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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*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.

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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.

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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)*.

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*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