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Chapter 7

THERAPLAY: ATTACHMENT-ENHANCING PLAY THERAPY

Evangeline Munns

Theraplay is a structured form of play therapy that often has a profound effect on the child in a short period of time. It is not a talking therapy and no interpretations are made. Occasionally, the child's feelings are reflected, but the main emphasis is on playful interactions between, first, the therapist and child as the parents observe and then with parents directly with their child. No toys are used. Bizarre behavior is ignored. The activities and games included are based on normal parent/child interactions. They are engaging, physical, and fun.

The main goals of theraplay are to enhance parent/child attachments and/or relationships, to raise the self-esteem of both child and parents, and to increase trust. Often in families where conflict is rampant, there is a sense of distrust, rejection, and emotional distance or overinvolvement; a lack of cooperation; and little laughter or joy. 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.

HISTORICAL BACKGROUND

Theraplay was founded by Ann Jernberg, a psychologist, in 1967. She received a federal grant to try to increase the bonding between mothers and their children in the Head Start program in Chicago. She needed an inexpensive, short-term treatment method, so she turned to the work of Austin Des Lauriers, who had originated a unique way of interacting with autistic and schizophrenic children (Jernberg, 1979). He used direct body and eye contact in engaging these children

and ignored their unusual and often bizarre behavior. Jernberg also incorporated elements of Brody's approach (1993), which emphasized nurturing through physical touching, rocking, and singing. Jernberg added another aspect—the use of regressive activities to bring the child back to a stage where he or she was cared for in a loving way and accepted unconditionally.

In 1971, Jernberg founded the Theraplay Institute in Chicago, which still today serves as the international headquarters for theraplay. Theraplay is practiced around the world, but is best known in the United States under the leadership of Phyllis Booth, director of training (Jernberg & Booth, 1999), and in Canada under the leadership of Evangeline Munns, clinical director of Blue Hills Play Therapy Services in Aurora, Ontario. Ulreke Franke directs a training center in Germany.

BASIC CONSTRUCTS, GOALS, AND TECHNIQUES

Theory

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. If that relationship is not a secure one, all other relationships can go awry, resulting in emotional difficulties as the child grows older. Theraplay goes back to that first relationship and tries to make it a healthier one. This is done by replicating what a normal parent might do with a young child, including regressive activities such as cradling, rocking, and feeding the child (in some cases, feeding a baby bottle) or powdering or lotioning of "hurts" on the child's hands or feet. Through such regressive activities, feelings and memories of an earlier time are evoked. The child revisits the roots of connecting to another human being in a caring atmosphere. This is one of the unique features of theraplay and one that often has a powerful effect on both child and parent as they learn to reconnect with each other in a basic, intimate, and accepting way. In the later stages of treatment, there is less emphasis on regression and more on age-appropriate activities. Parents learn to be attuned to their child and more responsive to their needs. They also start enjoying their child. The child's inner sense of a strong, competent self, of being worthy and loved, and of being securely attached to his or her caretakers grows.

Dimensions and Techniques

Jernberg observed hundreds of scenarios of normal parent/child interactions and categorized them into four main dimensions: structure, challenge, engagement, and nurture.

Structure

Structure can give the child the feeling that the world is safe, dependable, and predictable. Even with a young child, there are rules and boundaries; that is, the child can explore the environment but is not allowed to touch a hot stove or an electrical outlet. The child can throw a toy, but not a cup of milk. The child's daily routines around sleeping, eating, bathing, and so on give order to the child's life. Rhymes and songs a parent might sing have a pattern or rhythm to them. All of these give the child a sense of regularity and security.

In theraplay, structure may be emphasized by having the therapist or parent lead the activities or games where there are clear directions and rules. The whole session is preplanned with a clear beginning and ending. Games such as "Mother, May I" or "Simon Says" have definite rules in how they are played. Structure is emphasized with children who are impulsive, out of control, unmanageable, or uncooperative. Children who are tyrants or those who have been parentified learn that when adults are in control, the world can be a safer place for them, and they can relax and just be the children that they were meant to be.

Examples of Structuring Activities

- *Red light, green light:* The leader faces a wall. Whenever the leader shouts "green," the others creep up closer to the leader. When the leader shouts "red," everyone stops. If the leader turns around and spots anyone moving, that person has to go back to the wall from which he or she started. Whoever reaches the leader first becomes the next leader. The therapist makes certain that everyone gets a turn being the leader.
- *Outline of hands, feet, or body:* An outline of the child's body, feet, or hands is made on paper using a felt marker. The child, depending on age, may be asked to draw details such as his or her nails. A comparison of the child's actual hand and the hand outline is made, so the child can gain a clearer image of this part of his or her body. In addition, this can lead into a nurturing activity if some ink happens to be left on the child's hands. The therapist then can wash, dry, and lotion the child's hands, so the child feels cared for.
- *Races:* (Walking, hopping, crawling, or running along a straight line.) The child may start on the word *cherries* or any other word or number preplanned by the therapist. This can be made into a race between the therapist or child or among all family members. If so, this activity becomes a challenging, as well as a structuring, game.
- *Peanut butter-jelly:* The therapist says "peanut butter," and the child or rest of the group answers "jelly" in exactly the same way that the leader said "peanut butter," whether it was slow, fast, soft, loud, low-pitched, high-pitched, and so on.

- *Silly bones:* Therapist and child kneel facing each other. The leader gives directions such as "Silly bones says put our hands together" or "Silly bones says touch our elbows together," and so on. This is a good activity that can be expanded for family members who are distant from each other physically or emotionally. Each family member can take a turn being the leader.

Challenge

Every child, no matter what level of cognitive or physical ability, needs some challenge in his or her life. It is through the mastery of challenges that people learn to test themselves and, in doing so, gain an awareness of their strengths and weaknesses. Taking risks within their range of abilities can be fun and exciting and "adds spice to life." Being successful with challenging tasks raises one's self-confidence. Finally, challenging activities are often a good way of releasing inner tensions.

As far back as infancy, each individual had to face challenging tasks. The infant learns to lift its head a little higher or to roll over or to sit up unassisted. The toddler hangs on to the little finger of its mother and finally lets go, gaining freedom to walk on its own. The apprehension and then exhilaration on a little one's face are treasured memories. Through the mastery of many challenges, the child learns that risk taking can be fun and rewarding.

In theraplay, challenging activities are included for the timid, withdrawn, fearful child (one who has been perhaps overprotected by overanxious parents) or the child who is rigid in his or her defenses (e.g., an obsessive-compulsive or autistic child).

The key to doing challenging activities is to design tasks that are within the child's potential capabilities; otherwise, failure can result and have a negative effect. The therapist has to be sensitive to the child's fears and skill level and to pace the difficulty of the tasks accordingly. Challenging tasks usually require concentration, effort, and determination. Inner tension is released in this process. For this reason, challenging activities are often included for active, aggressive children as a way of expressing some of their energy and hostility in an acceptable way.

Examples of Challenging Activities

- *Balloon toss:* This is a very good activity for releasing energy in a fun way. Children are attracted to balloons, so even a difficult-to-engage child responds to tossing balloons in the air. The object of the game is to keep the balloon from landing on the floor. If the child is successful, other balloons can be added. This is an excellent icebreaker when parents come into the play session for the first time and are feeling ill at ease. It gets everyone moving around.

- *Ping-pong blow or cotton ball blow:* This can be played between therapist and child or among all family members. Everyone lies on their tummies facing inward in a circle, hands clasped with their neighbor. The leader calls out a name and tries to blow the ball to that person, who in turn calls out another name. Another version is just to try to blow the ball away from your area into the opponent's area. More balls can be added to increase the challenge. There is usually much laughter with this activity.
- *Paper punch and basketball throw:* The therapist holds a newspaper sheet tautly in front of the child, who punches through it with his or her fist. The therapist then takes half of the newspaper and tells the child to punch through again, resulting in two quarters of a newspaper. After several newspapers are punched through, the quarters of paper are scrunched up into balls and thrown into a hoop made by the therapist's arms clasped in a circle formation. The difficulty of this activity can be controlled by moving closer or farther away from the child but is always guided by the child's ability to succeed. This activity is very good for releasing aggression and tension.
- *Balancing beanbags:* Child and therapist (and other family members) race from one end of the room to the other, balancing beanbags or pillows on their heads. The therapist first gives a clear signal for starting.
- *Thumb, arm, or leg wrestling:* Therapist and child face each other. They clasp their right hands together with the thumbs resting against each other. The therapist chants "1, 2, 3, 4—I declare a thumb war," whereupon both try to press down the thumb (or arm, or leg) of the other.

Engagement

As an infant, the child normally is engaged by the parent in a variety of stimulating ways. Such play can seem intrusive, but there is a feeling that both are experiencing pure pleasure in each other's company. Affective attunement leads to a feeling of intimacy and connectedness (Stern, 1995). From these experiences, where each member is attuned to the other's feelings, the child learns how to empathize with others.

Theraplay tries to replicate this playful engagement. Intrusive activities are sometimes used, but the therapist is sensitive to the child's cues and is guided by the child's needs and reactions. The child learns that surprises can be fun and that interacting with another human being can be rewarding and stimulating. Engaging activities are frequently used with children who are avoidant or rejecting and have high protective barriers to intimacy, such as autistic children.

A note of caution: If working with a child who has been abused, intrusive activities must be introduced slowly and gently and stopped or modified if the child appears fearful or rejects them.

Examples of Engaging Activities

- *Mirroring:* The child and therapist face each other. The therapist makes motions with his or her hands, head, or whole body, while the child follows and imitates these motions without touching the therapist. After a few minutes, the child leads and the therapist mirrors the child. This activity requires concentration and a keen awareness of each other so that one can almost anticipate where the other will move.
- *Patty-cake or piece-porridge hot:* Therapist takes the child's hands or feet and claps them together while chanting the well-known verse of "Patty-cake." For older children, the verses of "Piece porridge hot" can be chanted while the therapist and child clap their hands together in a predetermined sequence. The tempo of this chant can be increased as the proficiency of the clapping sequence improves.

  Another version of imitating clapping sequences can be initiated without any chanting. The therapist claps out a simple sequence of perhaps two or three claps; if the child imitates the sequence correctly, more claps are added. Within the sequence, the therapist can gradually introduce a touching of each other (i.e., therapist claps twice and then claps the child's shoulders and then his or her own hands again). Child imitates this sequence. This activity is good for developing a sense of connectedness between partners, and touching is introduced in a safe, nonthreatening way.
- *Cotton ball fight and cotton ball soothe:* Participants face each other in a circle or rows, with a pile of cotton balls in front of each person. On the word "go," each person throws a ball at someone, calling out their name first. As the game progresses, it becomes more free, with everyone pitching balls at everyone else as fast as they can. The beauty of this activity is that anyone can throw the cotton ball as hard as they want, and the other person does not get hurt. This is a great activity for expressing aggression in a safe, fun way. Invariably, people end up laughing. This activity can be followed by "cotton ball soothe," where each person takes a cotton ball and gently rubs the cotton ball around the forehead, cheeks, nose, and so on of the person next to or across from them.
- *M&M hide:* The child lies on his or her back with a pillow under the head. The therapist hides three or four candies or raisins somewhere on the child's body. The parent then finds the candy and feeds the child. If the therapist is alone with the child, the child is asked to close his or her eyes while the

therapist hides the candy. The therapist then pretends to forget where the candies were hidden but finally finds them and feeds them to the child. With an older child, the therapist closes his or her eyes while the child hides the candies on himself or herself; then the therapist finds them and feeds them to the child. This activity is a favorite one for nearly everyone.

- *Jelly bean toes:* The therapist feels the toes of the child, saying, "I wonder what's in here—could it be peanuts, popcorn, or maybe even jelly beans! Let's find out! (as the therapist whips the sock off). Oh my, it is jelly beans—green, yellow, and red—my favorite!" (as therapist bends his or her head toward the child's toes and pretends to eat them). This activity is a delightful one for younger children and has been used for children as old as 8 or 9 years.

Nurture

Nurturance is a basic need of all children. It is expressed ideally by parents in countless ways in the daily caring of their small ones, whether through feeding, bathing, lotioning, powdering, cradling, caressing, hugging, kissing, rocking, singing, and praising their children—telling them how wonderful they are. There is a sense of unconditional acceptance. An infant only has to exist; it does not have to perform to be adored by its parents. These interactions help the child to feel valued, important, and safe in the knowledge that their parents will always be responsive to their needs. Nurturing is one of the most important dimensions that help a child to feel securely attached to its parents.

In theraplay, all children are nurtured in every session. The child is always fed, perhaps a simple snack such as potato chips, seedless grapes, popcorn, pretzels, and so on—something the child likes. If it is felt that the child's attachment difficulties started in infancy, the child might be cradled and rocked in a blanket in the therapist's arms while being fed a lollipop, freezie, or baby bottle. The therapist might sing a special song about the child while rocking the child. When parents enter the sessions, this nursing of the child is shifted to the parents. Children are nurtured in other ways as well, such as lotioning or powdering of hurts, combing of the child's hair, and so on. Nurturing is especially emphasized with children who have been abused and with aggressive, acting-out children, who seem to always be in trouble and generally receive criticism rather than nurturance.

Examples of Nurture

- *Lotioning or powdering of hurts:* The therapist examines the child's hands or feet and invariably finds little scratches, bruises, discolorations, maybe even just freckles, to gently lotion or powder. This activity occurs in every theraplay session regardless of the child's age. Sometimes, if the parent has come from a deprived or abusive background, the therapist powders the hurts of the parent as well.

- *Powder hand prints:* The child's hand is dusted with baby powder that is smoothed on so every crease in the palm is covered. The child's hand is then gently, but firmly, pressed onto a dark piece of construction paper. To get a clearer hand print, sometimes the child's hand is first covered with lotion before the powder is dusted on. The print is then compared to the real hand and details noted. If the whole family is participating, every member makes a hand print on a large piece of construction paper, resulting in a family portrait of their hand prints. Everyone's hand prints can be compared for similarities and differences. This is a nice way for children to get a clearer image of a body part and for family members to feel connected.
- *Fortune-telling:* The therapist powders the palm of the child so all the creases stand out and then makes up a fortune by reading the palm of the child. The fortune is always positive. Another variation of this activity is to discover numbers or letters in the palm of the child's hand after powdering it. Adolescents, in particular, enjoy these activities.
- *Beauty salon:* The child sits in front of a mirror while his or her hair is carefully combed. If the child is young, a clown face may be painted on (after moisturizing the face first so the makeup can easily be wiped off later). A special hat or other clothes might be added. With older children, makeup might be tastefully applied to a girl's face and jewelry added. For boys, shaving lotion is applied and then taken off with tongue depressors. Warm, wet towels are used to make the final wipes. Throughout, the therapist makes positive comments about the child's features. If the parent is participating, the parent applies the makeup or shaving lotion. This is another favorite activity for most children.
- *Rocking in a blanket:* This activity usually takes two adults. The child lies on a blanket on his or her back. The corners of the blanket are lifted up and a song is sung while the adults sway the blanket back and forth; for example, "Rock-a-bye, (child's name), in the treetop, when the wind blows the cradle will rock. When the wind stops the cradle won't fall and up will come (child's name), cradle and all." The child is then lifted up into the parent's arms. From this activity, it is easy to have the parent sit on a pillow on the floor against a wall and continue cradling the child while feeding it a lollipop or baby bottle. The adult continues rocking and singing a special song about the child; for example, "Twinkle, twinkle little star, what a special boy you

are. Shiny hair and rosy cheeks, two brown eyes from which you peek. Twinkle, twinkle little star, what a special boy you are." (Further theraplay activities are described in Jernberg & Booth, 1999; Munns, 1997, 2000.)

Treatment Planning and Process

The therapist preplans each session according to the needs of each child. The child's needs are determined partly from a thorough developmental and family history taken at the beginning of the treatment period. An assessment is also made using the Marschak Interaction Method (MIM; Di Pasquale, 2000), which consists of a series of standardized tasks designed to reveal family relationships and dynamics. The MIM is videotaped (with the parent's permission) and played back to the parents in the following session. Strengths are highlighted, problems discussed, goals are set, and a verbal contract of at least eight sessions is agreed on.

Parents observe the first three or four theraplay sessions through a one-way mirror or from a corner of the room with an interpreting therapist to answer their questions and help them become more attuned to their child's reactions. (If there is a shortage of staff, having an interpreting therapist may not be possible.) Parents participate directly in the remaining sessions. After each one-half hour of theraplay, there is usually a half-hour of parent counseling (the latter is optional, but strongly recommended). During the last session, a party is held where favorite activities are included. Parents bring their child's favorite food, and therapists give mementos of the sessions (hand prints, body outlines, etc.). Four checkups are held during the year.

If the parents have many emotional problems themselves, they are counseled to seek psychotherapy for themselves. However, the timing of this advice is crucial and is more likely to be accepted if given toward the end of treatment, after a trusting relationship has developed with the therapist.

Agenda for a Single Session

A typical theraplay session includes the following elements: a warm greeting at the door; a fun entrance into the center of the room; a welcome song; a checkup or inventory where the therapist notices and comments positively on the child's physical features and perhaps measures a few of them; activities relating to structure, challenge, engagement, and nurture; and a goodbye song. Each session always includes some kind of feeding and lotioning or powdering of hurts. Activities vary from calm, quiet, more intimate interactions, to large body movements with lots of freedom of movement and stimulation. This results in a balance of activities requiring close physical contact to those allowing for distance and space.

Example (for the Third or Fourth Session with Parents Coming In for the First Time)

Greeting: "Hi, Johnny, I've been waiting to see you all week!"

Entrance: Follow the leader. (The child imitates the actions of the leader as they walk into the room.)

Hello song: "Hello Johnny, hello Johnny, hello Johnny, I'm glad you came to play!" (to the tune of whatever fits).

Inventory or checkup: "Johnny, what have you brought today? I see you've brought those sparkling eyes, rosy cheeks, beautiful dark hair, and that little dimple right there when you smile. Look at that smile! I believe I should measure that smile! (Therapist uses a cloth tape measure.) Four inches wide! And look at those strong shoulders. Let's see how wide they are—18 inches! Wow!"

Lotioning or powdering of hurts: (previously described)

Play dough trophies: Therapist makes play dough impressions of child's body parts (i.e., finger, hand, nose, ear) and compares details in the impressions with child's actual body part.

Bubble burst: Therapist blows soap bubbles, and child runs and bursts them first with both hands and if successful, then with a finger, elbow, and so on.

Child hide and find: Child hides under a blanket somewhere in the room in preparation for parents to come and find him. (Parents come into the room. Parents pretend they can't find the child and wonder out loud where he might be. When they find him, hugs are encouraged.)

Toss balloons: (previously described)

Motorboat: In a circle formation holding hands, members move to the right while chanting: "Motorboat, motorboat go so slow, motorboat, motorboat go so fast, motorboat, motorboat step on the gas! (move quickly) Motorboat, motorboat move so slow, motorboat, motorboat move so fast, motorboat, motorboat out of gas! (Everyone falls or sits down.)

One potato, two potato hug: While in a sitting formation facing each other, a beanbag (the pretend potato) is passed around while everyone chants; "One potato, two potato, three potato four, five potato, six potato, seven potato more." Whoever has the potato on the word "more" gets a hug from his neighbors or from everyone. This is repeated until everyone gets the potato and hugs.

Feeding: In a circle formation, the therapist feeds everyone several rounds of potato chips or other snacks directly into their mouths. The parents get a turn feeding everyone as well.

Goodbye song: Everyone sings "Goodbye Johnny, goodbye mom, goodbye dad, goodbye (therapist's name), goodbye everyone, we're glad you came today." (With adolescents, a rap song can be invented.)

The child is then taken by the cotherapist to a separate area for play with toys, books, puzzles, or outside play, while the therapist discusses the session, homework, progress at home and school, and so on with the parents for about half an hour.

ROLE OF THE THERAPIST

The therapist, after obtaining a family history and family assessment using the Marschak Interaction Method, has a fairly clear idea of the child's needs and preplans the theraplay session accordingly. At first, the therapist models healthy interactions while the parents observe in the first three or four sessions. The therapist is sensitive to the child's cues and responds appropriately. If the child is impulsive and out of control, the therapist is calm, firm, and takes charge of the situation, with an emphasis on having the child obey adult directions. If the child is timid and fearful, the therapist is still in charge but is gentle, engaging the child slowly. If the child is withdrawn, the therapist may use surprises and fun activities to engage the child. The overall guiding principle for the therapist is to make a connection to the child in a way that raises the child's self-esteem and ability to trust others and to help build the child's inner representation of himself or herself as someone who is valued, loved, and cared for.

When parents enter the sessions, the therapist tries to strengthen the attachment between child and parents by choosing activities that promote attachment. The therapist gradually gives more of the leadership role to the parents; however, the therapist is always there to support and guide them. The therapist tries to strengthen the parents in the way they manage problematic behaviors; to be aware of and respond to their child's needs; and to be warm, affectionate, and accepting in their manner.

ROLE OF THE PARENT

After observing the therapist interacting with their child for the first three or four sessions, the parents' perception of their child often changes. They have brought their child into treatment because of the child's difficulties, and usually their focus is on all the child's negative aspects. The therapist does the opposite—focusing on all the positive attributes. The child most often responds in a pleasant way. Children usually start laughing and having fun. They soon become motivated to please the therapist, so being cooperative with adult directions becomes less of a problem. Parents who might be skeptical about how playing with their child is going to bring any meaningful results slowly realize a transformation is taking place. Their child can be a delight—not a source of constant worry.

The therapist may have to work through the child's resistance (if this is an oppositional child), but the parents learn how this can be done appropriately without any shouting or anger.

When the parents enter the therapy sessions, they are often nervous and anxious. The therapist tries to put them at ease by engaging them in an activity that is fun and stimulating. Quieter activities—such as silly bones, cotton ball soothe, lotioning hurts, feeding, and cradling (all activities are previously described)—where the parents gain a greater intimacy with their child, are chosen.

As the sessions progress, parents are asked to lead a few activities of their own choosing so that the managing of their child falls more and more to the parent. If the child resists, the therapist helps the child to be more cooperative. Practicing the activities at home is strongly encouraged and homework sheets are often assigned. Usually, the children are excited about doing this and may remind the parents of their "theraplay night" at home.

After the last session (the party session), another Marschak is given and videotaped, followed by a feedback session, which may include comparing the family's posttreatment-Marschak performance to the pretreatment Marschak (this is optional). Questions are discussed. Have goals been obtained? What else needs to happen? Do the child and/or parents need additional treatment of another nature? Recommendations are outlined and dates are set for the first of four checkups, usually in about six weeks' time. The family, knowing they will see the therapist comparatively soon, has an easier time of ending treatment.

Case Illustration

Jimmy was an eleven and a half-year-old boy referred for severe behavioral problems, poor peer relationships, sibling rivalry, conflict at home with parents, and, at school, moodiness and being generally unhappy. He had a sister, two years younger, who was a model student. Not surprisingly, there was strong sibling rivalry with this sister. However, he had another younger sister, about a year old, whom he loved. He had no friends. There was strong rejection of his stepfather. He was closer to his biological mother but was often uncooperative with her.

Jimmy's problems began early in infancy because of his parents' marriage difficulties. His parents eventually divorced and his mother remarried. The stepfather feared his stepson, avoided him, and left all of the disciplining to the mother.

The positive aspects of this child were that he was bright intellectually, he was tall and handsome, and he was well-coordinated physically.

After obtaining a family history, a Marschak Interaction Method was planned. On the date of the appointment, Jimmy refused to come. Another appointment was made and the Marschak revealed a sullen boy, depressed, hostile,

and suspicious, but able to lighten up and laugh during some of the more regressive activities. Mother and child could enjoy each other, and good eye contact was made during such activities. However, during more achievement-oriented tasks, Jimmy became more withdrawn. With his stepfather, there was obvious distance, rejection, and more of a pouting expression on his face. The stepfather gave in quickly to Jimmy's demands. When the whole family interacted, tension and strain were obvious, even though the parents tried hard to make the activities enjoyable.

Goals from the Marschak were:

1. To increase attachment between parents and child, especially between stepfather and son.
2. To increase the parents' abilities in managing their son's behaviors, especially helping the stepfather.
3. To increase the child's self-esteem, confidence, and ability to trust.
4. To increase this family's ability to enjoy one another and have fun.

The first session was preplanned, stressing structured activities where Jimmy had to follow adult directions and self-esteem-enhancing tasks:

First theraplay session: Jimmy was distrustful, did not smile, but managed to cooperate with all of the activities. (This was a brief honeymoon period.)

Second (attempted) theraplay session: Jimmy saw the audiovisual equipment and refused to come into the theraplay room, stating he would not enter if he was going to be videotaped. In the previous session, Jimmy was shown this equipment and told clearly that all sessions would be videotaped and why. Jimmy was reminded of this, but he still refused to enter. This behavior was accepted and no theraplay activities took place. Puzzles and books were given to him in the next room, while the therapist had a counseling session with the parents.

Second (actual) theraplay session: Jimmy complained that he was feeling sick, but his parents still brought him in, believing that he was simply showing another way of resisting. The therapist carried on the session but was mindful that he might have been truly sick. Jimmy complied with the activities, but when he complained that his throat hurt, the therapist realized that he probably truly was sick. She sympathized, "Oh, Jimmy, you really are sick; I am so sorry." At this point, a big tear rolled down his cheek. The rest of the session was changed so that the therapist could nurture him, such as playing "beauty salon." Throughout, the therapist praised him and was very caring in her manner. He was cooperative and much more cheerful for the rest of the session. The therapist felt she had made a major breakthrough with this child and looked forward to a cooperative child next week. She was mistaken.

Third theraplay session: This was a pivotal session, showing dramatic changes from the beginning of the session to the end.

Jimmy came in with his head down and his hands in his pockets. His body language communicated strongly: "I don't want to be here!" The therapist carried on in a cheerful, direct manner. Jimmy started resisting early in the session. He let his body slump and became generally like a "limp piece of spaghetti." In "Simon says," he pulled his T-shirt over his head rather than follow directions. The therapist mirrored him and tried to bring a sense of humor to the situation. In "tug of war," he started to come alive and talked spontaneously; however, as soon as he was not winning, he complained. In "paper punch and sword fight," he was cooperative, but the rules had to be tightly enforced. He became much more engaged and pleasant in his manner after these aggression-releasing activities. These activities were followed by calming activities such as "M&M hide" and "cotton ball soothe." The therapist then cradled Jimmy in her arms, while singing a special song about him as she fed him a lollipop. Amazingly, he fully cooperated with this activity. The therapist had planned for this activity because she felt he responded well to regressive activities during the Marschak and because his difficulties with attaching to others had started early in his life. This very resistive child became more open through the release of his underlying hostility and was then ready to receive the basic nurturing that he needed. Immediately after this session, when the parents came in for parent counseling, the stepfather still had a look of incredulity on his face. He had watched his son change from being an aggressive, resistive child, to one showing that there was a "baby inside" waiting to be nurtured. In this session, the stepfather started to have real insight into the needs of his child and to stop fearing him. Theraplay activities were encouraged at home, and the stepfather started spending more leisure time with him.

Fourth theraplay session: This session went well. At the end, the child was again cradled and a special song including his name was sung to him as he was fed a lollipop.

Fifth theraplay session: In this session, Jimmy was fully cooperative; he was cradled, rocked, and sung to while he was fed a baby bottle filled with pop. Parents came in halfway through the session, and the whole family enjoyed one another. At home, the stepfather started to take bike rides with his son after supper. The mother gave him back rubs at bedtime and tried to ease off pressuring him for academic achievement. The mother asked if all the children

could have baby bottles at home and the therapist agreed. (The children used the bottles only for a few weeks.)

Sixth, seventh, and eighth sessions: In all of the remaining sessions, the parents were included and had positive interactions with their son. The therapist frequently had Jimmy placed next to his stepfather and chose activities where there was close physical contact. Their relationship changed so significantly that it drew favorable comments from relatives at home.

Improvements occurred at school as well. Jimmy had a good teacher in his special class. He was promoted to a regular class starting in the fall, where he became a tutor for some of the younger children in his school. As well, the therapist had encouraged Jimmy to participate in a team sport of his choosing. He joined a trampoline team that ended up competing on an advanced level.

All goals were met—at least to some extent. One area, however, needed more attention. Jimmy started to have better times in playing with his cousins, but he still did not have any close friends. The final recommendation to this family was that Jimmy join a peer group that focused on social skills.

This case was a very rewarding one. The child had longstanding problems that were dramatically improved through theraplay in a short time. Other significant contributors to his success were his motivated parents, who cared for him and wanted the best for him, and his helpful teacher at school.

CLINICAL APPLICATIONS

Theraplay has been applied in a variety of formats and to a wide range of clinical populations. It has been used for the individual child, with the whole family, with couples, with groups (Rubin & Tregay, 1989), and with multifamilies (Sherman, 2000). Theraplay is applicable from infants to adults. In mental health settings, it has been used for emotional and behavioral problem children living in a residential setting, with troubled children on an outpatient basis, and in special classes in schools. Groups have included mother-child, father-son, and family groups. Family theraplay has been used successfully most often where there are relationship or attachment difficulties that can occur in adoptive, foster care, or divorced families (Finnell, 2000) or for children coming from deprived or abusive backgrounds. Impulsive, aggressive children, or those who are tyrants, have responded well to theraplay. Timid, withdrawn children such as those who are electively mute, have become more expressive emotionally and verbally. Autistic children show significant gains in their ability to relate to people and in being cooperative. Depressed, suicidal, homicidal children and/or parents have made positive changes. Psychotic children have been more in touch with reality and have spent less time in fantasy. Those with developmental delays or physical disabilities have responded well to theraplay's playfulness and self-esteem-enhancing approach.

Although theraplay has wide applications, it is not a treatment method for everyone; at least, it needs to be modified for certain populations. Clients who have been recently traumatized, through losing a close relative or friend, need a quiet time to grieve. Those who have had recent surgery need restful periods to heal. Children who have been physically or sexually abused often need more work in addition to theraplay, but all of these children can benefit from the nurturing aspects of theraplay, provided the therapist uses a gentle approach and respects their "no's." These children need to be empowered, and theraplay needs to be modified for them.

EMPIRICAL SUPPORT

Theraplay is well supported in its theoretical foundations, which are laid in attachment theory (Bowlby, 1988; Holmes, 1996; Karen, 1994; Stern, 1995). Research regarding the impact of secure and insecure attachment patterns in different cultures around the world (van Ijzendoorn & Sagi, 1999) has demonstrated the impact early relationships have in later life (Goldberg, 2000; Rutter, 1994; Waters, Weinfield, & Hamilton, 2000; Ziegenhain & Jacobsen, 1999) and between generations (van Ijzendoorn, 1995; Zeanah & Zeanah, 1989).

Jernberg emphasized physical contact in theraplay because, from her observations of normal parent/child interactions, it seemed such a basic and essential way for parents and children to connect with each other. Her observations have been supported by researchers such as Field (1995, 2000), who has done extensive research showing the significant gains infants make, not only in terms of weight increase, sensory-motor development, leaving the hospital earlier, and so on, but also in their emotional and social responsiveness when they receive daily body massages. The importance of physical touching has been emphasized by clinicians who have used massage and other forms of physical contact with sexually and physically abused clients (Ford, 1993; Hindman, 1991; James, 1994; Smith, Clance, & Imes, 1998; Smith-Lawry, 1998).

Theraplay is a preverbal form of therapy using a multisensory approach. Psychobiologists such as Shore (1998) and Marcellus (1998) in their research have shown how deprivation, trauma, abuse, or poor attachment can affect the early development of the brain. Because the right hemisphere receives sensory-motor input and processes social emotional experiences and because traumatic events are stored in the more primitive part of the brain, they have suggested that more attention needs to be paid to preverbal and nonverbal therapies. Theraplay fits into this category.

Research using theraplay directly suffers from a lack of *randomized* control groups although several studies have used control groups. Ritterfeld (1989, 1990) found that language-disabled children receiving theraplay significantly increased not only their social competence scores, but also their verbal expressiveness, as compared to a group receiving standard speech therapy and a control group receiving arts and crafts. Ammen (2000) found significant improvement in empathy scores in her high-risk teenage mothers' theraplay group, as compared to a control group, and significant gains in parent/child relationships, as measured by pre- and postscores in the theraplay group. Zanetti, Matthews, and Hollingsworth (2000) showed positive trends in their group theraplay research in school settings. Other researchers, lacking a control group, but using pre- and postscores, have found significant results. Munns, Jensen, and Berger (1997) in two separate pilot studies found a significant decrease in the aggressive factor in the Auchenbach Child Problem Checklist. Morgan (1989) demonstrated significant, positive changes in children's self-confidence, self-esteem, trust, and self-control, after receiving theraplay.

CONCLUSIONS

Theraplay appears to be a very promising therapeutic method. It is a cost-effective, short-term, structured, relationship-based form of play therapy, which replicates normal parent/child interactions. It strives to enhance attachment and healthy relationships between parents and their children and to raise their self-esteem and trust. Physical contact is emphasized in a playful, engaging way that is enjoyable for all participants. Parents first observe and then participate directly with their child, focusing on the child's positive strengths. Theraplay is applicable from infants to adults and has been used for a wide range of emotional, social, and behavioral problems—particularly those stemming from attachment and/or relationship difficulties such as those found in adoptive, foster-care, and divorced families.

Theraplay is based on attachment theory and the importance of physical contact in forming connections with others. Empirical evidence supports the use of theraplay, but it needs further research, particularly in studies using randomized control groups.

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Chapter 8

COGNITIVE BEHAVIORAL PLAY THERAPY

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Cognitive Behavioral Play Therapy (CBPT) is an offspring of cognitive therapy (CT) as conceptualized by Aaron Beck (1963, 1964, 1972, 1976). The cognitive model of emotional disorders involves the interplay among cognition, behavior, and physiology (A. Beck & Emery, 1985) and contends that behavior is mediated through verbal processes; the way individuals construe the world in large measure determines how they behave and feel and how they understand life situations (A. Beck, 1967, 1972, 1976). Cognitive theory contends that an individual's emotional experiences are determined by cognitions that have developed, in part, from earlier life experiences. Over the past 40 years, CT has been applied to an increasingly broad range of populations. Included are psychiatric populations, such as individuals with depression, anxiety, and personality disorders, as well as nonpsychiatric populations, such as prison inmates and medical patients (J. Beck, 1995).

CT as practiced with adults is inappropriate for use with adolescents and children without modification because a more developmentally appropriate approach is necessary. Over time, adaptations of CT for use with increasingly younger populations have emerged (e.g., adolescent, Emery, Bedrosian, & Garber, 1983; school-age children, Kendall & Braswell, 1985). However, many believed that CT could not be adapted for preschool and very young school-age children. Clinical lore suggests that therapy with preschoolers must involve some level of play therapy to engage the child in what is traditionally a more verbal endeavor. The developmental literature might suggest that preoperational-stage children do not have the cognitive sophistication and flexibility to benefit from CT. CT with adults requires the ability to follow a rational, logical sequence. It assumes that the individual has the capacity to differentiate between rational and irrational/logical and