

Theraplay: Building Healthy Attachments

by

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B.S., Oklahoma State University, 2004

A Report

submitted in partial fulfillment of the requirements for the degree

Master of Science

Department of Family Studies and Human Services  
College of Human Ecology

Kansas State University  
Manhattan, Kansas

2008

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## **Abstract**

Theraplay is a technique used to replicate healthy parent-child interactions in order to build healthy attachments. Theraplay is a short-term therapeutic approach that is intimate, physical, personal and enjoyable. The goal of Theraplay is to improve attachments, self-esteem and trust in the relationship. The use of Theraplay has been shown to be beneficial for people of all ages including infants up to geriatric clients. This report offers an overview of Theraplay, provides clinical issues in which Theraplay can be implemented, describes the Theraplay process, and gives implications for further research. Because Theraplay is a highly specialized field, this report also gives information on how to become certified in Theraplay. This report was written for Masters' and Doctoral students in the mental health field that have an interest in working with clientele with attachment injuries.

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## Acknowledgements

Thanks everyone...

Just kidding, I'll make this longer. First I would like to start by thanking my family. I want to first thank my mom, for listening to me when I called to complain about this report, and for the many other things you have done in my life. This includes giving me a secure attachment. ☺ My dad I want to thank for instilling the work ethic I have today. Hopefully I'll be able to make it in the 'real world.' Rusty, my older brother, thanks for being someone I can talk to about professional issues. I love you even though you are a 'bleeding-heart conservative.' Randy, my younger brother, you are pretty much my favorite person in the world. I want to be more like you as I get older. Grandma, thank you for everything. I'm proud when people tell me that I am so much like you. I appreciate everything you have done for us as a family, especially Sunday dinners. Aunt Rita, Jeff, Michelle, Clay, Jason, and Amanda, I am so glad that we are a close family and that I don't annoy you too much...most of the time. Zachery, Tyler, Kelsey, and Jennifer, you guys rock and I hope you grow up to be cool like me. ☺

My friends have been the saving grace for me in this program. Shannan Osborn, thanks for moving to Kansas. Not many people can say they moved states just for a friend. You make me laugh everyday. Lesley Hill, thanks for putting up with my crap and dishing it back to me when I need it. I can't fully express everything you've done for me, so I'll move to a different state with you. At this time, I would like to give a special shout out for Lesley to Officer Sweet and 'the baby.' Cyndi Sallman, thanks for guiding me to my destiny with play therapy. Also, a thanks for showing me that emotion isn't completely useless. ☺ Robert Copeland, you are a wonderful and amazing person. Thanks for loving me for being me. To all my other Manhattan friends, Ashley Nemchik, Ben Augustine, Seanna Nelson, Brigitte Bruna, Adrienne Olney, Katie Curtis, Amber Sims, Ah-Young Cho, Yvonne Amanor-Boadu, etc. thanks for keeping me company. LOVE YOU ALL!

To my Oklahoma friends, you have molded me into the person I am today. Hopefully, that is a good thing. Carrie Couch, Rebecca McGee, Miriam McFarland, and Jonathan McFarland, or my second family, thank you for everything and making me feel like I'm a part of your family. Carrie you have and continue to be a huge inspiration in my life. Sarah Wilkey



## **Dedication**

This paper is dedicated to my grandpa, Virgil Armstrong. Grandpa, I miss you so much everyday. I know you would be proud of me. I love you.

## **CHAPTER 1 - Introduction**

### *Vignette 1*

Sarah has never felt a close relationship to her son, Randy. The pregnancy was an accident, and she was not ready at seventeen to be a mother. Five years later, she still feels a strain on their relationship. Randy does not listen to his mother, and is displaying behavioral problems both at home and school. To Sarah, it feels as if her and Randy will always have this dysfunctional bond.

### *Vignette 2*

When Michelle gave birth to her twins, she was overcome with joy. Aside from Jennifer's hospitalizations caused by earaches, both the twins lived a fairly normal, healthy life. As the twins became older, she began to notice the tremendous differences in their personalities. While Kelsey was outgoing and vibrant, Jennifer seemed to be more introverted with her feelings and emotions. The sibling rivalry between the twins is also increasing exponentially as they grow. After Michelle and her husband divorce, Michelle feels overwhelmed at the outlook of raising the twins as a single mother.

### *Vignette 3*

Tyler and Rusty are working on building a relationship with their recently adopted son, Zachery. Although he was only two years old when they adopted him, they know he experienced a traumatic life. From what they know, Zachery was basically abandoned by his birth parents and had been in at least two different foster homes before coming to live with them. In the two months since they adopted him, they have seen Zachery has quite a temper when they attempt any discipline with him. Zachery has also been kicked out of day care because of his negative interactions with both the children and day care workers.

The three vignettes above are instances when Theraplay, an attachment based treatment, can be implemented in therapy. The following report will introduce the reader to the specialized technique of Theraplay and how it can be used with a variety of clients. Graduate students in the mental health field, specifically those working with families in a systems orientation, will find this report useful when working with clients who have experienced attachment injuries.

The aim of this report is to provide an overview of the Theraplay technique, including its history, foundational theories, examples of clinical issues in which Theraplay has been successfully implemented, a detailed outline of the progression of treatment, and an explanation of the certification process. This report will provide readers with an introduction to Theraplay and should not be used as a substitute for training, which is required for practice. Finally, this report will give implications for further research that can be pursued with Theraplay.

## **CHAPTER 2 - Overview of Theraplay**

This chapter will provide an overview of Theraplay. The overview will include an explanation of the Theraplay model and incorporate the history and theoretical foundations surrounding Theraplay. The chapter will also include information on the importance of development in the integration of the model.

### **What is Theraplay?**

Theraplay is a technique used to replicate healthy parent-child interactions in order to build healthy attachments. It is a short-term therapeutic approach that is intimate, physical, personal and enjoyable (Jernberg & Booth, 1999). Theraplay is not like talk therapy in that no interpretations are made (Munns, 2003). The emphasis instead is on the interaction and relationship between the therapist and child at first then moving on to the parent-child relationship (Munns, 2003).

The goal of Theraplay is to ultimately improve attachment, self-esteem and trust in the relationship. In families where conflict is apparent or where there have been previous attachment injuries; it can cause a sense of distrust, dismissal, emotional distance or enmeshment, a lack of cooperation, and inadequate joy in the relationship (Munns, 2003). “Theraplay tries to heal family relationships through emphasizing the positive qualities of the child, leading the parents to see their child in a new light and to experience their child as a source of delight rather than pain” (Munns, 2003, p. 156).

Theraplay is practiced in a variety of settings including schools, mental health facilities, hospitals, private practices, and homes. Although it is applied to a variety of issues and age ranges, as discussed in Chapter 3, it is mainly used for children between 1 ½ years old to 12 years old, along with their caretakers. “The kinds of problems that Theraplay addresses often have their origins in the earliest stages of a child’s development. Although most children who come for treatment are beyond the infant stage, they still need the nurturing touch, the focused eye contact, and the playful give and take that are such important components of the healthy parent-child relationship” (Jernberg & Booth, 1999, pp. 4-5). The surroundings that an infant or young child is exposed to, whether positive or negative, help the child learn who they are in relationship

to their environment, what to expect from that environment, who important people are, how they feel about those people, and how the child should be treated. Theraplay as a treatment modality helps to combat against a negative environment that a child experienced in order for the child to grow into a healthy adult.

## **History of Theraplay**

Ann Jernberg, a psychologist, founded Theraplay in 1967 (Munns, 2003). Jernberg had received a grant to increase bonding between mothers and children in the Head Start program in Chicago (Jernberg & Booth, 1999). Due to the nature of the setting, she needed an intensive, short-term treatment method. Jernberg turned to the work of Austin Des Lauriers, who worked with autistic and schizophrenic children, and Viola Brody, a noted developmental play therapist (Jernberg & Booth, 1999). Jernberg looked at Des Lauriers' method of vigorous intrusiveness and intimacy through direct body and eye contact (Jernberg & Booth, 1999). "Like Brody, [Jernberg] geared the treatment to the child's current developmental, not chronological, level" (Koller & Booth, 1997, p. 204). For example, a child that has experienced a trauma may become stuck in the developmental stage in which the trauma occurred. Therefore, even if the child is chronologically ten, they maybe stuck as a two-year-old developmentally if trauma occurred at that age.

Theraplay in its current form takes many aspects from Des Lauriers and Brody. It differs in the levels of intensity as well as the degree in which the therapist takes charge of the session (Koller & Booth, 1997). Jernberg focused on the early relationship between a mother and a child. She saw four main dimensions of a parent-child relationship that she chose to focus on in treatment: 1) Structure; which encourages safety with the caregiver in charge, 2) Challenge; which helps the child to challenge themselves and see success, 3) Engagement; the part of the relationship that encourages attunement and eye contact, and 4) Nurture; the physical touch of the parent-child relationship that is so important to healthy development and growth.

Theraplay uses the Marschak Interaction Method (MIM) assessment to observe the parent-child relationship before Theraplay techniques are introduced. The videotaped assessment consists of a series of simple tasks designed to elicit a range of behaviors in

the four dimensions used in Theraplay (Lindaman, Booth, & Chambers, 2000). The MIM evaluates the caretakers' ability to set limits, nurture, be attuned to child's needs, and encourage the child in a positive manner. After the MIM is administered, the therapist goes over the taped session with the parent and points out strengths and weaknesses in the parent-child interactions. Features of Theraplay are then used to meet the individual needs of the family.

Once Jernberg began the treatment, she started training other professionals on Theraplay. During this time, a few individuals started treating children in a different way and named what they did "Theraplay". This led to Theraplay becoming a registered service mark, which is the equivalent of a trademark in 1976 (Jernberg & Booth, 1999). In the 1980s, Theraplay expanded to the United States and Canada. It then expanded to Australia, Finland, Germany, Israel, Korea, and South Africa as a treatment modality (Jernberg & Booth, 1999).

### ***The Theraplay Institute***

Shortly after founding the treatment modality, The Theraplay Institute was established in 1971. Its purpose was to provide service and training to those interested in Theraplay (Jernberg & Booth, 1999). Currently, the Institute sponsors a research network, publishes a biannual newsletter and sells Theraplay-related books and videos (The Theraplay Institute, n.d.a). Information for parents, therapists, and others interested in Theraplay can be accessed from The Theraplay Institute's website at [www.theraplay.org](http://www.theraplay.org). The website offers a reference site to all known articles written on Theraplay. It includes research on Theraplay as an evidenced-based practice. The institute also sponsors an *International Theraplay Conference* in Chicago every odd-numbered year, featuring highly acclaimed experts in the field of child development as well as presentations from Theraplay experts from around the world (The Theraplay Institute, n.d.a).

### ***Play Therapy***

Although Theraplay differs vastly from traditional play therapy, often it is included under the umbrella of play therapy. Because of this reason, it is important to include a brief discussion of the history of Theraplay in relationship to play therapy. To

begin this discussion, here is a definition of play therapy. Kevin O'Connor (2000) describes play therapy as follows:

“Play therapy consists of a cluster of treatment modalities that involve the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development and the re-establishment of the child’s ability to engage in play behavior as it is classically defined” (p. 7).

Play therapy describes a broad treatment modality that includes various theoretical approaches such as client-centered, Jungian, developmental, Adlerian, and cognitive-behavioral play therapy. Play therapy began in the psychotherapy age with Anna Freud (Homeyer & DeFrance, 2007). The first to use play in therapy just saw the child’s play as a method of interpretation. The first therapists to use play therapy as a way of treating issues were David Levy with release play therapy, Gove Hambidge with structured play therapy, and J. Solomon in active play therapy (Homeyer & DeFrance, 2007). From there, the field has moved on to more contemporary uses of the modality such as Landreth’s non-directive approach, O’Connor’s ecosystem approach, Schaefer’s prescriptive approach, among many others including Theraplay. To relate Theraplay to play therapy, Munns (2003) called Theraplay a structured form of play therapy.

Theraplay derived its method from various approaches that have originated in the play therapy genre. As mentioned earlier, one of the most notable of these play therapy approaches is developmental play therapy. Brody developed the technique known as developmental play therapy that emphasizes touch and structure in the play therapy session (O’Connor, 2000). In addition to play therapy, it is beneficial to the understanding of Theraplay to look at the theories surrounding the approaches from which it derived. The most notable theories to discuss in this context are attachment and developmental theories.

### **Theories of Theraplay**

“Theraplay is based on attachment theory: It is believed that the first relationship a child has is the most important one in that child’s life because it forms the template for

later relationships” (Munns, 2003, p. 157). Furthermore, developmental theories are taken into account with the establishment and use of Theraplay. Since its organization in the early 1970s, Theraplay has developed an increasing body of research in the fields of child development and attachment theory that has given further support to its tenets (Koller & Booth, 1997).

### *Attachment Theory*

Before one can look at Theraplay as a form of treatment, understanding attachment theory is necessary. Ethological theory of attachment is the most widely accepted view of attachment. Bowlby formulated this theory, which views the infant’s attachment as an evolved response that promotes survival through ensuring safety and competence (Berk, 2003). Bowlby saw the importance of meeting needs of attachment early in life to promote healthy future development. Bowlby (1953) wrote, “it leaves no room for doubt regarding the general proposition – that the prolonged deprivation on the part of the young child of maternal care may have grave and far-reaching effects on his character and so on the whole of his future life” (p.50). Bowlby also saw that the degree of psychological distress experienced by a person that had been deprived of healthy attachments as a child depended upon the stage in which the child was when the deprivation occurred (Bowlby, 1953). Bowlby outlined four stages where significant attachment occurs in a child’s life:

- Preattachment phase occurs from birth to six weeks. This stage includes primal signals and closeness. The emphasis is on the caregiver’s scent and voice. At this age, the infant does not mind being left with a stranger and is not fully attached.
- “Attachment-in-the-making” phase occurs from about six weeks to eight months. The child begins to differentiate his or her caretaker from strangers. This is seen through the different responses the infant gives the two individuals. At this age, infants can be relieved from stress at the presence of their caretaker and they begin to develop a sense of trust.
- Phase of “clear cut” attachment occurs after eight months to about two years of age. The idea of separation anxiety becomes apparent at this

stage. This is where the child clearly becomes upset with the absence of their caretaker. Additionally, a secure base to their primary attachment figure begins to form.

- Formation of reciprocal relationship occurs beyond two years of age. This is the time where separation anxiety decreases as the child learns to understand that the caregiver will be back at a stated time.

(Bowlby, 1980, as cited in Berk, 2003)

Through his work, Bowlby also developed the idea of the internal working model. “A central tenet (Bowlby, 1969, 1973) of attachment theory is that people develop mental representations, or internal working models, that consist of expectations about the self, significant others, and the relationship between the two” (Pietromonaco & Barrett, 2000, p. 156). The internal working models form the foundation for all future attachment relationships, and guide a person’s life. If a child’s internal working model says that the child is “bad” and does not deserve love, which they may have learned in the parent-child relationship, the child will subconsciously act in ways that will match their internal working model. For example, the child may “act out” in order to get the type of response from his caregivers that will validate the negative internal working model that the child is “bad” and does not deserve to be loved.

When the internal working model is formed, it is very difficult to reverse. Dan Hughes, a noted psychologist in the field of attachment, discusses the idea of the internal working model in relation to one particular child. The child he discusses, Katie, grew up in a severely abusive home. After receiving services and being placed in a nurturing household she still displayed problematic behaviors.

(W)ith Katie, and with other children who have difficulty forming secure attachments, she has extreme difficulty integrating experiences of fun, love, and freedom to choose. She sabotages fun, undermines efforts to love her, and her choices are invariably not in her best interests...but we help her to remove experiences of rejection, humiliation, and contempt from socialization experiences. Most importantly, we will quickly reconnect with her emotionally after her experience of shame so that she will be able to sense her worth and feel the beginning of security in her

attachment(s)...even when she must experience consequences for her poor behavioral choices (Hughes, 2006, p. 85).

Consequently, looking at the case of Katie, one can see why Theraplay is so important in the way in which it is implemented. The focus of Theraplay is on uniqueness and the idea that the child is special. This is to directly combat the negative internal working model that a child might have formed at a young age.

When discussing attachment, Mary Ainsworth's work is pivotal. Ainsworth developed the Strange Situation to research attachment, and found "various environmental conditions that may activate attachment behavior in a young child who has already become attached to a specific figure are absence of or distance from that figure, the figure's departing or returning after an absence, rebuff by or lack of responsiveness of that figure or of others, and alarming events of all kinds, including unfamiliar situations and strangers" (Ainsworth, 1978, p. 7). In her work with the Strange Situation, Ainsworth (1978) developed three types of attachment styles. One group, the ideal, was labeled securely attached infants. These children were able to use adults as a secure base, to explore the world around them more effectively and positively, yet were able to receive comfort when their caregiver returned after being absent. Ainsworth saw that these infants had become accustomed to a long positive experience in the context of close bodily contact.

Ainsworth also discovered two types of insecure attachment. The first was insecure and avoidant, where the infant was not distressed by the parents departure and ignores the parent upon reunion. The second type of insecure attachment was insecure resistant attachment. Here, the infant tends to be too fearful to leave their parent's side and they fail to explore their environment. The child then becomes angry upon separation and is difficult to soothe by the parent when they return.

In the mid 1980s, a student of Mary Ainsworth, Mary Main, and Judith Soloman introduced a fourth attachment style called disorganized/disoriented attachment. This style was shown to reflect the greatest amount of insecurity. The child seems to be confused or shows flat emotion upon the parent reunion (Klykylo, 2001).

Ainsworth's (1978) study found that avoidant and resistant behaviors were not more frequent or intense when comparing the infant's reaction to a stranger and to the

mother. She found that the group she later called securely attached sought contact and were soothed by their mother probably because they were accustomed to positive contact with their mother. The group later referred to as resistant tended to cry more and experienced more separation anxiety than securely attached infants. Avoidant babies tended to display how they had been treated. The mothers of this group were more rejecting and tended to be adverse to close contact, and the infants showed a similar pattern in the study.

One must consider the following factors that might determine the type of attachment style of a child. The most important factors include the opportunity to establish an attachment, the quality of caregiving, the infant's characteristics, and their family context, including the parents' internal working model. All of these characteristics interconnect to form the attachment style in a child. At the base of these attachment theories is where Theraplay extracts its value.

### ***Developmental Theory***

Developmental stages are extremely important to consider in work with attachment. As mentioned, a person can become stuck in a particular developmental stage due to various traumatic issues that might have occurred. For the purpose of this paper the specific developmental theories discussed will include Piaget's cognitive development theory, information-processing approach, and Erikson's psychosocial stages of development.

### ***Cognitive Development***

Piaget's cognitive development stages formed out of the idea that children make sense of things around them through adaptation. Adaptation consists of both assimilating and accommodating. Assimilation involves using a current scheme to interpret the world, while accommodating is where the individual adjusts their old scheme and creates new ones to better fit with the environment (Berk, 2003). Piaget's ideas about cognitive change can explain how a negative attachment style may affect the way children adapt to the schemes in their life. The following table highlights Piaget's stages of development:

**Table 1-Piaget's Cognitive Development Stages**

<b>Stage</b>	<b>Ages</b>	<b>Characteristic</b>	<b>Key Components</b>
<b>Sensorimotor</b>	Birth to 2	Learn through senses	*Lack of object permanence
<b>Preoperational</b>	2 to 7	Representation that is yet to be logical	*Make-believe play *Egocentric *Inability to conserve
<b>Concrete Operations</b>	7 to 11	Thought logical, flexible, and organized in concrete manner	*Master conservation and hierarchical classification
<b>Formal Operations</b>	11 +	Develop capacity to think abstractly	*Hypothetico-deductive reasoning

(Piaget & Inhelder, 1969)

In one of his later writings, Piaget and Inhelder (1969) state the particular importance of the sensorimotor stage of development:

“If the child partly explains the adult, it can also be said that each period of his development partly explains the periods that follow. This is particularly clear in the case of the period where language is still absent. We call it the “sensori-motor” period because the infant lacks the symbolic function; that is, he does not have representations by which he can evoke persons or objects in their absence. In spite of this lack, mental development during the first eighteen months of life is particularly important, for it is during this time that the child constructs all the cognitive sub-structures that will serve as a point of departure for his later perceptive and intellectual development, as well as a certain number of elementary affective reactions that will partly determine his subsequent affectivity” (p. 3).

A child is generally in the sensorimotor stage during attachment development. The infant at this time can only learn through their senses and has yet to develop the ability to make sense of what happens in a logical, organized manner. Any experience of attachment injury during this phase is traumatic due to the infant’s inability to seek

recourse. Theraplay mitigates these attachment injuries by replicating positive attachment experiences that an infant might have shared with an attachment figure.

A Theraplay therapist should always keep developmental stages in the back of their mind in order to assess where a particular client may be in their development. As mentioned previously, the developmental age of a client is important to note because it may be significantly different than the child's chronological age. Therefore, if a ten-year-old child is developmentally stuck as a two-year-old, the child may display characteristic two-year-old behaviors, such as tantrums. The therapist should be aware of this concept to educate the parents on the differences between developmental and chronological ages and what those concepts mean in relation to their child. Ultimately the goal of Theraplay in a situation where a child's developmental stage does not correspond with the child's chronological age is for the child to experience the unmet needs they did not receive at that earlier developmental stage. Once those needs are met, the child can become 'unstuck' and move on to accomplishing other developmental tasks.

### ***Information-Processing Approach***

The information-processing approach of development is based on the work of Atkinson and Shrifin (1968, as cited by Huitt, 2003). Berk (2003) defines this approach:

Information from the environment is *encoded*, or taken in by the system and retained in symbolic form. Then a variety of internal process operate on it, *recoding* it, or revising its symbolic structure into a more effective representation, and then *decoding* it, or interpreting its meaning by comparing and combining it with other information in the system. When these cognitive operations are complete, the individuals use the information to make sense of their experiences and to solve problems (p. 270).

Much like the previous cognitive developmental theory discussed, the child learns a lot from the environment surrounding them, whether is it constructive or unconstructive. The information-processing approach posits that after harm has been done to the individual reversal would be difficult. This is because once the individual learns a way to handle a situation, maybe suitable to survival in some cases, it may be difficult to approach that dynamic later in life. Theraplay targets these early-learned

behaviors and memories to help the individual reprocess the way in which they view themselves and the world around them.

***Psychosocial Development***

The final developmental approach that is helpful to discuss when viewing attachment and early life is Erikson’s psychosocial stages. Erikson’s views were that at each developmental stage, the individual must face a psychosocial conflict that leads to acquiring a skill or aptitude. The individual resolves the conflict on a continuum from positive to negative, which determines healthy or maladaptive outcomes at each stage (Berk, 2003). The following table extracted from Berk (2003, p. 18) summarizes the stages in Erikson’s psychosocial developmental approach:

**Table 2-Erikson's Psychosocial Stages of Development**

<b>Psychosocial Stage</b>	<b>Period of Development</b>	<b>Description</b>
Basic trust versus mistrust (Oral)	Birth-1 year	From warm, responsive care, infants gain a sense of trust, or confidence, that the world is good. Mistrust occurs when infants have to wait too long for comfort and are handled harshly.
Autonomy versus shame and doubt (Anal)	1-3 years	Using new mental and motor skills, children want to choose and decide for themselves. Autonomy is fostered when parents permit reasonable free choice and do not force or shame the child.
Initiative versus guilt (Phallic)	3-6 years	Through make-believe play, children experiment with the kind of person they can become. Initiative-a sense of ambition and responsibility-develops when parents support their child’s new sense of purpose. The danger is that parents will demand too much self-control, which leads to over control, meaning too much guilt.

Industry versus inferiority (Latency)	6-11 years	At school, children develop the capacity to work and cooperate with others. Inferiority develops when negative experiences at home, at school, or with peers lead to feelings of incompetence.
Identity versus identity confusion (Genital)	Adolescence	The adolescent tries to answer the question, Who am I, and what is my place in society? Self-chosen values and vocational goals lead to a lasting personal identity. The negative outcome is confusion about future adult roles.
Intimacy versus isolation	Young adulthood	Young people work on establishing intimate ties to others. Because of earlier disappointments, some individuals cannot form close relationships and remain isolated.
Generativity versus stagnation	Middle adulthood	Generativity means giving to the next generation through child rearing, caring for other people, or productive work. The person who fails in these ways feels an absence of meaningful accomplishment.
Integrity versus despair	Old age	In this final stage, individuals reflect on the kind of person they have been. Integrity results from feeling that their life was worth living as it happened. Old people who are dissatisfied with their lives fear death.

Again, Erikson's stages should be viewed on a continuum. Therefore, the stages are not resolved either/or, but are resolved on a range of the psychosocial conflicts. If a stage is resolved further to the negative end of the continuum, a domino effect can occur. For instance, if a child resolves the first stage more towards mistrust than trust, it will affect the remaining stages of the person's life unless it is able to be resolved.

Erikson gives an anecdote about the importance of previous stages in his book, *Toys and Reason* (1977). "A possible emotional reason for our fixation on beginnings

was well expressed recently in “Peanuts.” Lucy, the doctor, was “in” and her advice was available for a pre-inflationary five cents. Little Linus introduced the therapeutic encounter with the claim that he felt he was now on the way to solving some of his childhood problems. Lucy approved forcefully: “That’s good, Linus, because then you’ll be ready for teen-age problems, young adult problems, marriage problems, middle-age problems, declining years and old age problems.” (pp. 53-54).

According to Erickson, if a healthy attachment and trusting relationship is not formed in the first two years, it can affect the person for the remainder of their life. All of these developmental theories discussed the above point to the importance of the first few years when attachment is developed. If a child has not had an intervention to mitigate the effects of attachment injuries in their first years of life, the child is more likely to experience challenges when forming secure attachments throughout the lifespan.

### ***Personality Theory***

Theraplay shares many of its basic assumptions with four views of Kohut’s Self Psychology, and Winnicott’s Object Relations Theory (Koller & Booth, 1997). These four views tend to traverse both of these theories as well as attachment and developmental theories. These theories can be combined to form the idea of personality theory. The following is a summary of the four major assumptions of Theraplay that relate to personality theory:

1. The Theraplay approach assumes that the primary motivating force in human behavior is a drive towards relatedness. Personality development is essentially interpersonal. The early interaction between parent and child is the crucible in which the self and personality develop.
2. The playful, joyful empathic, attuned responsiveness of caretakers is essential to the development of a strong sense of self, feelings of self-worth, and secure attachment.
3. The capacity to soothe and nurture oneself in later life depends on early experiences of being soothed and nurtured.

4. When things go well in the relationship, the infant develops an inner representation of himself or herself as lovable, special, competent, and able to make an impact on the world; of others as loving, caring, responsive, and trustworthy, that is, as being reliably available; and of the world as a safe, exciting place to explore. In other words, within a secure attachment, the infant begins a process of learning about himself or herself and the world that is positive and hopeful and which will have a powerful influence throughout his or her life.

(Koller & Booth, 1997, pp. 206-209)

### **What Makes Theraplay Effective?**

Despite the relative newness of Theraplay, numerous studies have reported its effectiveness in treating children. In a study conducted by Bojanowski (2005) to measure the usefulness of Theraplay pre- and post- Theraplay treatment, she found a significant level of positive change specifically in the areas of nurture, challenge and engagement.

Theraplay was also found to be effective in two studies conducted in Germany. The studies were research field experiments that began in 1997. The first was a longitudinal study conducted in Germany of children that had communication disorders and severe behavioral disorders. Theraplay was used to increase attention, cooperation, and approachability. When the study was completed in 2005, eight years later, the results were both clinically and statistically significant. The researchers determined that the study had very high internal but low external validity and so a second study was conducted. This second study sought to get similar results on a wider range of clients. The clients in the study ranged from six months to seven years old with a variety of presenting problems. The results showed that Theraplay reduced the severity of the presenting client's symptoms significantly in areas of attention, social behavior disorders, affective/anxiety disorders, and even language and pervasive development disorders (Wettig, Franke, and Fjordbak, 2006).

### ***Brain and Touch Research with Theraplay***

Wettig, Franke, and Fjordbak (2006) highlight the research studies on the effectiveness of Theraplay and what exactly makes the method so successful. The

authors also discussed the importance of the theoretical background. They see that the first explanation for the effectiveness of Theraplay goes back to the ethological research of Harlow and Harlow (1966, as cited in Wettig, Franke, and Fjordbak, 2006), who used monkeys to demonstrate the significance of the emotional interaction with a mother and child. The study found that the baby monkeys were more apt to seek out the terry cloth monkey in times of stress as opposed to the wire monkeys that provided the babies with milk.

The authors also highlight the importance of understanding neurobiology. Research has shown that PET (positron emission tomography) scans offer evidence to suggest how the experiences of positive and negative events are coded in the brain. The authors hypothesize that Theraplay changes the neural networks of a child. Wettig, Franke, and Fjordbak (2006) cite the work of Siegal and Hartzell (2003) that state that positive emotional interactions between parents and children may allow for the development of new neurons in the hippocampus and more synapses in the prefrontal and orbitofrontal cortex of the right (emotional) hemisphere of the brain. This fact gives further credence to the idea of Theraplay leading to a positive lasting effect on children.

Other observations of MRI and PET scans show the effect of early attachment, deprivation, and trauma on the developing brain. In fact, by the end of the third year of life, about 90% of the brain is developed. Trauma and disruptions in early attachment before the age of three have significant results on a child throughout their lives without adequate treatment (Munns, 2008).

The right hemisphere of the brain is dominant these first crucial years of life. This hemisphere of the brain is related to sensory motor input and output and processes social emotional experiences. Trauma that occurs during these years is stored in the older part of the brain including the right hemisphere, midbrain, and brain stem. Using talk therapy to treat injuries that occurred early in life is difficult for this reason, because talking requires higher brain functioning and includes the left-brain hemisphere (Munns, 2008).

Due to this research, psychobiologists say treatment should: 1) treat children using more nonverbal therapies such as Theraplay, art, dance, and play therapy; 2) Treat children young; 3) If there are attachment problems, relationship based therapy should be

used (Munns, 2008). Overall, brain research points to the importance of treatments such as Theraplay in working with children with trauma and attachment injuries early in life.

The use of play in Theraplay is also a factor that creates change in the individual. “Early childhood play between a child and his or her caregiver is seen as an important element of healthy development and influences the pattern of later interactive behavior and relationships. Theraplay offers play, language, and interaction to the child at his or her respective levels of social and emotional development, a mental starting place by which the child can become healthier” (Munns, 2003, as cited in Wettig, Franke, & Fjordbak, 2006. pp. 106-107).

The other main component of Theraplay, touch, also lends itself to the efficiency of the method. Wettig, Franke, & Fjordbak (2006) cite many studies where touch produces positive effects such as the work of Brody (1978), Montagu (1986), and Field (2001). Touch has also been shown to carry some healing ability. The work of Tiffany Field (as cited by Munns, 2008) has used infant massage with premature babies resulting in a 47% gain in weight and leaving the hospital an average of six days earlier than a control group. Furthermore, lack of touch is also related to an increase in aggressive behaviors (Munns, 2008). Children seem to seek out touch through aggression if their needs for nurturing touch are not met. Therefore, the use of Theraplay, with its emphasis on nurturing touch, can provide healing for attachment injuries and has even shown to decrease externalized aggression.

The next chapter will discuss the effectiveness of Theraplay across a wide range of presenting problems and a variety of clientele. It will also include a discussion on the contraindications for the use of Theraplay in a clinical setting.

## **CHAPTER 3 - Clinical Issues**

This chapter provides the reader with clinical issues in which Theraplay would be beneficial. This is accomplished through a literature review of the use of Theraplay with different populations and issues. Additionally, discussion of risks involved in the therapeutic process and ways to minimize the risks are referenced. The chapter will also include the type of populations not recommended for Theraplay or Theraplay treatment alone.

### **Theraplay and the Presenting Issue**

Thus far, most of this paper has discussed the use of Theraplay as it directly relates to the parent-child relationship and attachment. However, Theraplay has also been shown to be beneficial in many other settings and with various populations. Many research projects have been conducted in order to make Theraplay a more evidenced-based practice. Numerous research projects have shown the positive changes that Theraplay makes in such a short period of time.

### ***Indications of Theraplay Use***

Various research projects have been conducted around the world using Theraplay. Everyone from infants to the elderly has been researched in this modality. The presenting issues in the research groups have also been extremely diverse. Due to the variety of research studies, organization of the research into sections highlighting the purpose is needed. The organization is as follows:

- Method
- Presenting Issues
- Special Populations
- Setting
- Target Age Groups
- Outcomes

## ***Method***

### ***Marschak Interaction Method***

Research on the Marschak Interaction Method of assessment have shown the test to exhibit strong reliability for determining factors present in a healthy child-parent relationship. One particular study on the Marschak Interaction Method (MIM) was conducted with thirty-one mothers and their preschool children. The study showed the mothers ability to challenge, engage, structure, and nurture their children demonstrated more exploring and regulatory behaviors among children, than those mothers that were not able to challenge, engage, structure and nurture their children (Martin, Snow, & Sullivan, 2006, as cited in Lender & Lindaman, 2007).

Another way Theraplay and the MIM could be effective is in the use of custody evaluations (Acklin, 2006). In this case Theraplay would not be considered an intervention per se, it can however, be helpful in creating a healthy attachment environment for the child. This is an area that is understudied.

## ***Presenting Issues***

### ***Difficulties in the Mother-Child Relationship***

Jernberg and Jernberg (1993) did a case study with a nine-year-old girl, “Marie”. Before treatment, the Jernberg’s set up an initial interview with the mother. Marie was experiencing panic-attacks and had recently lost a significant amount of weight. Marie refused to go out in public places. The mother admitted to always having a stressed relationship with her child and describes Marie as unhappy and always needing attention. The therapists learned that she was not a planned child. When the therapist observed Marie for the first time, they noticed that she did not have a normal child-like behavior and acted more like a twenty-year-old actress in a TV drama. She had a flat affect and seemed to be concealing her true self. Marie stated that her biggest fear was throwing up at school. The Jernberg’s article tracks through the entire treatment process with Marie, even transcribing specific parts of treatment. Additionally, the authors described in detail the difference between pre and post MIM assessment sessions. After six sessions, Marie’s mom calls the treatment a success. Marie has more energy, gains weight, and the

relationship between mom and daughter improved (Jernberg & Jernberg, 1993). It should be noted that the sessions were more intense than regular Theraplay due to the distance the family had to travel to receive treatment. This article would be an excellent resource for the first time Theraplay therapist to read in determining how the creator of Theraplay, Ann Jernberg, conducts her sessions.

### ***Behavioral Problems***

A Canadian pilot study comprised of 17 children, mostly boys aged 3 to 13 years old that were referred to a mental health clinic for a range of acting out behaviors. Using the MIM and Child Behavioral Checklist pre and post treatment, researchers found a significant drop in aggression in an average of eight sessions (Munns, Jenkins, & Berger, 1994, as cited in Lender & Lindaman, 2007). Another pilot study conducted two years later by the same research team used a sample size of 25 children. The researchers used the MIM, the Child Behavioral Checklist, and the Parenting Stress Index pre and post Theraplay treatment. The authors found even greater results in the drop of aggressiveness and other externalizing problems measured on the Child Behavioral Checklist. A significant improvement was also seen in the parent's stress level (Munns, Jenkins, & Berger, 1996, as cited in Lender & Lindaman, 2007).

### ***Articulation Disorders***

Theraplay has also shown some effect on children coping with articulation disorders. The goal of a research study by Kupperman, Bligh, and Goodban (2005) was to increase interaction in order to develop an increase in the desire and ability to communicate. Six children were included in the study in between ages three and six. Each child had two weekly speech/Theraplay sessions for six weeks. The clinicians found Theraplay to be effective in activating or reactivating a child's normal speech patterns. The clinicians emphasized the role of nurturing in all aspects of a child's development, including speech.

### ***Self-Contained Clients***

Jernberg (1988a) suggested that a child that has experienced a disruption in the attachment process might become unable to cope with the risks that intimacy pose and

therefore, become loners as adults. The fear of intimacy can lead to other problems such as a lessened tolerance for stress and a greater likelihood of divorce. Jernberg mentioned two case studies in her article on self-contained clients.

One woman came to Jernberg for help with her marriage. Jernberg found that the woman had distancing behaviors with her husband. For example, if he tried to tell her that he loved her she might reply scoffing, “Love is silly.” The woman seemed to have the same distant relationship with her own mother that went through significant bouts of depression during her childhood. Treatment centered on the attachment relationship in general. Throughout the course of treatment, she was able to become more trusting and able to feel like she could give and receive love.

In another case, a 14-year-old boy Jernberg worked with using Theraplay went from being unable to maintain a close relationship with peers or adults, breaking into cars, and other delinquent behaviors to being able to receive affection in session from his therapist openly (1988a). People that tend to be self-contained or loners can face a multitude of problems due to their fears of intimacy. Theraplay is one viable treatment method that can help the client experience a healthy relationship in a safe environment allowing the client to become more trusting in their relationships.

### ***Self-Regulation Problems***

Bundy-Myrow (2005) discussed the use Theraplay with self-regulation problems in children. The definition of self-regulation is hard to describe and encapsulates many issues. It can basically be described as an “evolving ability by which one integrates personal, interpersonal, and environmental experiences to maximize adaptive functioning” (Bundy-Myrow, p.36, 2005). Bundy-Myrow described how self-regulation fits with attachment in that it is formed through attunement. The first experience a child has with this regulation is the parent-infant relationship. This relationship is often referred to as a dance, where the players know the steps and flows smoothly with the partners mirroring each other. However, if this pattern of behavior is not present, or is present in a negative way, a child can develop poor regulation. A child with poor self-regulation might display this by one or more of the following: sensory-based arousal difficulties, trouble controlling emotions, and/or demonstrating behavioral flexibility according to normative expectations (Bundy-Myrow, 2005).

If conducting Theraplay with self-regulation problems, the therapist might include activities to address self-awareness and sensory activities. An example would be to go to a low intensity activity such as “cotton ball soothe” and have the child focus on the feeling of the cotton ball. The therapist would then move to a more high intensity activity that might require the child to get up and move and apply a more kinesthetic component. A good activity might be singing the song “Row, Row, Row Your Boat” with the rowing action. During the activity the therapist can ‘row’ a boat with a child, switching from singing and rowing at varying speeds, e.g., very fast to slow.

The therapist will also need to be aware of any sensory processing disorder in the child. If such a disorder exists, referral to an occupational therapist might be necessary for assessment and treatment. Bundy-Myrow gave a case example of a five-year-old boy who exhibited externalizing behaviors, overactivity, and sensory differences. After 14 Theraplay sessions, the boy is able to stay calm, controlled his movements in a non-disruptive manner, gained better control of body, improvement in verbal and non-verbal skills, and he learned techniques to keep his body calm when he had to wait (Bundy-Myrow, 2005). It should also be noted that self-regulation tends to be one area with which children with Attention-Deficit Hyperactivity Disorder (ADHD) struggle. Theraplay with a child with ADHD could help with problems relating to self-regulation.

### ***Special Populations***

#### ***Children with Down Syndrome***

The study suggest that methods, such as Theraplay, which use sensory-focused play can lay the groundwork for more normalized patterns of symbolic language in children with Down Syndrome (Dent & Fouts, 2002, as cited in Lender & Lindaman, 2007). Theraplay helps a child with eye contact and attunement that are often trouble areas for children with Down Syndrome. By having these more fundamental elements in place, the child will be more able to develop a pattern of symbolic language.

#### ***Pervasive Developmental Disorder (PDD) or mild to moderate Autism***

One Theraplay study included eight children ages three to nine diagnosed with a Pervasive Development Disorder. Theraplay was implemented in a two-week, daily one-

hour session with the caregiver-child dyad and therapist. Data for intervention measures showed significant improvement, especially in the interaction between the child and parent. Significant neurochemical changes were also found. Epinephrine increased over time and the norepinephrine to epinephrine ratio decreased becoming closer to optimal range. In the nervous system, norepinephrine and epinephrine worked together in the 'fight or flight' response. Additionally, the parent-child dyads scored better on the MIM interaction tests (Franklin, Moore, Howard, Purvis, Cross, & Lindaman, 2006, as cited in Lender & Lindaman, 2007).

Another study sought to use early intervention methods with children ages two and three diagnosed with a pervasive development disorder. The study included three treatment groups and two control groups. The treatment group consisted of a Theraplay session and Theraplay homework assignments. In addition to therapy, parents were counseled on how to deal with behavioral problems. The MIM was used to gather data. The treatment groups saw significant change in scores on mother/child interaction, attachment behavior, exploration behavior, and initiative behavior increased. The control group saw no change on the same domains (Park, 1999, as cited in Lender & Lindaman, 2007).

### ***Domestic Violence***

A group Theraplay study included mothers who had been victims of domestic violence and who had children under the age of five. After eight weeks, both the women and their children seemed to benefit from Theraplay (Dodd, 2004, as cited in Lender & Lindaman, 2007). The mother felt more confident in their ability to parent their child, and felt a closer relationship with their children overall. The children also benefited because they developed a greater sense of security and safety with their parent.

### ***Abused Children***

It is only advisable to apply Theraplay to abused children after adequate safety is ensured. Theraplay should also not be the only treatment method sought, but as a supplement to other forms of treatment when working with children that have experienced abuse. A study of such a treatment was completed in a South Korean group home for children in fourth, fifth, and sixth grades with a history of abuse. The

experimental and control groups consisted of six children each. The experimental group participated in twelve Theraplay sessions over a six-week time period. After the study, the Theraplay group showed higher self-esteem, were less competitive-aggressive, pretentious-narcissistic, and rebellious-distrusting. The study concluded that Theraplay was effective in alleviating the negative effects on self-esteem and interpersonal relationships that are common features of child abuse (Hong, 2004, as cited in Lender & Lindaman, 2007).

### ***Foster and Adopted Children***

Theraplay is used frequently with foster and adopted children. This is because children in these situations have experienced inconsistencies, failures, or losses that have disrupted or prevented the development of secure attachment (Booth & Lindaman, 2000). Theraplay should not be the only form of treatment if significant other issues are present such as abuse and trauma (The Theraplay Institute, 2004).

Many studies focus on the effectiveness of Theraplay in adoptive and foster families. A study conducted in Finland sought to see if Theraplay with foster parents and their foster children would affect the child's behavior. Using the Child Behavior Checklist intermittently throughout the Theraplay sessions and after treatment concluded, the results found significant positive change in overall scores that continued to improve six months after treatment. Parents who rated their liking of Theraplay, had an average score of nine on a scale of one to ten, with ten being the most positive (Makela & Vierikko, 2004, as cited in Lender & Lindaman, 2007).

Another analysis included a small sample study with ten children (eight adopted, two biological), were treated using Theraplay as an intervention with a Certified Theraplay therapist. Analysis of data showed a significant decrease in problem behavior. The author felt that even though the sample size was small, Theraplay's effectiveness was impressively strong (Meyer & Wardrop, 2005, as cited in Lender & Lindaman, 2007).

## *Setting*

### *School-Based Therapy*

The book “School-Based Play Therapy” includes a chapter on Theraplay. The author states that, “Theraplay provides classroom teachers a new way of rethinking negative interaction patterns and provides children with positive models and ways of being with others” (Martin, 2001, p. 163). She also suggests that before implementation, the teacher must: 1) Be confident in using Theraplay, 2) Rationalize his or her deviation from the traditional teacher role, 3) Know the children’s background, (For example, physical touch is a component of Theraplay and the teacher would need to be sensitive to children that have or might have experienced abuse) and 4) Inform parents and school administrators of its use. The author recommends that two adults be present in the activities to observe and help assist in the process (Martin, 2001). One adult can be the primary director of the session, while the other adult can help if a child gets out of hand. This allows the session to continue to flow even if disruptions are present.

The use of Theraplay in the school setting can be helpful to learning. According to Maslow’s hierarchy of needs, the basic needs such as self-esteem, safety, and physiological components, must be met before higher needs such as problem-solving, acceptance of facts, and achievement can be experienced (Norwood, 2007). Theraplay seeks to meet those basic needs so that learning in school would be more plausible if the child is not receiving their basic needs at home.

The book, “Play with Them: Theraplay Groups in the Classroom” by Rubin and Tregay (1989) is on the use of Theraplay groups in a classroom setting. The groups are conducted slightly differently than individual Theraplay and involve a more structured approach. The rules include: “No Hurts,” “Stick Together,” and “Have Fun.”

The authors state that, “The teachers who tried these groups in their rooms felt that the children benefited from being together in a relaxed environment while still having to get along with each other. At times, the teachers were surprised by behaviors that they had never seen occur in the regular academically oriented classroom setting. ‘We realized that, in this rather intimate, family-like group, the children were reacting more as they might with their own family or in other purely social situations’” (Rubin & Tregay, 1989, p. 19). The book provides details of the necessary things to consider for

teachers interested in Theraplay. The book is a great resource for teachers considering this approach.

### ***Target Age Groups***

#### ***Teenage Parents***

Theraplay can be helpful for teenage mothers. For one, huge attachment issues can develop with a child that is unexpected, which is likely the case for a teenage mother. The techniques can also be helpful for the new mother in learning healthy parent-child interactions. A program called “My Baby & Me” was evaluated in a study by Ammen (2000) to assess the effectiveness of training young parents in Theraplay. In 2000, over eighty teens had participated in the program. The ten-week group sessions’ preliminary results showed a significant growth in the teen parents’ empathy, a more positive experience of the parent-child relationship, and increased communication with their peers. The study also showed that the relationship with the teen parent and their own mothers declined. The author suggested that this might be due to tension around the teen being more autonomous in the parenting role.

#### ***Adolescents***

Evangeline Munns, a noted Theraplay Therapist, has spent much of her time researching the use of Theraplay in the adolescent population. Munns finds Theraplay beneficial because adolescents are in the transition of childhood and adulthood. “Theraplay offers a number of features that can be attractive for the adolescent. It emphasizes building up a child’s self-esteem (adolescents need a lot of this). It is nonverbal (the child does not have to talk about his/her problems or feelings). It enhances the parent/child relationship or attachment (most common referral problem), and it is engaging and playful (appealing to adolescents because it is fun)” (Munns, 2005, p.30). For instance, Theraplay will focus on the positive aspect of the child and call the parent to do the same thing. This is different from other types of therapies that are problem-saturated. Building up the parent-child relationship itself will lead to other changes in both the adolescent and the parent.

Evangeline Munns (2005) identified a list of things to keep in mind when working with adolescents using Theraplay. They are:

1. Keep sessions structured.
2. Add more challenging activities.
3. Sexual awareness is heightened in an adolescent, so keep that in mind when doing physical touch.
4. Videotape all sessions to safeguard therapist against being falsely accused of inappropriate touch.
5. Be honest and straightforward.
6. Adolescents need acceptance and praise, but they generally recognize false praise so don't 'overdo' it.
7. Be patient, use humor, and be non-judgmental.
8. Be prepared for rejection at first. Theraplay can seem 'babyish' for an adolescent focused on being an adult. The therapist needs to be aware of this dynamic.
9. Be confident, upbeat, and full of fun.
10. Stick with it.
11. Learn their language to minimize misunderstandings.
12. Don't allow physical hurts and do not get into physical power struggles.

In a case study conducted by Munns (2005), a 13-year-old boy participated in seven Theraplay sessions with his mother. He was brought into therapy because he was hostile and the mother could not manage him. After Theraplay, both the adolescent and the mother made improvements. It was found that the mother had unrealistic expectations for her son, which caused a lot of tension. Through Theraplay, the mother became more aware of her son's abilities and the bond between them was strengthened. The son was able to control his impulses better, and his mother was able to structure and limit her son more effectively.

Koller (1994) also discusses how Theraplay can be helpful in working with adolescents and gave similar reasons as Munns. In Koller's case study, a 15-year-old boy was referred to therapy due to poor performance in school. The child never knew his

biological father and his mother married his stepfather when he was four years old. His parents complained that they could not motivate him to do school work. The MIM assessment with the adolescent showed that he was basically in charge and his parents walked on eggshells, and sought the child's permission to do any activity. After eight highly structured, playful activities, the adolescent began doing his homework, which in turn increased his grades. He became more calm and relaxed in the classroom and attracted more peers with his more outgoing behavior.

### ***Theraplay and the Elderly***

Theraplay has also been adapted to help older adults. "Geriatric Theraplay grew out of the belief that in aging, as in any other phase of development, there is the need for and the potential for feelings of self-worth, competence, attractiveness, lovability, and satisfaction in responding to others" (Lindaman & Haldeman, p. 207, 1994). The following guidelines have been found to be helpful in working with elderly clients:

1. Slow the pace.
2. Value spontaneous reminiscence.
3. Conduct activities in a manner allowing face-saving.
4. Be alert to diminished sensitivity in sight, hearing, smell, taste, and touch.
5. Give special consideration to feet and hands.

(Lindaman & Haldeman, 1994)

The case studies included in the article demonstrated Theraplay as a way to help engage individuals more and express his or her personality. A case study by Jernberg (1988b) with a 92-year-old woman was useful in increasing the families' opportunity to appreciate an aging member and increased her cooperativeness and responsiveness. Another case study showed how a client's depression subsided with Theraplay. Lindaman and Haldeman (1994) also give the idea of having group Theraplay with the elderly in a nursing home setting to help alleviate depression and loneliness that can often accompany the elderly.

## *Outcome*

### *Emotional Intelligence and Self Esteem*

Theraplay has also helped with self-esteem and emotional intelligence. A study in South Korea included a control and an experimental group of preschoolers, where the experimental group received 12 group Theraplay sessions over a six-week time period and the controlled group received no sessions. The results on the Emotional Intelligence Checklist showed no statistical significance between the control and experimental group. The experimental group reported significant increase compared to the control group in the capacity of self-awareness, expressions, self-control, capacity of awareness of others, cooperativeness, and overall emotional intelligence (Kwon, 2004, as cited in Lender & Lindaman, 2007).

A study conducted in Hong Kong with 46 children between grades two and four, measured the effectiveness of Theraplay in reducing internalization of problems and in increasing self-esteem. After treatment, the children showed a statistically significant decrease in internalizing behaviors as compared to the control group and a statistically significant increase in self-esteem as compared to the control group (Siu, 2007, as cited in Lender & Lindaman, 2007).

### *Contraindications of Theraplay Use*

The Theraplay Institute (2004) released a short draft of instances where the use of Theraplay would not be the best modality for treatment. However, the modality might be useful once the population is stabilized as discussed in each of the scenarios below.

- **Children with dangerous, acting out behaviors.** Theraplay might be beneficial at some point for a dangerous child, but will not meet all the safety needs of the family. A child that is of considerable danger to him- or her-self and family may need hospitalization to ensure around the clock monitoring and/or a therapeutic home before they can be of help in other ways. Trauma work after an in-home treatment would be the next step for a child with dangerous acting out behaviors.
- **Children with psychosis.** Children with psychosis might benefit briefly from Theraplay, but a longer treatment would be needed. Containment, such as

- **Children who have been sexually abused.** Theraplay can be used with this population, but changes need to be made. For instance, the use of lotion would not be encouraged due to the nature of the sensory piece of sexual abuse. A cotton ball might be used instead to point out hurts. Other forms of treatment in addition to Theraplay would be needed as well. It is not recommended that Theraplay be started as soon as treatment starts. Other treatments should be implemented first to assess the child and build the child's sense of safety.
- **Recently traumatized children.** Focusing on the trauma would be the first step in treatment of this population. If there is any issue relating to forming an attachment to the caregiver, Theraplay might be useful then. This is permitting if the caretaker did not initiate the trauma. A reason to use Theraplay to help with attachment and trauma would be if the parent were driving when the child was involved in a car accident. The child might have some attachment issues pertaining to the parent and safety. Treatment would then focus on the parent doing their best to keep the child safe. Again the trauma work needs to be completed prior.
- **Foster/adopted children with a history of grief and trauma.** The Theraplay Institute (2004) recommends treatment in attachment therapies and trauma such as developed by Hughes, Gray, Levy, Orlans, Keck and Kupecky for this population in addition to Theraplay. Dan Hughes in particular does a lot of work with attachment issues that would work well for foster or adopted children with a history of grief and trauma.
- **Parents unable to focus on child/rens' needs.** If parents' personal challenges hinder the process of growth of their child, Theraplay would not be the first treatment choice. Such parents should receive their own therapy or treatment for their personal challenges before engaging them in Theraplay with their child/ren.

## **Therapeutic Risks in the Process**

As with any form of therapy, there are certain risks involved that should be considered in the Theraplay process. Before starting Theraplay, the therapist should keep these risks in mind throughout the process with each client.

### ***Countertransference***

Countertransference can occur when working with a child. This is due to the nature of the activities that may trigger a need within the therapist that they did not have met as a child or otherwise. In order to combat these risks, the therapist must be aware of themselves, their reactions, and feelings and be able to detect signs of countertransference. The therapist should make sure the activities in the session are for the child's benefit and not for the therapist's benefit. Planning the sessions, using supervision and personal therapy (when necessary) can help the therapist to avoid countertransference with their clients.

### ***Resistant Child***

A child may become resistant to any number of the dimensions of Theraplay. In fact, it is common for the child to go through a resistant stage once they become comfortable and are on the way to change. Resistance is usually handled with a paradoxical approach. If the child starts to get quiet and withdraws, the therapist might whisper and say, "We are being quiet as mice; let's see if your nose squeaks like a mouse, too." The therapist needs to be alert with a resistant child, and maintain the same playful nature throughout the session.

### ***Resistant Parents***

If proper education and instruction is not given, the Theraplay process may seem invasive to the parent watching. Therefore, it is extremely important to talk with the parents about what Theraplay is, the research supporting the process, and what it will entail for their child. Touch is a very important part of Theraplay, so it will also be imperative for the therapist to discuss with the parents the importance of touch. Additionally, the therapist should have a release to permit the use of therapeutic touch in the Theraplay sessions.

## CHAPTER 4 - The Theraplay Process

This chapter is designed to show in detail the process of Theraplay from the initial intake and assessment to the follow-up. The purpose is to show the readers how the process is generally carried out with clients. Additionally, the chapter will address the role of the therapist implementing Theraplay and how Theraplay would be applied to the a case vignette illustrated in Chapter 1. The chapter ends with a succinct view of the parents' experience of the Theraplay process.

### Overall Organization of Theraplay Treatment

Theraplay is an ideal modality of treatment in the current world of managed care, because it can be conducted in such a short time. Although typically about fifteen sessions are suggested in using the Theraplay method, it can generally be modified to fit the number of sessions allotted. The Theraplay Institute in Chicago (n.d.b) gives a brief summary of how the Theraplay process is normally organized:

**Table 3-Theraplay Treatment Protocol**

Session	Program
<b>1</b>	Initial interview with mother and/or father.
<b>2</b>	One parent and child participate in Marschak Interaction Method. Theraplay staff members observe and videotape this interaction.
<b>3</b>	Same as 2, except that other parent participates.
<b>4</b>	Feedback session with mother and father.
<b>5-8</b>	The therapist interacts with child while parents and another staff member observe. Explanations are given to parents as to what takes place. Questions are answered and parents are encouraged to try Theraplay techniques at home. With recently adopted or very young children, the parent(s) may be in the room from the beginning.
<b>9-15</b>	Same as 5-8, but during the last half of each session, parents enter Theraplay room and join in the activities.

**16-19**

Additional sessions and/or four follow-up sessions with parents and child at quarterly intervals over the next year.

(Extracted from The Theraplay Institute, n.d.b)

Sessions are prepared in this manner in order for the therapist to first receive adequate information before beginning the Theraplay process. Through gathering initial information, the sessions can be structured according to the individual family's needs. After sessions begin, the caretaker merely watches the therapist administer Theraplay activities on the client in hopes that the caretaker will be ready to take over the entire sessions at the end of treatment. Check-up sessions are needed following treatment to assure that the caretaker is continuing to practice the Theraplay techniques in the home.

### ***Initial Intake Interview***

As with most therapy intakes, an initial intake for Theraplay focuses on the issues surrounding the problems the family brings into therapy. What sets this intake apart from others is that it has a specific focus on topics surrounding attachment and relationships. The following outline is an example of areas the initial intake interview for Theraplay should explore:

- The reason for the referral
- The developmental history
- Parents' expectations and attitudes
- Parents' experience within their own families
- Parents' relationship with each other (Jernberg, A.M. & Booth, P.B., 1999)

### ***Reason for the Referral***

The first section in the initial intake should be to get an understanding of the clients' explanation of the problems as they see it. It might also be useful for the therapist to obtain information from outside sources such as teachers and pediatricians that have one-on-one interactions with the identified client. When gathering the information, a discussion on the history of the problem along with how it manifests itself

in certain situations will be useful. Getting a complete view of everything surrounding the problem, as should be involved with all therapy intakes, is the first step.

### ***Developmental History***

A complete developmental history of the client is necessary to provide the therapist with information about the family dynamics around each developmental stage of the child's life. Developmental questions should start at the time of conception and continue until the child's current developmental milestones. Questions that can be asked surrounding the pregnancy include: Was this a planned pregnancy? What were your hopes for your baby? What was the pregnancy like? These questions help to set the initial picture the parents or caregivers had for their child, which helps set the stage for their attachments (Jernberg, A.M. & Booth, P.B., 1999).

Other areas to explore include the temperament of the child as an infant, the child's process and progress reaching developmental milestones, and any difficulty associated with it. An accurate account of all caretakers, parents, siblings, and other family members that have been present throughout the child's life will help in the assessment as well. Getting an idea of how attached the child was to these persons and the current quality of these relationships can help assess attachment disruptions that might have occurred in the child's life. A medical history of the child as well as information on any disruptions in relationships with attachment figures due to absence or illness should also be explored (Jernberg, A.M. & Booth, P.B., 1999).

### ***Parents' Expectations and Attitudes***

The therapist will want to explore the parents' expectations towards their child and attitudes towards being a parent. Questions that ask the parents what they expect of a one-year-old, two-year-old, and so forth can provide such information. Cultural issues need to be considered when exploring parenting expectations. For example, some cultures approach discipline and structure more strictly than others. It is imperative to put the information gathered within the context of the family's culture to ensure an accurate assessment of the presenting issue and to inform treatment.

### ***Parents' Experience with Their Own Families***

Exploring the attachment history of the parents can also be helpful in the initial intake since a parent's own attachment history has a significant impact on their attachment patterns with their children. Questions should address their feelings about their family of origin, their parents' expectations of them, and other questions about their family history that might inform their attachment with their own child (Jernberg, A.M. & Booth, P.B., 1999).

### ***Parents' Relationship with Each Other***

The final detail that should be gathered in the initial interview with the parents is their relationship with each other. This information should be compiled regardless of whether or not the parents are currently raising the child together. The data acquired should help the therapist assess the level of commitment of each parent and the similarities and differences of their parenting styles. Information regarding parental conflict should also be obtained.

### ***Case Illustration***

The first vignette in the introduction chapter about Sarah and Randy will be used to illustrate the Theraplay process. Recall that Sarah had Randy at a young age and five years later does not feel that her and her son have a good relationship. Randy is not listening and displaying behavioral problems.

### ***Intake Process with Vignette 1***

Sarah came in for an intake by herself. The therapist first asked Sarah about her reasons for wanting therapy for Randy, Sarah shared Randy's behaviors in school and at home. He was apparently aggressive and never listened to Sarah. Sarah described that at times, she has to literally hold Randy down for half an hour to get him to calm down. The therapist went on to assess Randy's developmental milestones. Although Randy was a little late to potty train, he was on track developmentally in school as reported by his teacher. As for expectations for Randy and what a five-year-old 'should' act like, Sarah said that a five-year-old should listen to their parents and be able to obey. When the therapist asked Sarah about her experiences growing up, she said that her parents were very structured and disciplined. She hated it a lot of times and thinks

that she had sex in high school as a way to rebel against her parents. Sarah's parents were furious when they found out about Sarah's pregnancy and told her that she needed to keep the baby (Randy) as a way of punishment for her actions. Sarah is single and does not pursue intimate relationships.

The therapist gathered from this intake that Sarah has many issues relating to structure with her own past and with her son now. Additionally, Sarah did not have a positive view of her parenting and has trouble with knowing her strengths. The therapist decided to focus a lot on strengths with Sarah. The MIM was then scheduled to further assess Sarah's relationship with Randy.

### ***Marschak Interaction Method (MIM)***

Once the initial interview with the caregivers is complete, the Marschak Interaction Method (MIM) can be implemented. The MIM is a structured technique for observing the relationship between two individuals, for instance, the biological parent and child, foster or adoptive parent and the child, teacher and child (Lindaman, S.L, Booth, P.B, & Chambers, C.L., 2000). When doing strictly Theraplay with the family, this will be the first time the therapist sees the parent-child interaction. Observations through the MIM give rise to the needs of the parent and the child in the Theraplay process.

The Theraplay Institute in Chicago gives an excellent summary of the purposefulness of the MIM by stating:

“The MIM evaluates the parent's capacity: to set limits and to provide an appropriately ordered environment (Structure), to engage the child in interaction while being attuned to the child's state and reactions (Engagement), to meet the child's needs for attention, soothing and care (Nurture), and to support and encourage the child's efforts to achieve at a developmentally appropriate level (Challenge). At the same time it allows assessment of the child's ability to respond to the parent's efforts.” (The Theraplay Institute, n.d.c)

The four dimensions that the MIM measures directly correlates with the underlying basis of the Theraplay process, which will be discussed in the next section.

### ***Administration of the MIM***

Each MIM session takes between 30 to 45 minutes, although some can be as short as 10 minutes or as long as 90 minutes (Lindaman, Booth, & Chambers, 2000). If two parents are in the child's life, they will complete dimensions of the MIM both one-on-one with their child and as a parental system with their child. The sessions are videotaped for the therapist to review and discuss at a later date with the parents.

When administering the MIM, the parent(s) are asked to carry out tasks with their child that demonstrate how structure, engagement, nurture, and challenging activities are executed in his or her personal relationship with his or her child. A list of tasks is included in Appendix A.

A structure task might ask the parent to make a picture for the child to copy. The therapist would watch how the parent implements the activity and how the child responds. An engagement task might involve the parent and child putting hats on one another. The therapist needs to look for eye contact, comfort, and attunement with both the parent and child. Nurturing tasks involve any kind of physical touch such as applying lotion or combing hair. If the child rejects nurture, Theraplay would focus on a number of regressive, caretaking activities to help the child get these needs met (Lindaman, Booth, & Chambers, 2000). A challenge activity might ask the parent to build a structure with blocks and have the child copy the structure. The therapist would observe if the parent made the task too easy or difficult for the child's developmental level, and if so would discuss these issues with the parents through the video. Any dimension that the family seems to struggle with in some way will be focused on in Theraplay.

At the end of the MIM assessment, the clinician should then ask a few follow-up questions to see if their interaction in the therapy setting was similar to that of their interaction elsewhere. Additionally, the therapist would ask the parent which activity they felt their child enjoyed the best and liked the least. Asking these questions can help the therapist assess the attunement the parent has with their child. The section following the vignette example will discuss the four dimensions in detail, giving the reader an idea of what to look for that might be considered healthy and unhealthy in the parent-child relationship.

### ***MIM applied to Vignette 1***

When Sarah and Randy came in for the MIM assessment with the therapist, Sarah was briefed about the procedure and the session was video-recorded with her consent. The session began with Sarah who read out loud instructions from a card. The instructions are of activities that she completed with Randy for as long a duration as she felt necessary.

When Sarah started to read the instructions “Put lotion on child,” Randy looked over her shoulder at the card. Sarah then proceeded to get out the lotion and Randy immediately grabbed for it and squeezed a big glob out on his hand. Sarah seemed frustrated by this action and took the lotion from him calmly and said that she is supposed to put lotion on him. Hearing this, Randy let Sarah apply the lotion on him.

Throughout the rest of the assessment, it is obvious that Randy tried to take control, however Sarah did have a way of handling herself that seemed to work for the most part. Randy also appeared to seek to be nurtured by his mom in positive ways.

After the MIM activities were completed, the therapist met with Sarah privately to review the taped session. The therapist pointed out many of the positive things that Sarah did and Sarah seemed to light up with the praise and validation. By giving Sarah more confidence, the therapist believed that she would be able to take charge more effectively. The session ended with the therapist discussing the benefits of focusing the up-coming Theraplay sessions on structure.

### ***Theraplay Session***

Ideally, the Theraplay sessions would include two therapists, the lead therapist in the room with the child and the interpreting therapist behind a mirror with the parents. While the lead therapist conducts the first few sessions with the child one-on-one, the interpreting therapist would interpret the lead therapist’s actions and the response of the child to the parents. The parents are then encouraged to start to try the techniques at home. After the initial few sessions, the parents would then join the lead therapist in conducting the entire session.

Each Theraplay session should be planned in advance. About 10-12 activities are planned for each session, and the plan is subject to change based on the child’s response

(Jernberg & Booth, 1999). Every session should begin with greeting and check-up activities that focus on the individual attributes of the child and should end with a closing that helps transition the child out of the session (Jernberg & Booth, 1999). In between these activities the four dimensions of Theraplay should be included in every session. The activities should alternate between high-levels of activity to low-level activity in order to help the child with self-regulation. Low-level activities should be included in both the opening and closing of the session to prepare the child for transition (Jernberg & Booth, 1999). “In addition to planning for the alternation between active and quiet, you should choose activities from among the four Theraplay dimensions according to the child’s particular needs that you discovered during your assessment” (Jernberg & Booth, 1999, p. 90). The activities themselves are typically very short. The total session should take about 30 minutes, leaving the therapist to talk with the parents for 20 minutes after the session.

### ***Structure***

The purpose of structure activities is for the parents to be at the top of the hierarchy of the family with the children underneath. In a healthy example of structure, the parents would set appropriate boundaries and limits that the child accepts. “Appropriate structure conveys the message ‘You are safe with me because I will take good care of you’” (Lindaman, Booth, & Chambers, 2000, p. 384). Some examples of unhealthy exchanges to look for in the assessment process where structure might be the focus in the Theraplay process include:

- Parent in peer or child role
- Parent unable to set limits
- Parent turns authority over to child
- Parent in teacher role (pedantic, rigid, focused only on task at hand).
- Interaction disorganized or chaotic.
- Child defiant, insisting on doing things his own way.

(Lindaman, Booth, & Chambers, 2000, p. 384)

## ***Engagement***

The purpose of engagement activities is for the parent to be attuned to the child's emotional state, developmental level, and overall needs. "Appropriate efforts to engage the child communicate the message, 'You can interact in appropriate ways with others. You can be close to others. You have feelings that I can appreciate and share. Others have feelings as well. You are fun to be with'"(Lindaman, Booth, & Chambers, 2000, p. 386). Some examples of unhealthy interactions where engagement might be the focus in the Theraplay process include:

- Parent remains aloof, allows too much distance or fails to engage the child.
- Parent can't leave the child alone, takes over tasks the child could accomplish on his own.
- Child won't let parent get close.
- Child ignores or rejects parent.
- Parent unresponsive to child, unaware of child's feelings, unable to calm child.
- Parent projecting his or her own feelings onto child.
- Parent unaware of child's feelings.
- Parent so serious and task oriented that there is no room for pleasure and light-heartedness.
- Parent teases at child's expense.
- Parent's joking and playfulness take priority over accomplishing task.
- Child is silly and unable to attend.
- Child is too serious.

(Lindaman, Booth, & Chambers, 2000, pp. 386-387)

## ***Nurture***

The purpose of nurturing activities is to show the child that he or she can get their needs met without having to work for it (Jernberg & Booth, 1999). Nurturing is the caretaking role that the parents take to help the child form a secure attachment. Healthy nurturing communicates, "You are loveable and worthy of care. You can count on me to

respond to your needs for care, affection, and praise” (Lindaman, Booth, & Chambers, 2000, p. 387).

As with the previous dimensions, nurture can also be a problematic interaction in the parent-child relationship. A few instances to watch for in the assessments that might elude towards unhealthy nurturing in the relationship include:

- Parent infantilizes child.
- Parent withholds gratifying experiences.
- Parent turns nurturing tasks into teaching tasks.
- Parent asks child to nurture/take care of him or her.
- Parent does not recognize or acknowledge child’s tension or distress.
- Parent’s response to child only escalates child’s discomfort.
- Parent does not prepare child for separation.
- Child is aloof, acts as if it did not matter that parent leaves.
- Child is clingy and unable to let parent leave.
- Child is timid, helpless, and fearful.
- Child has problems accepting care and nurture.

(Lindaman, Booth, & Chambers, 2000, pp. 388-389)

### ***Challenge***

Challenge activities focus on helping the child become more independent and help them stimulate their development. “Experience with appropriate challenges gives the child a sense of mastery and develops realistic self-expectations. The message is, ‘You are capable of growing and of making a positive impact on the world’”(Lindaman, Booth, & Chambers, 2000, p. 390). Unhealthy examples where the caregiver might need to focus on the challenge dimension of Theraplay consists of:

- Parent’s expectations are too high (or too low).
- Parent avoids challenging child.
- Parent is too competitive.
- Child avoids challenge.
- Child expects too much of himself.
- Parent or child shows no pleasure in achievement.

- Parent does not acknowledge child's efforts.

(Lindaman, Booth, & Chambers, 2000, p. 390)

### ***List of Activities***

Each activity in the Theraplay process covers one or more of the four dimensions listed above. An example of Theraplay activities by dimension is listed in Appendix B.

### ***Example of Theraplay Sessions for Vignette 1***

Randy and Sarah came into the first session ready to start. Randy showed little resistance and loved to spend 30 minutes playing with two adults. After the first session, Sarah was impressed. The therapist told Sarah that often Theraplay has a honeymoon stage and that she should not expect things to continue to go as smoothly. The therapist also assured Sarah that such a regression is often then followed by progression.

As predicted, Randy started to resist the activities in the next few sessions. He especially resisted activities that center on structure of which the therapist is in-charge. When the therapist started with the activity "Mother May I," Randy insisted on being in charge and tried to make the therapist do what he wanted. Here, the therapist quickly moved on to the next activity to keep charge of the session. At this point, Randy started to scream and refused to be involved. The therapist used paradox and told him in a loud voice that Randy needed to scream even louder. Randy gave the therapist a puzzled look and stopped screaming. As time went on, Randy chose to get involved again in all the activities in the following sessions.

## **Role of the Therapists**

Not everyone will have the skills and aptitude for becoming a Theraplay Therapist. The therapist must be attuned and quick-witted to work in the Theraplay process. Listed below are the roles for both the lead and interpreting therapist. Not all therapists will be able to have a second therapist readily available, so the lead therapist will have to carry out both roles. This too is discussed.

### ***Lead Therapist***

The role of the lead therapist is active and directive (Kottman, 2001). The therapist spends the whole session engaged in Theraplay with the client while the interpreting therapist is observing with the parents. The therapist should plan the session catering to the needs of the individual child before the session. However, during the session, the therapist may decide to change or adapt some of the activities to fit with the child's reaction.

Since the relationship is the critical component of Theraplay, the lead therapist needs to be the most interesting thing in the room in order to keep the attention of the child. The therapist will take charge of the session, but constantly do so in a fun and playful manner. The lead therapist will also try to interpret the feelings that the client might be feeling from time to time in session in order for the child to start to understand and label feelings in an appropriate way.

The lead therapist will show the parents observing a relationship with their child much like an infant and caretaker. Theraplay uses a lot of touch and nurturing. The therapist is attentive to the child's every response in the session. The therapist defines limits and boundaries maintaining the focus on safety for the child. "Using this picture as a guide for treatment, the Theraplay therapist models his behavior on that of the attuned, responsive parent. He engages the child in a playful, reciprocal, interactive relationship. He confidently takes charge. And he responds empathically to the child's needs using the Theraplay dimensions as a guide" (Jernberg & Booth, 1999, p. 14).

### ***Interpreting Therapist***

The role of the interpreting therapist is verbal and directive. This therapist sits with the caretaker at the beginning of Theraplay and then joins the sessions with the caretakers. The interpreting therapists main role is to work with the caretakers. "The interpreting therapist (a) explains the process unfolding between the child and the Theraplay therapist, (b) describes different activities that could help the child, (c) elaborates on the need for the various Theraplay dimensions in the parent-child relationship, (d) coaches parents as they enter the Theraplay process and participate in

activities, and (e) provides support and encouragement for changes the parent make in their interactions with the child” (Kottman, 2001, p. 74).

### ***Handling Both Roles with One Therapist***

In most settings, another therapist will not be available to provide interpreting services for the parents during the Theraplay sessions. In these cases, the Theraplay therapist must act as both therapists. If there is an observation room available, the parents can use it and the therapist can join them after the session to interpret and allow the parents to ask questions. Another way to interpret would be to videotape the sessions and then observe the tapes afterwards with the parents (Jernberg & Booth, 1999). It is important to provide this interpretation role to the parents so that they will be able to eventually take over as the person “in charge” in sessions. Additionally, the parents will understand why each activity is helpful for their child.

### **Application of Theraplay to Case Vignettes**

In the Introduction (Chapter 1), examples of cases where the use of Theraplay would be helpful were discussed. The following illustrates the potential outcomes from using Theraplay in each case described in Chapter 1.

#### *Vignette 1*

As discussed earlier, Sarah eventually sought help to deal mainly with Randy’s behavioral problems. At first, Randy was extremely resistant to the structured activities the therapist implemented. This concerned Randy’s mother because his behavior seemed to worsen. The therapist assured Sarah that this was common and that change would occur once Randy saw that he is safe with his mom in charge. The therapist worked with Randy for four sessions and started to have Sarah come into the sessions to help with the activities. Randy particularly enjoyed the nurturing activities where his mom would hold him in her arms and sing to him.

After six weeks of Theraplay, Randy’s behavioral problems significantly decreased. Theraplay continued for six more sessions and ended with a party emphasizing the accomplishments of both Randy and Sarah. Sarah felt she finally had

the relationship with her son that she always wanted and felt confident in her ability to parent her child. A check-up session was scheduled for a month after the final session.

### *Vignette 2*

Michelle heard about a therapist in town working with children doing group therapy. She felt the twins both needed some help since the divorce. Meeting with the therapist, Michelle felt a sense of comfort at the promise of change. Michelle was mainly concerned for her daughter Jennifer because she seemed to be acting out more since the divorce. The therapist suggested group Theraplay with a focus on Michelle's relationship with Jennifer, and Michelle was willing to try anything the therapist thought would help.

During the first group sessions with Jennifer and Michelle, Jennifer clung to her mother's side and did not want to participate with other children or the therapist in the group. Slowly, Jennifer started to come out of her shell after a couple of weeks. Jennifer seemed more vivacious and playful than Michelle had ever seen. Jennifer loved the nurturing activities she was receiving from her mother in session. Michelle also reported she started to have special time with each of her daughters at home, pointing out what made them each different and special. Jennifer seemed to have a sense of confidence she never displayed previously. Michelle noticed that both of her daughters got along better and Michelle felt she understood her daughters both better than before the group sessions.

### *Vignette 3*

Rusty and Tyler knew that they would probably need help with Zachery due to his chaotic background. The couple enlisted the help of a predominate play therapist in their city that worked specifically with adoptions and foster care. The therapist suggested that the use of Theraplay might help Zachery to feel safe and secure building a healthy bond with his new parents. The Theraplay process did take longer than the normal twelve-week sessions typically carried out in Theraplay. The parents were seeing a change in Zachery and committed to more Theraplay sessions with the therapist. The therapist also implemented individual play therapy sessions with Zachery due to the severity of the case.

After four months of therapy, Zachery was less angry overall and was developing into a happy-go-lucky child. Zachery would repeat the things he learned in Theraplay, such as dad and daddy are in charge and label his emotions. Rusty and Tyler now felt as if they were able to try things on their own for a while. The therapist mentioned that as Zachery reaches major developmental milestones he might need to come back for some sessions. The parents were confident in their ability to handle Zachery and felt assured to bring Zachery back to the therapist if any more problems ensued.

These vignettes provide a brief example of how Theraplay can be used to treat various problems. Although the only examples given were of parent-child relationships, as previously discussed in the report, Theraplay can be used on a wide range of issues and age groups. Theraplay combined with the therapists' knowledge of the technique and the importance of the involvement of the entire system can truly change attachment relationships for the better helping to solve various problems that occur when there are attachment difficulties. Theraplay can help children understand their emotions and help them to feel safe in their environment. It also helps parents and caregivers to more fully understand their children and their needs.

### **Parent's Experience of the Theraplay Process**

In order to build a better understanding of the parent's experience of the Theraplay process, Christine Vorster conducted a qualitative study with parents who were involved in Theraplay with their children (1994). Vorster study posits that the process initially results in a symmetrical relationship as the parent realizes their shortcomings through the involvement in the child's therapy. This initial relationship evolves into a complimentary relationship when the parent opposes the therapist's attempt to direct therapy.

Vorster also found that individuation of the child, which is a component of Theraplay, can be seen either positively or negatively by the parent. For example, Vorster saw that the parent taking charge instead of the therapist as being positive, whereas some therapists might see this differently. She suggests talking to the parents before starting the Theraplay process about individuation and how it can be helpful for a child would be beneficial in reducing negative views of this trait. Vorster's study can

help therapists to be aware of how a parent might react to Theraplay, and be prepared to respond accordingly.

## **CHAPTER 5 - Implications for Research and Practice**

Theraplay is an emerging practice that needs to be studied. The Theraplay Institute believes in the importance of evidenced-based practice and lists such studies on their website. The following chapter will discuss implications for further research and practice.

### **Implications for Further Research**

Research and clinical practice inform each other. The importance of research is to acquire analyses that support the current clinical practices and to identify new and more efficient clinical practices to achieve the desired results. Theraplay has a large body of research to inform its practice; however, researchers have identified areas that are lacking research. Some of the more urgently needed studies are included below.

#### ***Neurobiology and Theraplay***

An article discussed previously when working with children with a Pervasive Development Disorder sought to see the changes Theraplay had on a chemical level in the brain. The authors found significant positive change in the levels of epinephrine and norepinephrine (Franklin, Moore, Howard, Purvis, Cross, & Lindaman, 2006, as cited in Lender & Lindaman, 2007). Very few other research articles and books delve into the chemical effects Theraplay has on the brain. For instance, it would be interesting to see if Theraplay affected the chemical make-up of the brain in different populations. If so, what specifically would it affect? Different populations may experience different effects. Comparing abnormal populations with a group of children that are on a normal developmental trajectory would add to the literature.

A book by Dan Siegel and Mary Hartzell (2003) also noted the lack of research on attachment and neuroscience: “The fields of attachment research and of neuroscience have been virtually independent of each other when it comes to studying human beings” (p. 116). So much more research can be done in this area that the possibilities are endless. Does age play a factor in repairing attachment? How about the presenting issue? By knowing more about the neurobiology affects of Theraplay clinicians can be

informed of how significant their work is in changing the client on both an external and internal level.

### *Attachment Measures*

Although Theraplay seeks to improve attachment, very few measures that focus specifically on attachment are used in the research studies. The addition of attachment measures in research studies, such as pre- and post-test measures could help identify the effectiveness of Theraplay in approving attachment relationships. Attachment measures could also be administered to identify the effectiveness of different Theraplay interventions administered to address the different forms of attachment problems that are presented in therapy. The identification of the usefulness of different Theraplay interventions for different attachment problems would help direct clinical work.

### *Target Populations*

While there are numerous populations where research studies can be extended to, the following populations are recommended for Theraplay research as the literature on these groups is scarce and an understanding of their needs is necessary for effective Theraplay treatment: families with child custody issues, father-child dyad, and culturally diverse groups. Child custody is one area in which research needs to be done before clinicians can practice evaluations. For example, the use of the MIM could be an important tool when evaluating for child custody. Research to see if administering the MIM could add to the evaluators' knowledge before determining a custody situation could contribute to the process.

Another population that has not received significant attention is father figures. Most studies include the mothers. An area where Theraplay may be useful is in the military setting with fathers that are going to be deployed or recently returned from deployment. Few studies if any, include the use of Theraplay with a male Theraplay therapist. A study on therapist gender difference could again fill a gap in the literature.

Although Theraplay is used across cultural groups, research comparing its use in various cultures is lacking. Since family structures are so discrete from culture to culture, Theraplay would have to be modified in some ways to fit the various cultures. A useful

research project might seek to find how Theraplay should be modified to fit the needs of the different cultural and ethnic groups.

### ***Sample Size***

Most every research article on Theraplay listed the sample size as a deterrent in their research. Sample sizes are small for most of these projects and need to be increased. An increased sample size will allow researchers to lower variability and increase the reliability of their studies.

### **Suggestions for Practice**

The suggestions for practice offer the reader a more practical guide for work in Theraplay. Specifically, it offers the reader how to do Theraplay outside of the actual Theraplay process. This section also gives Marriage and Family Therapists insight to how their field corresponds with Theraplay.

### ***Procedures for Becoming Certified as a Theraplay Therapist***

It is first important to note that Theraplay is a service marked by the equivalent of a trademark. It is strongly recommended for those interested in Theraplay to take the necessary steps to become a certified Theraplay therapist if one is going to use the technique with his or her clients. Informally sought training is not advisable. Not only is this unethical; it can lead to harmful consequences for one's clients if inadequate supervision and training is sought.

An applicant for Theraplay certification must have certain qualifications before beginning the process of certification. A candidate for becoming a Theraplay therapist must be qualified, licensed, certified, or be a registered professional in a field that works with children and families. Professions such as psychiatry, psychology, social work, special education educators, occupational therapy, marriage and family therapy, and therapeutic foster parents are examples of professions that fall under the umbrella of qualified professionals. It is assumed that these professionals have adequate knowledge of human development, ethical issues, and professional experience working with children and families (The Theraplay Institute, 2004).

A candidate that is experienced in working with children and families but does not have a professional degree, such as those that have a degree in early childhood education, can become “Associate Theraplay Therapists.” The main difference is that they will be required to have monthly supervision by a certified supervisor. If the individual then completes the professional requirements they can change their status to a Certified Theraplay Therapist (Jernberg & Booth, 1999).

### ***Steps to Becoming Certified***

The training in Theraplay includes introductory and intermediate courses in both Theraplay and the Marschak Interaction Method (MIM). The Theraplay Institute recommends applicants start practicum immediately following the introductory course so some experience in the Theraplay method can be practiced before taking the intermediate courses. Before practicum can begin, the candidate must apply for practicum by submitting written materials for approval by the Theraplay Institute. Once an applicant is accepted, practicum work can begin.

The required number of sessions to complete practicum is 200, with a minimum of ten different cases. The minimum amount of time of completion of the 200 sessions is one year. Clinical cases should include a broad range of presenting problems, ages, cultures, and family dynamics. Supervision must be given on 40 of these sessions. Of the 40 sessions, 36 must be Theraplay sessions, four must be MIM sessions with written reports, and two must be full sessions that will be considered a mid-term and final examination. A few different supervision options are given to candidates in order to meet these requirements including group or individual supervision, long-distance supervision, or a mixture of long-distance and face-to-face supervision (The Theraplay Institute, 2004).

The practicum process not only serves to help the candidate become better at conducting Theraplay, but also serves as a gate-keeping measure. Not everyone that applies for the Theraplay candidacy will be appropriate for the program. If a candidate is not showing potential in becoming a Theraplay therapist, they will be helped to understand why and will be withdrawn from the program (Jernberg & Booth, 1999).

After completing all the requirements, the therapist will become certified in Theraplay. Certification status enables the candidate to identify themselves as a Certified

Theraplay Therapists and to identify the treatment provided as Theraplay®. In order to reach supervisor/trainer status, the therapist must have been considered a Certified Theraplay Therapist for at least two years (Jernberg & Booth, 1999).

To maintain standards of being a Certified Theraplay Therapist, the therapist must complete continuing education requirements every three years and maintain an annual membership in The Theraplay Association. Options for continuing education include attendance of advanced practice seminars or the International Conference, submission of videotape for supervision, or submission of an article that is accepted and published in The Theraplay Institute newsletter (The Theraplay Institute, 2004).

### ***Presenting Theraplay to Other Professionals***

Theraplay, and even general play therapy, are distinctive approaches that are in the early stages of development compared with other psychotherapy treatments. Therefore, a practitioner who wishes to apply Theraplay must be able to explain the process of Theraplay. Here are some ideas that a therapist might use to present Theraplay to other professionals:

- Show a video of Theraplay
- Do a presentation and have the group do some of the Theraplay activities
- Present research on the effectiveness of Theraplay
- Present research on child development, brain development, attachment, and the importance of touch

It is important that a therapist that is using Theraplay in treatment receive approval from their agency and/or the families that will be receiving Theraplay treatment. Additionally, getting information to other staff and colleagues in the agency will be important in order for the Theraplay therapist to feel supported in his or her work.

### ***Parent Collaboration***

Parents are paramount in the Theraplay process. Therefore, the therapist must spend a significant amount of time joining and understanding the parents. The Theraplay therapist must not come from a stance of blame, but of understanding and willingness to help improve the relationship a parent has with his or her child. Munns (2007, p. 73) gives therapists specific strategies for training parents in the Theraplay method.

- **Give parents a more positive, empathic view of their child.**
  - Observation. Watching the therapist focus on positives in their child.
  - Guided Observation. For example, asking the parent how they think their child is feeling at a particular moment.
  - Role playing the child's part
- **Steps Leading to Competence in Being Theraplay Therapists to Their Children.**
  - Discussion
  - Modeling
  - Guided practice
  - Homework
  - Role playing
  - Taking charge
- **Teaching Parents about Developmental Issues and How to Handle Behavior Problems.**
  - Teaching appropriate developmental expectations
  - Teaching the concept of inner representations
  - Consulting about behavior management
- **Meeting Parents' Unmet Needs.**
  - Parent support
  - Theraplay for parents
  - Dealing with parent issues
  - Refer for individual or marital work when needed

Theraplay will not be as effective as it could without parents' full understanding and support. A therapist implementing Theraplay must realize the important role of the parent and collaborate with them.

### ***Marriage and Family Therapy and Theraplay***

Theraplay fits in favorably with the background and premise of a Marriage and Family Therapist (MFT) as both focus on the system in which the client exists in and on

structure of the family. Both the Theraplay therapist and the MFT recognize the family as a pivotal part in the change process of an individual. Additionally, family therapy models such as Structural and Emotionally-Focused fit well with Theraplay. Theraplay recognizes the importance of the parental hierarchy, as in Structural Therapy, and uses this component in every session. Both Emotionally-Focused Therapy and Theraplay formed their basis on attachment theories. Both of these family therapy approaches can contribute to Theraplay. A MFT who ascribes to Structural Family Therapy and/or Emotionally-Focused Therapy will be able to apply Theraplay in their practice with ease.

### **Conclusion**

This report was designed to give Masters and Doctorate level students, as well as practicing therapists, an overview of Theraplay and how it might be useful in the work with their clients. This was not intended to be an all-inclusive project, but rather an overview of Theraplay. Hopefully, this report inspired the reader to learn more about Theraplay and how it may be used with their clientele.

This report presented an overview of Theraplay including its history and when the approach might be beneficial to certain clientele. The usefulness of the approach is also explained through the lens of different theoretical backgrounds that the approach derives itself from. Theraplay is a fascinating approach that any clinician working with attachment issues in clients should be aware of in their work with children and families. Theraplay offers a new hope for families coping with attachment issues in order for families and children to lead healthier lives.

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## Appendix A -

### **Marschak Interaction Method: Recommended Basic Lists of Tasks**

#### *One to Three Years Old*

1. Adult and child each take one squeaky animal. Make the two animals play together.
2. Adult teaches child something child doesn't know.
3. Play patty-cake with the child.
4. Hold child's hands still for the count of twenty.
5. Rub lotion on child.
6. Adult leaves room for one minute without child.
7. Adult tells child about when child was a baby, beginning, "When you were a little baby..."
8. Ring bell where child cannot see it.
9. Adult builds simple structure with blocks and encourages child to copy it.
10. Adult and child feed each other (raisins, candy, crackers, etc.).

#### *Three Years and Older*

1. Adult and child each take one squeaky animal. Make the two animals play together.
2. Adult teaches child something child doesn't know.
3. Adult and child each take one bottle. Apply lotion to each other. Adult combs child's hair and asks child to comb adult's hair.
4. Adult tells child about when child was a baby, beginning, "When you were a little baby..." For an adopted child: Adult tells child about when child first came to live with him/her.
5. Adult leaves room for one minute without child.
6. Play a game that is familiar to both of you.
7. Adult and child each take paper and pencil. Adult draws a quick picture, encourages child to copy. Adult takes one set of five (eight) blocks. Hands other set to child. Adult builds structure with own blocks. Then says to child, "Build one just like mine with your blocks."
8. Adult and child put hats on each other.

9. Adult and child feed each other (raisins, candy, crackers, etc.).

*Adolescent*

1. Adult and child each take one squeaky animal. Make the two animals play together.
2. Adult teaches child something child doesn't know.
3. Adult and child look at each other's hands and read each other's fortune.
4. Adult and child each take one bottle. Apply lotion to each other. Adult combs child's hair and asks child to comb adult's hair.
5. Play a game that is familiar to both of you.
6. Adult leaves the room for one minute without child.
7. Adult and child engage in three rounds of thumb wrestling.
8. Adult asks child to describe a day in child's life ten years from now.
9. Adult and child put hats on each other.
10. Adult and child feed each other (raisins, candy, crackers, etc.).

(Jernberg & Booth, 1999, pp. 391-392)

## Appendix B -

### Short List of Theraplay Activities by Dimension

#### *Structure*

**Bean Bag Game.** Place beanbag or soft toy on your own head, give a signal and drop the beanbag into child's hands by tilting your head toward the child. Take turns.

**Peanut Butter and Jelly.** Say "peanut butter" and have child say "jelly" in just the same way. Repeat five to ten times, varying loudness and intonation.

**Red Light, Green Light.** Ask child to do something, for example, run, jump, move arms. Green light means go, red light means stop. For a more challenging version, stand across the room facing away from the other participants. When you say "green light," the child and parents or co-therapist creep toward you as quietly as they can. When you say "red light," turn quickly to see whether anyone is still moving. Anyone caught moving must return to the beginning. The goal is to creep up and touch the person whose back is turned.

#### *Engagement*

**Blowing Over.** Sit facing the child and holding hands (or cradle the child in your lap), have child "blow you over." Fall back as the child blows. Once child understands the game, you can blow her over.

**Peek-A-Boo.** Hold child's hands (or feet) up together in front of your face. Peek around or separate hands (or feet) to "find" the child.

**Sticky nose.** Put a colorful sticker on your nose. Ask child to take it off. Or stick a cotton ball on your nose with lotion. Have child blow it off.

#### *Nurture*

**Caring for Hurts.** Check hands, feet, face, and so forth, for scratches, bruises, hurts, or "boo-boos." Put lotion on or around hurt, touch with cotton ball, or blow a kiss. Check for healing in the next session.

**Decorate Child.** Make rings, necklaces, bracelets with play-doh, crazy foam, crepe-paper streamers, or aluminum foil.

**Feeding.** Have a small snack and drink available for all sessions. Take the child on your lap or face her as she sits propped on pillows. Feed the child, listening for crunches, noticing whether the child likes the snack and when the child is ready for more. Encourage eye contact.

### *Challenge*

**Balloon Tennis.** Keep balloon in air by using specific body parts: heads, hands, no hands, shoulders, and so forth. If you choose feet, everyone lies on the floor and keeps the balloon in the air by kicking it gently.

**Partner Pull-Up.** Sit on the floor holding hands and facing each other with toes together. On a signal, pull each other up to a standing position.

**Pillow Push.** Place a large pillow between you and the child. Have child push against pillow to try to push you over.

(List extracted from Jernberg and Booth, 1999, pp. 393-405)