rahmen der Diagnostik von Eltern-Kind-Interaktionen" (Development of a Method of Analysis for the Assessment of Parent-Child Interactions). Unpublished master's thesis, Technische Universität, Berlin, 1993.

Hötzel, M. "Auf einer Insel—Die Bedeutung von Verslein bei Theraplay" (Itsy Bitsy Spider—The Importance of Verses with Theraplay). *Schwierige Kinder-verstehen und helfen*, 2002, *26*, 28–30.

Hurst, T. "Die Anfänge von Theraplay" (The Beginnings of Theraplay). *Schwierige Kinder-verstehen und helfen*, 2001, *24*, 24–25.

Imperiale, N. "Professor Preaches the Power of Positive Discipline." *Chicago Tribune*, May 3, 1994, Tempo, p. 3.

Ing, L. "Theraplay in an Inpatient Unit for Psychotic Disorders." *The Theraplay Institute Newsletter*, Spring 2004.

Jernberg, A. M. "Psychosomatic Similarities in Adoptive Mothers and Their Infants." *Human Development Bulletin*. Paper presented at 9th Annual Symposium, Chicago, March 1, 1958.

Jernberg, A. M. "Theraplay Technique." In C. E. Schaefer (ed.), *Therapeutic Use of Child's Play*. New York: Jason Aronson, 1976.

Jernberg, A. M. *Theraplay: A New Treatment Using Structured Play for Problem Children and Their Families*. San Francisco: Jossey-Bass, 1979.

Jernberg, A. M. "Combining Theraplay with Sensory Integration for Children with Sensory Motor Dysfunction." Paper presented at the Annual Meeting of the American Psychological Association, Los Angeles, August 1981.

Jernberg, A. M. "Theraplay: History and Method." In E. Nickerson and K. O'Laughlin (eds.), *Helping Through Action-Oriented Therapies*. Amherst, MA: Human Resource Development Press, 1982a.

Jernberg, A. M. "Theraplay: The Initial Stages of Treatment." *Association for Play Therapy Newsletter*, 1982b, *1*(1), 3–5.

Jernberg, A. M. "Theraplay: The Nursery Revisited." In L. E. Abt and I. R. Stuart (eds.), *The Newer Therapies: A Sourcebook*. New York: Van Nostrand Reinhold, 1982c.

Jernberg, A. M. "Therapeutic Use of Sensory-Motor Play." In C. E. Schaefer and K. J. O'Connor (eds.), *Handbook of Play Therapy*. New York: Wiley, 1983.

Jernberg, A. M. "Theraplay: Child Therapy for Attachment Fostering." *Psychotherapy*, 1984, *21*(1), 39–47.

Jernberg, A. M. "The Theraplay Technique for Children." In P. A. Keller and L. G. Ritt (eds.), *Innovations in Clinical Practice: A Source Book*, Vol. 5. Sarasota, FL: Professional Resource Exchange, 1986.

Jernberg, A. M. "Helping Foster or Late-Adopted Children to Make It in the Classroom." *Stepping Stones*. Illinois Council on Adopted Children, Inc., July/August 1987a, pp. 9–11.

Jernberg, A. M. "Theraplay für das aggressive Kind" (Theraplay for the Aggressive Child). *Forum des Zentralverbandes für Logopädie* (Forum of the Central Union for Speech and Language Pathology), 1987b, *4*, 1–3.

Jernberg, A. M. "Untersuchung und Therapie der pränatalen Mutter-Kind-Beziehung" (Evaluation and Treatment of the Mother-Child Relationship). In B. G. Fedor-Freybergh (ed.), *Pränatale und Perinatale Psychologie und Medizin: Begegnung mit dem Ungeborenen* (Prenatal and Perinatal Psychology and Medicine: Encounter with the Unborn). Sweden: Saphir, 1987c.

Jernberg, A. M. *Theraplay: eine direktive Spieltherapie*. Deutsche übersetzung und Bearbeitung nach der amerikanischen 1. Auflage von U. Franke (Theraplay: A Directive Play Therapy. Translated and revised from the first American edition by U. Franke). Stuttgart: G. Fischer, 1987d.

Jernberg, A. M. "Promoting Prenatal and Perinatal Mother-Child Bonding: A Psychotherapeutic Assessment of Parental Attitudes." In P. G. Fedor-Freybergh and M.L.V. Vogel (eds.), *Prenatal and Perinatal Psychology and Medicine: Encounter with the Unborn*. Park Ridge, NJ: Parthenon Publishing Group, 1988a.

Jernberg, A. M. "The Theraplay Approach to the Self-Contained Patient." In E. M. Stern (ed.), *Psychotherapy and the Self-Contained Patient*. Special Issue of *The Psychotherapy Patient*, 1988b, *4*(3/4), 85–93.

Jernberg, A. M. "Theraplay als eine Ergänzung der sensomotorischen Integrationstherapie" (Theraplay as a Compliment to Sensory Integration Therapy). *Praxis Ergotherapie* (Sensory Integration Practice), 1988c, *1*, 292–304.

Jernberg, A. M. "Theraplay for the Elderly Tyrant." *Clinical Gerontologist*, 1988d, *8*(1), 76–79.

Jernberg, A. M. "Training Parents of Failure-to-Attach Children." In C. E. Schaefer and J. M. Briesmeister (eds.), *Handbook of Parent Training: Parents as Co-Therapists for Children's Behavior Problems*. New York: Wiley, 1989.

Jernberg, A. M. "Attachment Enhancing for Adopted Children." In P. V. Grabe (ed.), *Adoption Resources for Mental Health Professionals*. New Brunswick: Transaction Publishers, 1990a.

Jernberg, A. M. "Bindungsförderung für adoptierte Kinder" (Attachment Enhancing for Adopted Children). *Kindeswohl: Zeitschrift fur Pflegekinder-und Adoptionswesen* (Journal for Foster Children and the Practice of Adoption), 1990b, *4*, 25–28.

Jernberg, A. M. "Helping Children Cope with War." *The Theraplay Institute Newsletter*, Winter 1990–91, pp. 4–5.

Jernberg, A. M. "Assessing Parent-Child Interactions with the Marschak Interaction Method (MIM)." In C. E. Schaefer, K. Gitlin, and

A. Sandgrund (eds.), *Play Diagnosis and Assessment*. New York: Wiley, 1991.

Jernberg, A. M. "The Marital Marschak Interaction Method (MMIM): A Technique for Structured Observation and Clinical Intervention in Helping Troubled Marriages." *The Theraplay Institute Newsletter*, Winter 1992a, pp. 1–2.

Jernberg, A. M. "The Older Sibling." *The Theraplay Institute Newsletter*, Fall 1992b, pp. 4–5.

Jernberg, A. M. "The Prenatal Marschak Interaction Method (PMIM): A Tool for Bonding." *The Theraplay Institute Newsletter*, Winter 1992c, pp. 4–5.

Jernberg, A. M. "Attachment Formation." In C. E. Schaefer (ed.), *The Therapeutic Powers of Play*. Northvale, NJ: Jason Aronson, 1993.

Jernberg, A. M. "Theraplay für das aggressive Kind" (Theraplay for the Aggressive Child). In U. Franke (ed.), *Therapie aggressiver und hyperaktiver Kinder* (Therapy for Aggressive and Hyperactive Children) (2nd ed.). Stuttgart: Gustav Fischer Verlag, 1995.

Jernberg, A. M., Allert, A., Koller, T. J., and Booth, P. *Reciprocity in Parent-Infant Relationships*. Chicago: The Theraplay Institute, 1983.

Jernberg, A. M., and Booth, P. B. "Theraplay and the James Method of Treatment for Traumatized Children." *The Theraplay Institute Newsletter*, Winter 1990–91, p. 1.

Jernber, A. M., and Booth, P. B. *Theraplay: Helping Parents and Children Build Better Relationships Through Attachment-Based Play* (2nd ed.). San Francisco: Jossey-Bass, 1999.

Jernberg, A. M., Booth, P. B., Koller, T. J., and Allert, A. *Preschoolers and School Age Children in Interaction with Their Parents: Manual for Using the Marschak Interaction Method (MIM)*. Chicago: The Theraplay Institute, 1982.

Jernberg, A. M., and DesLauriers, A. "Some Contributions of Three Pre-School Children to Behavior Changes in Their Mothers." Paper presented to the Research Seminar, Psychosomatic and Psychiatric Institute, Michael Reese Hospital, Chicago, June 1962.

Jernberg, A. M., Hurst, T., and Lyman, C. *Here I Am*. 16 mm film. Wilmette: The Theraplay Institute, 1969.

Jernberg, A. M., Hurst, T., and Lyman, C. *There He Goes*. 16 mm film. Wilmette: The Theraplay Institute, 1975.

Jernberg, A. M., and Jernberg, E. "Family Theraplay for the Family Tyrant." In T. Kottman and C. E. Schaefer (eds.), *Play Therapy in Action: A Casebook for Practitioners*. Northvale, NJ: Jason Aronson, 1993.

Jernberg, A. M., Thomas, E., and Wickersham, M. *Mothers' Behaviors and Attitudes Toward Their Unborn Infants*. Chicago: The Theraplay Institute, 1985.

Joronen, K. "Theraplay–ett verktyg för logobeden" (Theraplay: A Tool for Speech Therapists) [Swedish text]. Unpublished master's thesis, Helsinki University, Finland, 2006.

Kashwer, C. D. "Assessing the Relationship Between a Mother and Her Unborn Child: The Prenatal Marschak Interaction Method Rating System." Unpublished doctoral dissertation, Alliant International University, Fresno, 2004.

Kekäle, P. "Kikkakoppa vai uudet silmälasit? Theraplay puheterapeutin työvälineenä" (Some Tricks or New Eye-glasses? The Theraplay Method as a Tool for Speech Therapists). Unpublished licentiate thesis, Oulu University, Finland, 2007.

Kim, Y-.K., and Nahm, S. "Cultural Considerations in Adapting and Implementing Play Therapy." *International Journal of Play Therapy*, 2008, *17*(1), 66–77.

Kirby, E. K. "Parents and Adopted Children Together (PACT): Therapeutic Retreat for Postadoptive Families." Unpublished doctoral dissertation, Chicago School of Professional Psychology, 2007.

Koller, T. J. "The Relationship of Infant Temperament to Mother-Infant and Father-Infant Interaction." Unpublished doctoral dissertation, Illinois Institute of Technology, Chicago, 1980.

Koller, T. J. "New Family Bonding." *The Theraplay Institute Newsletter*, 1981, pp. 3–6.

Koller, T. J. "Stealing in the Adopted Child in School." *Stepping Stones*. Illinois Council on Adopted Children, Inc., July/August 1987, pp. 11–15.

Koller, T. J. "Adolescent Theraplay." In K. J. O'Connor and C. E. Schaefer (eds.), *Handbook of Play Therapy, Vol. 2: Advances and Innovations*. New York: Wiley, 1994.

Koller, T. J., and Booth, P. "Fostering Attachment Through Family Theraplay." In K. J. O'Connor and L. M. Braverman (eds.), *Play Therapy: Theory and Practice*. New York: Wiley, 1997.

Korpi, A. "Alle kouluikäisten poikien kerhotoimintakokoeilu, erään kasvuprosessin kuvaus" (An Experiment in Playing Club Among Preschool Boys: A Description of Progress and Process).

Unpublished survey specialisation, Helsinki University, Finland, 1988.

Krebs, S. "Workshop Gruppen-Theraplay" (A Workshop in Group Theraplay). *Schwierige Kinder-verstehen und helfen*, 1999, *18*, 11–13.

Krone, D. "Philipp's 14. Theraplay-Stunde" (Philipp's 14th Theraplay Session). *Schwierige Kinder-verstehen und helfen*, 1999, *18*, 9–10.

Kupperman, P., Bligh, S., and Goodban, M. "Activating Articulation Skills Through Theraplay." *Journal of Speech and Hearing Disorders,* 1980a, *45*, 540–545.

Kupperman, P., Bligh, S., and Goodban, M. "Use of Theraplay in Speech Impairment." *Journal of Speech and Hearing Disorders*, 1980b, *45*, 545–548.

Laakso, M. "Parent Session in Theraplay: A Way to Consolidate Therapeutic Alliance and Joint Focus." In E. Munns (ed.), *Applications of Family and Group Theraplay.* New York: Jason Aronson, 2009.

Lender, D. "Theraplay bei Kindern mit fetalem Alkoholsyndrom (FAS)" (Theraplay with Children with Fetal Alcohol Syndrome). *Schwierige Kinder-verstehen und helfen*, 2006a, *37*, 6–11.

Lender, D. "What's Behind These Theraplay Activities: A Window into Attachment." *The Theraplay Institute Newsletter*, Summer 2006b.

Leslie, E., and Mignon, N. "Group Theraplay for Parents in a Public Housing Program." *The Theraplay Institute Newsletter*, Fall 1995, pp. 6–7.

Lessander, A. "Hintergründe autistischer Störungen und die Schlüsselfunktion von Theraplay" (The Basics of Autistic Disorders and the Key Function of Theraplay). *Schwierige Kinder-verstehen und helfen*, 2006, *39*, 9–13.

Lindaman, S. "Theraplay for Adopted Children." *Adoption Therapist*, 1996, *7*(1), 5–8.

Lindaman, S. L., Booth, P. B., and Chambers, C. L. "Assessing Parent-Child Interactions with the Marschak Interaction Method (MIM)." In K. Gitlin-Weiner, A. Sandgrund, and C. Schaefer (eds.), *Play Diagnosis and Assessment* (2nd ed.). Hoboken, NJ: Wiley, 2000.

Lindaman, S. L., and Haldeman, D. "Geriatric Theraplay." In C. E. Schaefer and K. J. O'Connor (eds.), *Handbook of Play Therapy, Vol. 2: Advances and Innovations.* New York: Wiley, 1994.

Lindaman, S. L., and Lender, D. "Theraplay with Adopted Children." In E. Munns (ed.), *Applications of Family and Group Theraplay.* New York: Jason Aronson, 2009.

Lleras, B. "Veränderungen bei Müttern hinter der Scheibe" (Changes of Mothers Behind the Two-Way Mirror). *Theraplay Journal*, 1992, *5*, 22–23.

Lleras, B. "RührMichNichtAn. Julian-Theraplay bei einem Pflegekind" ('Don't Touch Me': Julian, a Foster Child in Theraplay Treatment). *Schwierige Kinder-verstehen und helfen*, 2000, *21*, 14–20.

Lleras, B. "Theraplay bei Kindern von depressiven Müttern" (Theraplay with Children of Depressed Mothers). *Schwierige Kinder-verstehen und helfen*, 2002, *26*, 16–22.

Lleras, B. "Spiegelung Affektregulierung Selbstregulierung Mentalisierung-wichtige Aspekte bei Theraplay" (Mirroring, Affect Regulation, Self-Regulation, Mentalisation-Important Aspects of Theraplay). *Schwierige Kinder-verstehen und helfen*, 2007, *42*, 22–25.

Lovejoy, T. "Theraplay in a Preschool Mental Health Program." *The Theraplay Institute Newsletter*, Fall 1995, p. 8.

Macke, H. "Lauras Weg aus ihrer eigenen Welt zu uns-Teil 1" (Laura's Path out of Her Own Little World into Ours-Part 1). *Schwierige Kinder-verstehen und helfen*, 2007, *41*, 4–11.

Macke, H. "Lauras zweite Etappe" (Laura's Second Step). *Schwierige Kinder-verstehen und helfen*, 2007, *43*, 4–6.

Maddox, A. J., and Bettendorf, C. "Theraplay in Combination with Sensory and Handling Techniques: The Body/Mind Connection in Pediatrics." In E. Munns (ed.), *Applications of Family and Group Theraplay*. New York: Jason Aronson, 2009.

Mahan, M. G. "Theraplay as an Intervention with Previously Institutionalized Twins Having Attachment Difficulties." Unpublished doctoral dissertation, Chicago School of Professional Psychology, 1999.

Mäkelä, J. "What Makes Theraplay Effective: Insights from Developmental Sciences." *The Theraplay Institute Newsletter*, Fall/Winter 2003.

Mäkelä, J. "Kosketuksen merkitys lapsen kehityksessä" (The Importance of Touch in the Development of Children). *Finnish Medical Journal Review*, 2005, *14*, 1543–1549.

Mäkelä, J. "Wie wirkt Theraplay? Einsichten aus der Entwicklungs-psychologie" (What Makes Theraplay Effective? Insights from Developmental Sciences). *Schwierige Kinder-verstehen und helfen*, 2005, *35*, 4–7.

Mäkelä, J. "Herz ist gefragt. Theraplay in SOS Kinderdörfern" (Heart Wanted: Theraplay in SOS Children's Villages). *Schwierige Kinder-verstehen und helfen*, 2008, *45*, 11–13.

Mäkelä, J., and Vierikko, I. *Kuinka yhteys löytyy?* (From Heart to Heart: A Report of the Theraplay-Project in SOS-Children Villages in Finland). Erikoispaino: Oy, 2004.

Mäki, T., Tiensuu, J., and Turkka, U. "Theraplay-menetelmän soveltaminen päiväkodissa" (The Theraplay Method Adapted in Day-care). Competence study, Helsinki University, Finland, 1993.

Maness, N. "Integrating Theraplay into the Navajo Beauty Way." *The Theraplay Institute Newsletter*, Summer 2000.

Marschak, M. *A Comparison of Polish and Italian Fathers in Interaction with Their Pre-school Sons*. New Haven: Yale Child Study Center, 1960a.

Marschak, M. "A Method for Evaluating Child-Parent Interactions Under Controlled Conditions." *The Journal of Genetic Psychology*, 1960b, *97*, 3–22.

Marschak, M. "Child-Parent Tie in Present Day Japan." *Child and Family*, 1967a, pp. 6, 72–79, 80–88.

Marschak, M. "Imitation and Participation in Normal and Disturbed Young Boys in Interaction with Their Parents." *Journal of Clinical Psychology*, 1967b, *23*(4), 421–427.

Marschak, M. *Nursery School Child/Mother Interaction*, 1967c. Film. Available from New York University Film Library, 26 Washington Place, New York, NY, 10003.

Marschak, M. "The Obstinate Checklist." *Journal of the American Academy of Child Psychiatry*, 1969, *8*, 456–464.

Marschak, M. *Two Climates of Israel*, 1975. Film. Available from New York University Film Library, 26 Washington Place, New York, NY, 10003.

Marschak, M. *Parent-Child Interaction and Youth Rebellion*. New York: Gardner Press, 1980.

Marschak, M., and Call, J. D. "Exposure to Child-Parent Interaction as a Teaching Device." *Journal of Medical Education*, 1964, *39*, 879–880.

Marschak, M., and Call, J. D. "A Comparison of Normal and Disturbed Three-Year-Old Boys in Interaction with Their Parents." *American Journal of Orthopsychiatry*, 1965, *35*, 247–249.

Marschak, M., and Call, J. D. "Observing the Disturbed Child and His Parents: Class Demonstrations for Medical Students." *Journal of the American Academy of Child Psychiatry*, 1966, *5*, 686–692.

Martin, D. "Applications of Theraplay in Early Childhood Classrooms." *The Theraplay Institute Newsletter*, Fall 1995, p. 4.

Martin, D. "Theraplay for Classrooms." In A. A. Drewes, L. J. Carey, and C. E. Schaefer (eds.), *School-Based Play Therapy*. Hoboken, NJ: Wiley, 2001.

Martin, D. "Gruppen Theraplay im Kindergarten" (Group Theraplay in a Kindergarten). *Schwierige Kinder-verstehen und helfen*, 2003, 29, 23.

Martin, E. E. "Intergenerational Patterns of Attachment: A Prediction of Attachment Styles Across Three Generations Using the Adult Scale of Parental Attachment and the Marschak Interaction Method Rating System." Unpublished doctoral dissertation, University of Mississippi, 2005.

Martin, E. E., Snow, M. S., and Sullivan, K. "Patterns of Relating between Mothers and Preschool-Aged Children Using the Marschak Interaction Method Rating System." *Early Child Development and Care*, 2008, *178*(3), 305–314.

McKay, J. M., Pickens, J., and Stewart, A. "Inventoried and Observed Stress in Parent-Child Interactions." *Current Psychology: Developmental, Learning, Personality, Social*, 1996, *15*(3), 223–234.

Meißner, M. "Theraplay und Unterstützte Kommunikation" (Theraplay and Facilitated Communication). *Schwierige Kinder-verstehen und helfen*, 2006, *40*, 4–10.

Miller, J. "Working with Tribal Aboriginal People in Australia." *The Theraplay Institute Newsletter*, Summer 2000.

Miller, P. "Therapeutic Touch with Sensory Defensive Children." *The Theraplay Institute Newsletter*, Fall 1997, *9*, 7–9.

Minty, B. "Theraplay: A New Treatment Using Structured Play for Problem Children and Their Families" [Book review]. *British Journal of Social Work*, 1981, *11*(1), 111–112.

Morgan, C. E. "Theraplay: An Evaluation of the Effect of Short-Term Structured Play on Self-Confidence, Self-Esteem, Trust, and Self-Control." Unpublished manuscript: York Centre for Children, Youth, and Families; Ontario, Canada, 1989.

Morin, V. *Fun to Grow On.* Chicago: Magnolia Street Publications, 1999.

Moser, K. "Gruppentheraplay in einem Integrationskindergarten" (Group Theraplay in an Integrated Kindergarten). *Theraplay Journal*, 1993, *7*, 15.

Moser, K. "Gruppentheraplay mit erwachsenen geistig Behinderten?" (Group Theraplay with Mentally Retarded Adults?). *Theraplay Journal*, 1997, *14*, 26–28.

Moser, K. "Gruppentheraplay im Seniorenzentrum" (Group Theraplay in a Home for Seniors). *Schwierige Kinder-verstehen und helfen*, 2005, *35*, 8–10.

Moser, K. "Wer wird jetzt in den Raum gerollt? GTP mit Vorschulkindern" (Whose Turn Is It to Be Rolled into the Room? Group Theraplay with Preschool Children). *Schwierige Kinder-verstehen und helfen*, 2006, *40*, 12–17.

Moser, K. "Synchron Theraplay" (Synchronizing Theraplay with a Mother and Her Two Children). *Schwierige Kinder-verstehen und helfen*, 2008, *44*, 10–13.

Moser, K., and Franke, U. "Gruppen-Theraplay: Die Ermutigung." (Group Theraplay: The Encouragement). *Zeitschrift für Individual-psychologie*, 2002, *27*(2), 124–129.

Moyer, M. "Group Theraplay in a Special Needs Day School." *The Theraplay Institute Newsletter*, Fall 1995, pp. 8–9.

Mullen, J. "What Is Theraplay? How Can It Help My Child?" *The Theraplay Institute Newsletter*, Winter 1999/2000.

Munns, E. "Theraplay." *Playground*, Spring 1994, pp. 3–4.

Munns, E. "Theraplay at Blue Hills Play Therapy Services." *The Theraplay Institute Newsletter*, Fall 1995, p. 7.

Munns, E. "Theraplay." In B. Bedard-Bidwell and M. Sippel (eds.), *Hand in Hand*. London, Ontario: Thames River Publishing, 1997.

Munns, E. (ed.) *Theraplay: Innovations in Attachment Enhancing Play Therapy*. Northvale, NJ: Jason Aronson, 2000a.

Munns, E. "Traditional Family and Group Theraplay." In E. Munns (ed.), *Theraplay: Innovations in Attachment-Enhancing Play Therapy*, Northvale, NJ: Jason Aronson, 2000b.

Munns, E. "Group Theraplay." In B. Bedard Bidwell (ed.), *Hand in Hand*, Vol. 2. Burnstone, Ontario: General Store Publishing House, 2000c.

Munns, E. "Theraplay: Attachment Enhancing Play Therapy." In C. E. Schaefer (ed.), *Foundations of Play Therapy*. Hoboken, NJ: Wiley, 2003.

Munns, E. "Theraplay with Adolescents." In L. Gallo-Lopez and C. E. Schaefer (eds.), *Play Therapy with Adolescents*. Lanham, MD: Jason Aronson, 2005.

Munns, E. "Gruppen-Theraplay mit Eltern und ihren Vorschulkindern" (Group Theraplay with Parents and Their Preschool Children). *Schwierige Kinder-verstehen und helfen*, 2006, *39*, 14–15.

Munns, E. "Mirror Activity." In L. Lowenstein (ed.), *Assessment and Treatment Activities for Children, Adolescents and Families:*

Practitioners Share Their Most Effective Techniques. Toronto: Champion Press, 2008.

Munns, E. "Theraplay with Zero to Three Year Olds." In C. Schaefer, S. Kelly-Zion, J. McCormick, and A. Ohnogi (eds.), *Play Therapy for Very Young Children*. Lanham, MD: Rowman Littlefield, 2008.

Munns, E. (ed.). *Applications of Family and Group Theraplay.* New York: Jason Aronson, 2009.

Munns, E., Jenkins, D., and Berger, L. "Theraplay and the Reduction of Aggression." Unpublished manuscript: Blue Hills Child and Family Services; Aurora, Ontario, Canada, 1997.

Myrow, D. L. "In Touch with Theraplay." *The Theraplay Institute Newsletter,* Fall 1997, *9*, 1–4.

Myrow, D. L. "Theraplay for Children with ADHD." *The Theraplay Institute Newsletter*, Winter 1999/2000a.

Myrow, D. L. "Time for Parents." *The Theraplay Institute Newsletter*, Winter 1999/2000b.

Myrow, D.L. "Applications for the Attachment-Fostering Aspects of Theraplay." In E. Munns (ed.), *Theraplay: Innovations in Attachment-Enhancing Play Therapy*, Northvale, NJ: Jason Aronson, 2000.

Nagelschmitz, J. "Ein Vergleich des Interaktionsverhaltens von Müttern und Vätern mit ihren sprachentwicklungsgestörten söhnen im vorschulalter durch die H-MIM" (A Comparison of Interactive Behavior of Mothers and Fathers of Language Delayed Preschool Boys Using the H-MIM). *Schwierige Kinder-verstehen und helfen*, 2002, *27*, 4–12.

Nell, K. "Paradoxical Elements in the Psychotherapeutic Relationship in Theraplay." Unpublished master's thesis, University of Pretoria, South Africa, 1984.

New, D. K. "Observer Bias Influences in the Marschak Interaction Method Rating System." Unpublished doctoral dissertation, Alliant International University, Fresno, 2005.

Newberger, D. A. "Theraplay: A New Treatment Using Structured Play for Problem Children and Their Families" [Book review]. *Journal of Learning Disabilities*, 1981, *14*(2), 106.

Nolting, C., and Porretta, D. L. "A Play Therapy Model: Implications for Physical Education Teachers of Preschool Children with Disabilities." *Physical Educator*, 1992, *29*(4), 183–189.

O'Connor, K. J. *The Play Therapy Primer: An Integration of Theories and Techniques*. New York: Wiley, 1991.

O'Connor, K. J., and Ammen, S. *Play Therapy Treatment Planning and Interventions: The Ecosystemic Model and Workbook*. San Diego, CA: Academic Press, 1997.

O'Connor, K. J. "Creating a Coherent Attachment History: Combining Theraplay and Cognitive-Verbal Interventions." *The Theraplay Institute Newsletter*, Spring 2004.

Ogintz, E. "Kid Burnout: Work Stress Trickles Down to the Playground." *Chicago Tribune*, April 6, 1989, Tempo, p. 1.

Owen, P. L. "Fostering Preschooler Attachment and Development Through a Relationship-Based Group Parent-Training Program." Unpublished doctoral dissertation, Alliant International University, Fresno, 2007.

Preto, V. M., and Munns, E. "Nurturing the Aggressive Child, Theraplay: A Case Study." *Playground*, Spring 1994, pp. 9–10.

Putka, G. "Tense Tots: Some Schools Press So Hard Kids Become Stressed and Fearful—Flashcards, Computers, Tests All Day Long Take a Toll on Fast-Track Students—Burning Out by the Age of 10." *Wall Street Journal*, July 6, 1988, p. 1.

Rantala, K. "Theraplay korjaa kiintymyssuhteen vaurioita" (Theraplay Repairs Attachment Disorders). *Psykologi*, 2003, *7*, 12–13.

Rantala, K. "Theraplay vahvistaa hyvän kasvun edellytyksiä" (Theraplay Supports Healthy Growth). *Sosiaaliturva*, 2004, *10*, 25–26.

Rantala, K. "Terapeuttin leikka sairaan lapsen hoitona—kokemuksia Theraplay-Työskentelytavasta" (Therapeutic Play as Treatment for a Sick Child: Using the Theraplay Method). In E. Saarinen (ed.), *Sairaan ja vammaisen lapsen hyvä elämä* (The Good Life of the Sick and Disabled Child). Helsinki: Oy Edita Ab, 1998a.

Rantala, K. "Sairaan ja vammaisen lapsen hyvä elämä" (A Good Life for a Sick or Handicapped Child); "Terapeuttinen leikki sairaan lapsen hoitomuotona; kokemuksia Theraplay työskentelytavasta" (Therapeutic Play as a Treatment with a Sick Child: Experiences Using the Theraplay Method). *Edita*, 1998b, pp. 134–143.

Reeves, K. "Achieving Therapeutic Goals Through Group Theraplay—and Having Fun with It!" *The Theraplay Institute Newsletter*, Fall 1990, pp. 2–3.

Reeves, K., and Munns, E. "Group Theraplay in a Playschool Setting." *Playground*, Spring 1994, pp. 12–13.

Rieff, M. L. "Theraplay with Developmentally Disabled Infants and Toddlers." *The Theraplay Institute Newsletter*, Fall 1991, pp. 4–5.

Rieff, M. L. "Revisiting the Theraplay Dimensions with Post-Institutionalized Children." *The Theraplay Institute Newsletter*, Fall 1996, pp. 4–5.

Rieff, M. L., and Booth, P. "Theraplay for Children with PDD/Autism." *The Theraplay Institute Newsletter*, Spring 1994, pp. 1–7.

Ritterfeld, U. "Evaluation einer psychotherapeutischen Interventions-methode, Theraplay, bei sprachgestörten Vorschulkindern" (Evaluation of a Psychotherapeutic Intervention Method, Theraplay, with Language Disordered Preschool Children). Unpublished study qualifying for the Diplomat in Psychology, Universität Heidelberg, 1989.

Ritterfeld, U. "Theraplay auf dem Prüfstand. Bewertung des Therapieerfolgs am Beispiel sprachauffälliger Vorschulkinder" (Putting Theraplay to the Test: Evaluation of Therapeutic Outcome with Language Delayed Preschool Children). *Theraplay Journal*, 1990, *2*, 22–25.

Ritterfeld, U. "Das Rätsel Paul. Möglichkeiten einer systematischen Beobachtung der Eltern-Kind-Interaktion" (Paul, the Problem: Possibilities of a Systematic Observation of Parent-Child Interaction). *L.O.G.O.S. interdisziplinär*, 1993, *1*(1), 18–25.

Ritterfeld, U. "Welchen Stellenwert kann Theraplay in der logopädischen Behandlung haben?" (What Importance Can Theraplay Have in Language Therapy?). In H. Grimm und F. Weinert (eds.), *Intervention bei sprachgestörten Kindern* (Intervention with Language Disordered Children). Stuttgart: Fischer, 1994.

Ritterfeld, U., and Franke, U. *Die Heidelberger Marschak-Interaktionsmethode* (The Heidelberg Marschak Interaction Method). Stuttgart: G. Fischer, 1994.

Robbins, J. "Nurturing Play with Parents." *Nurturing Today*, Summer 1987, p. 6.

Robison, M., Lindaman, S. L., Clemmons, M. P., Doyle-Buckwalter, K., and Ryan, M. "'I Deserve a Family': The Evolution of an Adolescent's Behaviors and Beliefs About Himself and Others When Treated with Theraplay in Residential Care." *Child and Adolescent Social Work Journal,* forthcoming.

Ross, S.L.G. "Attachment-Based Group Therapy for Mothers and Children Affected by Domestic Violence." Unpublished master's thesis, University of Manitoba, Canada, 2004.

Rotenberk, L. "Touching." *Chicago Sun-Times*, August 17, 1986, Living Section, pp. 8–9.

Rubin, P. "Speech Theraplay in the Public Schools: Opening the Doors to Communication." *The Theraplay Institute Newsletter*, Summer/Fall 1982, pp. 3–7.

Rubin, P. "Theraplay: Schlüssel zur Kommunikation" (Theraplay: Key to Communication). *Theraplay Journal*, 1990, *2*, 3–8.

Rubin, P. "Multi-Family Theraplay in a Shelter for the Homeless." *The Theraplay Institute Newsletter*, Fall 1995, p. 5.

Rubin, P. "Understanding Homeless Mothers: The Dynamics of Adjusting to a Long-Term Shelter." Unpublished doctoral dissertation, Illinois School of Professional Psychology, Chicago, 1996.

Rubin, P. "Theraplay in einem Frauenhaus" (Theraplay in a Women's Shelter). *Schwierige Kinder-verstehen und helfen*, 2002, *27*, 14–17.

Rubin, P., Lender, D., and Mroz, J. "Theraplay and Dyadic Developmental Psychotherapy." In E. Munns (ed.), *Applications of Family and Group Theraplay*. New York: Jason Aronson, 2009.

Rubin, P. B., and Tregay, J. *Play with Them—Theraplay Groups in the Classroom: A Technique for Professionals Who Work with Children*. Springfield, IL: Thomas, 1989.

Rubin, P., and Tregay J. "Die fünf Theraplay-Elemente" (The Five Theraplay Dimensions). *Theraplay Journal*, 1990, *1*, 4–9.

Ruokokoski, I. "Theraplayterapian esittelyvideo vanhemmille ennen hoitoa" (Video Presenting Theraplay to Parents Before Theraplay Treatment). Unpublished final thesis in family therapy training, Oulu Counselling and Family Centre supported by Stakes, Oulu, Finland, 2007.

Safarjan, P. T. "Use of the Marschak Interaction Method (MIM) in Forensic Evaluation." *The Theraplay Institute Newsletter*, Winter 1992, p. 3.

Salmi, A-M. "Theraplayterapiaa ja leikkiä" (Theraplay Therapy and Play). Competence study, Turku University, Finland, 2004.

Salo, S., and Mäkelä, J. *Vuorovaikutushavannoin käsikirja—kävuodet 2–8* (MIM-Manual for Observing Interaction: Ages 2–8). Psykologien Kustannus: Oy, 2006.

Salo, S., and Tuomi, K. *Hoivaa ja leiki–vauvan ja vanhemman vuorovaikutuskirja* (Nurture and Play: Interaction Book for Babies and Parents). Psykologien Kustannus: Oy, 2008.

Schoeman, E. M. "Theraplay with a Pre-Adolescent Stutterer" [Afrikaans Text]. Unpublished master's thesis, University of Pretoria, South Africa, 1985.

Schoeman, E. M. "The Development of a Complementary Psychological Treatment Programme for Cochlear Implant Teams." Unpublished doctoral dissertation, University of Pretoria, South Africa, 2004.

Searcy, K. L. "The Mercy Approach to Theraplay." In M. Burns and J. Andrews (eds.), *Selected Papers: Current Trends in the Treatment of Language Disorders*. Evanston, IL: Institute for Continuing Education, 1981.

Seppänen, S. "Ikkulapsiperhe terapiassa–perheterapian ja theraplayn vuoropuhelua" (Family with Infants in Therapy: Dialogue Between Family Therapy and Theraplay). Unpublished final thesis in couples and family therapy training, Häme Summer University, Finland, 2005.

Sherman, J. "Father-Son Group Theraplay." In E. Munns (ed.), *Applications of Family and Group Theraplay*. New York: Jason Aronson, 2009.

Simons, L. *Interplay Groups: Group Sessions to Develop Social Interaction Skills*. Bellevue, WA: Family Interplay Associates, 1995.

Siu, F.Y.A. "Internalizing Problems Among Primary School Children in Hong Kong: Prevalence and Treatment." Unpublished doctoral dissertation, Chinese University of Hong Kong, 2006.

Siu, F.Y.A. "Theraplay for Chinese Children." In E. Munns (ed.), *Applications of Family and Group Theraplay*. New York: Jason Aronson, 2009a.

Siu, F.Y.A. "Theraplay in the Chinese World: An Intervention Program for Hong Kong Children with Internalizing Problems." *International Journal of Play Therapy*, 2009b, *18*(1), 1–12.

Sjölund, M. "Framgäng för ny form av lekterapi I Chicagos slum" (Success of a New Form of Play Therapy in Chicago's Slums). *Psykolognytt*, 1980, p. 28.

Smilie, G. "In Sync." In E. Munns (ed.), *Applications of Family and Group Theraplay*. New York: Jason Aronson, 2009.

Spicer, L., and Fuller, B. "Theraplay-eine Universalsprache?" (Theraplay a Universal Language?). *Schwierige Kinder-verstehen und helfen*, 2003, *30*, 12–14.

Steyn, M. P. "The Interaction Between a Child Suffering from Tourette Syndrome and His Parents, with Specific Reference to the Marschak Interaction Method." Unpublished master's thesis, University of Pretoria, South Africa, 1994.

Steudel, E. "Fühlen, lachen, hören oder Hakan erspielt sich Selbstvertrauen" (Feeling, Laughing, Listening: Hakan Gains

Self-Esteem Through Group Theraplay). *Schwierige Kinder-verstehen und helfen*, 2006, *38*, 12–14.

Stubenbort, K. F. "The Effectiveness of Intervention for Maltreated Preschoolers: An Attachment Theory Perspective." Unpublished doctoral dissertation, University of Pittsburgh, 2003.

Sutherland, P. L. "A Group Therapy Program for Aboriginal Women and Children Who Have Been Exposed to Family Violence." Unpublished master's thesis, University of Manitoba, Canada, 2002.

Talen, M. R. "Community-Based Primary Health Care: A New Role for Theraplay." *The Theraplay Institute Newsletter*, Fall 1995, pp. 1–3.

Talen, M. R., and Warfield, J. "Guidelines for Family Wellness Checkups in Primary Health Care Services." In L. VandeCreek, S. Knapp, and T. L. Jackson (eds.), *Innovations in Clinical Practice: A Source Book, Vol.15*. Sarasota, FL: Professional Resource Exchange, 1997.

Thorlakson, C. L. "Teaching and Learning to Care: An Early Years Prevention Program in Emotional Intelligence." Unpublished master's thesis, University of Manitoba, Canada, 2004.

Van Der Hoven, E. G. "Theraplay as Therapeutic Intervention with Anorexia Nervosa in Early Adolescence" [Afrikaans Text]. Unpublished master's thesis, University of Pretoria, South Africa, 1983.

Väyrynen, S. "Mitä leikissä tapahtui? Minäkäsityksen ja vuorovaikutustaitojen kehittyminen terapeuttisen leikin avulla" (What Happened When We Were Playing? Strengthening Self-Esteem During Therapeutic Play). Laudatur studies, Helsinki University, Finland, 1995.

Viitanen, P. "Theraplay vuorovaikutusterapia sijoitettujen lasten kehityksen tukena" (Theraplay Interaction Therapy as a Developmental Support to Foster Children). Unpublished licenciate thesis, Jyväskylä University, Finland, 2007.

Von Gontard, A., and Lehmkuhl, G. "Spieltherapien-Psychotherapien mit dem Medium des Spiels: II. Neue Entwicklungen" (Playtherapies-Psychotherapies with the Medium of Play: II. New Developments). *Praxis der Kinderpsychologie und Kinderpsychiatrie*, 2003, *52*(2), 88–97.

Vorster, C. M. "The Parent's Experience of Theraplay." Unpublished master's thesis, University of Pretoria, South Africa, 1994.

Wardrup, J. L., and Meyer, L. A. "Research on Theraplay Effectiveness." In E. Munns (ed.), *Applications of Family and Group Theraplay*. New York: Jason Aronson, 2009.

Warnke, A. "Theraplay: A Directive Play-Therapy" [German text] [Book review]. *Zeitschrift fur Kinder-und Jugendpsychiatrie und Psychotherapie*, 1991, *19*(2), 119.

Weber, P. "Theraplay Groups for Adolescents with Emotional Problems." *The Theraplay Institute Newsletter*, Summer 1998.

Weir, K. N. "Using Integrative Play Therapy with Adoptive Families to Treat Reactive Attachment Disorder: A Case Example." *Journal of Family Psychotherapy*, 2008, *18*(4), 1–16.

Weiss, D. "Equine Assisted Therapy and Theraplay." In E. Munns (ed.), *Applications of Family and Group Theraplay*. New York: Jason Aronson, 2009.

West, C. "Theraplay mit Jugendlichen" (Theraplay with Adolescents). *Schwierige Kinder-verstehen und helfen*, 2005, *36*, 13–15.

West, C. "Theraplay: A Head Start Treasure." *The Theraplay Institute Newsletter*, Winter 2006.

Westman, H. "SOS-lapsikyliin sijoitettujen lasten emotionaalinen oireilu ja käytöshäiriöt sekä Theraplay-intervention vaikutus oireiluun" (Emotional Symptoms and Behavioural Problems and Effects of Theraplay Intervention Among Children Who Are Placed in SOS Children's Villages, Finland). Unpublished master's thesis, Tampere University, Finland, 2008.

Wettig, H. "Bericht über das Forschungsprojekt Theraplay" (Report About the Theraplay Research Project). *Schwierige Kinder: verstehen und helfen*, 1999, *17*, 4–11.

Wettig, H. "Veränderung der Einstellung von Eltern zu ihren verhaltensauffaelligen Kindern nach Theraplay" (Change of Parent's Attitude to Their Conduct Disordered Children After Treatment Using Theraplay). Unpublished master's thesis, University of Heidelberg, Germany, 2002.

Wettig, H. "Scheue Kinder-mutige Kinder. Veränderung durch Theraplay" (Shy Children-Courageous Children. Change Through Theraplay). *Schwierige Kinder-verstehen und helfen*, 2003, *31*, 8–14.

Wettig, H. "Aggressive Kinder-scheinbar nicht zu bremsen. Die Wirkung von Theraplay" (Aggressive Children: The Effects of Theraplay). *Schwierige Kinder-verstehen und helfen*, 2004, *34*, 15–23.

Wettig, H. *Die Wirkung von Theraplay auf Klein-und Vorschulkinder mit klinisch bedeutsamen Verhaltensstoerungen, Aufmerksamkeitsdefiziten mit und ohne Hyperaktivitaet und mit rezeptiven Sprachstoerungen*. (The Effectiveness of Theraplay with Toddler and Preschool Children Diagnosed with Clinically Significant Conduct Disorders, Attention Deficit Disorders with or Without Hyperactivity, ADHD or ADD, and Receptive Language Disorders). Doctoral dissertation. *Library of the University of Heidelberg* (available as download), Germany, 2007.

Wettig, H., Franke, U., and Fjordbak, B. S. "Evaluating the Effectiveness of Theraplay." In C. E. Schaefer and H. G. Kaduson (eds.), *Contemporary Play Therapy: Theory, Research, and Practice*. New York: Guilford Press, 2006.

Wettig, H., Franke, U., and Coleman, A. R. "Evaluating the Effectiveness of Theraplay in Treating Shy, Socially Withdrawn Children." In review. 2009.

Wiksed, A. "Lasta voi auttaa kiinnittymään" (You Can Help the Child to Attach). *Yhteiset lapsemme*, 2004, *4*, 8–10.

Wilson, C. J. "Identification of Parents at Risk for Child Abuse: A Convergent Validity Study of the Marschak Interaction Method." Unpublished doctoral dissertation, California School of Professional Psychology, Fresno, 2000.

Wilson, P. "Review of Here I Am." *Hospital and Community Psychiatry*, 1973, *24*, 347–348.

Winkler, B. "Bedeutung der Nicht-Direktivität und der Direktivität in der nicht-direktiven und direktiven Spieltherapie" (The Significance of Non-Directive and Directive in Non-Directive and Directive Play Therapy). Unpublished master's thesis, Würzburg, 1994.

Winstead, M.L.R. "Theraplay with Children in Foster Care: A Case Study." *The Theraplay Institute Newsletter*, Summer 2008.

Witten [Whitten (sic)], M. R. "Assessment of Attachment in Traumatized Children." In B. James (ed.), *Handbook for Treatment of Attachment-Trauma Problems in Children*. New York: Lexington Books, 1994.

Wright, S. U. "The Marschak Interaction Method as a Short-Term Therapeutic Medium for Parent and Child with Interaction Problems." Unpublished master's thesis, University of Pretoria, South Africa, 1993.

Yando, R. "Play-tonic Relationships?" [Book Review.] *PsycCRITIQUES*, 1981, *26*(11), 875–876.

Zanetti, J. J. "An Extension of Dyadic Counseling to Multi-Family Group Training with Application for Head Start Families." Unpublished doctoral dissertation, College of William and Mary, 1996.

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ANN M. JERNBERG was the founder and director of The Theraplay Institute until her death in 1993. She provided the inspiration for the Theraplay approach and was the author of the first edition of this book.

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Cover design by Cassandra Chu

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ISBN 978-0-470-28166-6