

# Learning the Basics of the Theraplay Method

— T heraplay 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.<sup>1</sup> 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.<sup>2</sup>

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.<sup>3</sup> 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.<sup>4</sup> 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.<sup>5</sup> 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.<sup>6</sup> 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.<sup>7</sup>

### **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.<sup>8</sup> 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.

