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7

Theraplay with Zero- to Three-Year-Olds

Evangeline Munns

BASIC RATIONALE

Theraplay is a treatment method that is ideally suited for the zero- to three-year-old population for a number of reasons. First, it tries to replicate what normal parents do with their young children. Theraplay goes back to the roots of connectedness, which normally begins in the first years of a child's life. One of its main goals is to enhance the attachment between parent and child, which is one of the most important developments in childhood. Research from around the world has shown that if a child does not have a secure attachment with a chief caregiver, then there is a strong likelihood that the child will develop emotional, social, or behavioral problems later on in life, unless remediating factors intervene (Rutter 1994; Schore 1998; Spratt and Doob 1998; van IJzendoorn, Juffer, and Duyvesteyn 1995; Webber-Stratton and Taylor 2001).

Second, Theraplay places an emphasis on physical contact with the child, which is exactly the kind of sensory stimulation a baby needs. The tactile sensory system is the most advanced sensory system when a child is born (Eliot 2000). (Touch includes four sensory abilities: cutaneous touch, temperature, pain, and proprioception.) The infant can perceive and process tactile stimuli especially in the oral region, and that is one of the reasons that the baby often mouths objects in its attempts to explore its world. The majority of Theraplay activities, especially with a young child, involve touch.

Third, Theraplay has many activities incorporating the vestibular system—a sense that allows us to perceive our body movements and balance and is the second most highly developed sensory system at birth (Eliot 2000).

Babies take delight in motions such as rocking, bouncing, being carried, and gentle jiggling, and can be comforted by these repetitive movements. Theraplay activities with very young children will often include nursery rhymes that encompass simple repetitive rhythms such as bouncing or rocking.

Fourth, Theraplay is not a verbal therapy. Words are not as meaningful to young children as they are to adults. Theraplay is an action-oriented, physical, fun type of play therapy that children usually love.

Fifth, one of the main tenets of Theraplay is to build the self-esteem of the child, emphasizing the child's positive attributes. This, along with the sensitive, nurturing caretaking of the child, contributes to the child's positive "internal working model" (Bowlby 1988), that he or she is a valued, important little person.

Overall, Theraplay helps parents to be attuned to their child's needs and to be contingently responsive along with taking pleasure in each other. If this indeed takes place, the parent helps the child to become self-regulated and in this process, attachment is strengthened (Booth 2000; Gerhardt 2004).

Theraplay for the zero to three age group needs to be modified because of the rapid growth in all aspects of the young child, especially in the development of the brain. Particularly in the first year, there is a spurt of growth in synaptic connections between neurons. This is followed by a "pruning" of connections that are not used, which results in a deterioration or fading away of such synapses (Gerhardt 2004). By the end of the third year, nine-tenths of the brain is developed. The Theraplay modifications will be discussed after first giving a background to Theraplay and describing its classic approach.

HISTORY AND BACKGROUND

Theraplay was founded by Dr. Ann Jernberg, a psychoanalytical psychologist, in 1967 when she was given a federal grant to enhance the bonding between mothers and their children in a Head Start program in Chicago (Jernberg and Booth 1999; Munns, 2000). Because it was found to be clinically effective in a short period of time, it became more widely known. Today it is practiced around the world, with its international headquarters located at the Theraplay Institute in Chicago.

Theraplay has been used individually, with families (most often), and in a group format, whether it is peer groups or parent-child groups. Parent-child groups with young and older children have been found to be very helpful not only for parent-child relationships, but also as a format for children to learn social skills and for parents to be supportive with each other (Martin 2000; Munns and Ahmad 2006; Sherman 2000).

THEORY

The theory underlying Theraplay rests on attachment theory. The main purpose of Theraplay is to enhance the attachment between child and parent. The most important relationship a child has is its first one with its major caregiver. If that is not a strong, healthy, secure attachment, then the child will likely have difficulties in his or her life later on, growing up and as an adult, unless there are remediating factors such as having another nurturing figure who cares for the child in a responsive, consistent way (Fonagay 2003). Theraplay goes back to the stage where the attachment process was derailed and tries to replicate what a normal parent would do with a child at that age. At times this may mean incorporating some regressive activities (such as feeding, rocking the child in a blanket, caring for hurts, etc.). Theraplay goes back to that early stage with the goal of forming a secure attachment. In this process the parent is guided to be attuned to the child's cues and to regulate the child's emotions, which in turn helps the child to achieve self-regulation (Booth 2005).

RESEARCH

Attachment theory is well supported by research worldwide, but Theraplay needs further research, although a good start has been made in this direction. There are many case studies supporting Theraplay (Jernberg and Booth 1999; Munns 2000), a number of studies using pre and post scores (Makela and Vierikko 2004; Munns, Jensen and Berger 2000), and an increasing number using control groups. The research studies using control groups do point to the effectiveness of Theraplay (Ammen 2000, showing a significant increase in empathy scores of high-risk teenage mothers with their infants; Meyer and Wardrop 2006, indicating a significant drop in behavior problems; Ritterfield 1990, significant increases in expressive language and positive social-emotional scores; Sui 2006, a significant increase in self-esteem scores and a significant decrease in internalizing symptoms; Wettig, Franke, and Fjordback 2006, showing a significant decrease of symptoms in children with attention/hyperactivity and social/emotional disorders; Yoon 2007, finding a significant improvement in social/emotional behavior and a reduction in parental stress scores). More research is in progress (Lassenius-Panula and Makela 2007; Weir 2007). In addition, there is growing evidence of the importance of touch (Field, 1995; Thayer, 1998), which is a strong factor in Theraplay.

WHAT IS THERAPLAY?

Theraplay is a structured form of play therapy that is short-term (12 to 16 half-hour sessions weekly over a period of approximately 4 months, but

sometimes longer with severe problems). Theraplay has been used successfully for a wide age range (infants to adults) and a wide spectrum of social, emotional, and behavioral difficulties (Munns 2003, 2005). It is nonverbal (no interpretations are made, although some reflections are sometimes given), with an emphasis on focusing on the positive strengths of the child (problems are not discussed with the child, and bizarre behavior is ignored). No toys are used and minimal supplies are needed, so it is cost-effective. It is based on interactions between therapist and child, while parents first observe for about four sessions and then participate directly with their child under the guidance and support of the therapist. The Theraplay session is ideally followed by a half-hour parent counseling session where a debriefing of the Theraplay session takes place, along with a discussion of home and school behavior. Parents are encouraged to try Theraplay activities at home every week. Toward the end of the treatment period, parents are increasingly given a leadership role in the sessions.

The agenda for each session is preplanned by the therapist, integrating information from a detailed family history including each parent's history, as well as information from a parent-child assessment using the Marschak Interaction Method (MIM). The MIM is a family assessment tool based on simple activities requiring parent-child interactions that give a picture of how parents structure, challenge, engage, and nurture their children and how their children respond (DiPasquale 2000).

Each Theraplay session is based on goals for the four underlying dimensions of Theraplay—structure, challenge, engagement, and nurture.

DIMENSIONS

Structure

Every child needs structure in her or his life. Children need consistent routines such as times for feeding, bathing, playing, and sleeping, so they can establish a rhythm and predictability in their daily lives. This helps to regulate them. They need rules to govern their behavior and to establish a safe environment for them. Structure gives them a sense of security. Often, in treatment, children are referred because they are impulsive, lacking in control of their feelings, aggressive, defiant, restless, and dysregulated. Theraplay would emphasize structure in these children's lives. Activities and games with clear rules and signals to start or end—such as "Red light" or "Simon says" or balloon races—might be used.

One of the intentions of structuring activities is to have the child cooperate with simple directions, first with the therapist and then with the parents.

Challenge

Challenge helps the child take appropriate risks and expand his or her world. The child learns that he or she can take some chances, and this can bring rewards. In mastering new skills, the child gains a sense of competence and self-confidence. It is important to offer challenges that are in the scope of the child's abilities to master. Success brings a sense of pride and accomplishment. Failure can bring a loss of self-esteem, shame, and fear.

The parent at home will present challenges even for the very young child, such as learning to sit up alone, to walk, to throw and catch objects, and so on. Children love challenges when they feel they can succeed. Praise and encouragement are important to support the child's attempts. This is especially important for children who are withdrawn, timid, frightened, or overprotected. In Theraplay such children are supported in trying simple activities such as keeping a balloon up in the air; bursting a soap bubble with both hands, then with one finger, and the like; blowing ping-pong balls while on their tummy; imitating a clap pattern (e.g., patty-cake and later, other more complicated sequences). Challenging activities are also given to children that have a lot of inner tension and need a safe outlet for their aggression. An activity such as a cotton-ball fight or paper punch (punching through a tautly held newspaper sheet) might be included in the session.

Engagement

Engagement is a way of directly interacting with the child. It may include playfully intruding into the child's space. Care is taken to be aware of the child's acceptance or rejection of this playful intrusion, particularly with very young children or with those who have been previously abused. If signs of aversion are displayed in a preverbal child such as head turning away, facial frown, downcast eyes, and so forth, then the therapist stops and tries to find another way that is more appealing to the child. Activities are not forced on the child.

Usually children love to be engaged, and there are hundreds of ways of interacting that children find delightful. Young children usually enjoy singing and nursery rhymes such as "This is the way a horsy rides" while being bounced on the adult's ankle. Another favorite is "This little piggy went to market," where the adult wiggles each of the child's fingers or toes and ends up with a gentle tickle under the child's chin. Mirroring is another popular activity (parent mirrors the child's movements and sounds). Engaging activities often involve a face-to-face position with good eye contact. This kind of stimulation has a direct effect on the hard wiring of the brain (Gerhardt 2004; Schore 1998). Mirror neurons are excited in the child's brain in the same area of the brain that excitation takes place in the adult's brain

resulting in "brain to brain" connection (Siegel 1999). Young children need this kind of stimulation so their brains can develop in an optimal way and so they develop a sense of empathy with others (Gerhardt 2004).

In Theraplay, engaging activities are emphasized for children who are withdrawn, who resist intimacy (autistic children), or who are lethargic or depressed.

Nurture

This is one of the most important dimensions of Theraplay. All children need nurturing, especially the very young and those who have been neglected, deprived, or abused. Ordinarily, a young child at home receives much nurturing such as cuddling, rocking, caressing, patting, kissing, feeding, bathing, powdering, grooming, singing songs such as "I love you," et cetera. All of these activities make the child feel valued, important, accepted, cared for, and loved. Theraplay tries to replicate this, and some form of nurturing takes place in every session, regardless of the child's age. Nurturing activities are activities such as lotioning or powdering of "hurts" on the child's hands or feet; feeding the child a snack; making powder handprints; combing the child's hair; face painting; rocking the child in a blanket while singing a special song about the child while the child sucks on a lollipop, a bottle, or from a juice box. If a child resists nurturing (often a child with a poor self-image will resist), then another way is found that the child can accept. For example, a child might resist lotioning of "hurts," so the therapist may do an outline of the child's hands and then wash and powder or lotion the hands. Once the child experiences lotioning in this way, then he or she usually accepts caring of "hurts" in the next session.

If a child is tactile defensive, it is important to get an accurate assessment, because this may be a result of sensory motor processing difficulties or possibly poor attachment or abuse. If this is a sensory motor difficulty, then further treatment with an occupational therapist might be recommended (Chaloner 2006).[1]

The discussion that follows has been garnered partly from my own experience, but also from seasoned Theraplay therapists working with zero to three-year-olds (Ammen 2000; Booth 2000; Chaloner 2006; Rubin and Mroz 2006). Note that not all of the points below have been discussed with all of these authors. However, it is predicted that there would have been general agreement if this had been done.

MODIFICATIONS

It was previously mentioned that Theraplay needs to be modified for children zero to three years of age. Modifications need to be appropriate

to the child's developmental stage. For infants and toddlers, although the therapist tries to follow his or her agenda and direct the child, there may be many times when the child's lead should be followed until the therapist can reengage the child. The therapist has to be very attuned to the child, being especially sensitive to nonverbal communication. This does not mean that the therapist only follows the lead of the child. The therapist can attempt to follow her or his agenda, but if the child shows aversion, resistance, fear, or a lot of anxiety, then the therapist needs to stop and find another way to reach her or his goals. The therapist must always be aware of the child's maturity level and what the child can or can't do. The following are important considerations:

- Young children's attention spans are relatively short. Activities need to be appropriate in length, and the whole session may be shortened to say 20 minutes rather than a half hour, depending on the child.
- They need varied stimuli, otherwise they may lose interest.
- They need more than words, because often they can't understand words (although they do react to tone of voice). So visual stimuli along with movement can often catch their attention.
- Babies tire easily.
- Remember the importance of appropriate amounts of sensory stimulation in all sensory modalities, but not to the extent of overwhelming the sensory systems. The therapist needs to know when to soothe the child and when to stimulate him or her. This helps the child toward self-regulation. Note that it is often difficult to tell if a child has a true regulatory problem before six to eight months, because this can sometimes be resolved through maturation of the child (Chaloner 2006).
- Use a gentle voice. Avoid loud sounds that can be alarming to the child.
- Children love rhythm in song and action.
- Take small steps—don't make sudden, abrupt changes.
- Give lots of warm physical affection as modeling for the parent, but also focus on the parent interacting with their child in this way.
- Allow for some freedom of movement. Don't try to have the child sit for too long.
- Get down on the floor with the child (note that Theraplay therapists do this with all ages).
- If the child is under age two, then have the parents nearby during the observation period. Don't try to separate the parents from the child, until the child is comfortable with the therapist. This may mean that the parents are directly involved from the beginning without the observation sessions first.

CASE EXAMPLE

Some of the Theraplay principles and activities might be best illustrated with a case example of a two-and-a-half-year-old boy with severe aggressive behavior. We shall call him Jason (not his real name). Jason was referred to our mental health children's center for biting (to the point of drawing blood), hitting, spitting, and swearing and being defiant. He had been dismissed from several day care centers, and his parents had consulted with several mental health agencies to no avail. The aggressive behavior was also seen at home to the point that a pet cat would hide under furniture when Jason entered the room. Neighborhood children had ceased to play with him because of his fighting. Even older children were frightened of him (a note of pride was heard as the father said this).

After taking an in-depth family history, including the family history of each parent, it was revealed that both mother and father had come from backgrounds of physical abuse and addictions. The maternal grandmother had used drugs and the paternal grandfather was a binge alcoholic who beat his wife and son repeatedly. The biological parents had also used drugs and alcohol in the past. Jason's father had been jailed a number of times for the use of drugs, assault, and robbery. The father had just been released from jail at the beginning of therapy. When asked about his occupation, he replied, "I'm a bum."

The mother had been placed in an abusive foster home as an infant, but later returned to the care of her addicted teenage mother and maternal grandmother. The mother ran away from home at the age of 13 years and was a street child for a number of years. She had stopped using cocaine and was trying hard to establish a stable home for Jason. The mother had been quite aggressive growing up and as an adult. Her ambition for her son was high—she expected him to go to university and had already taught him the alphabet. Both parents wanted a better life for their son and were highly motivated to put effort into this.

The Marschak Interaction Method (MIM), an assessment of family relationships, revealed that the parents gave a lot of attention and praise to their son and could take delight in his behavior. However, they also gave a lot of power to their son. He often made the decision to start or stop activities. Parents tended to accede to his demands or would coax him. They were nurturing to him, but tended to be rough in touching him. Goals from this assessment were:

1. To enhance the attachment between parents and child, especially between mother and child
2. For parents to be more gentle in their physical contact with him

3. For Jason to be more cooperative and to support the parents in taking charge of his behavior
4. To reduce Jason's aggressive behavior

The parents observed Jason with the therapist behind a one-way mirror for the first four sessions as an interpreting therapist explained the purpose of each activity, as well as guiding the parents to be more attuned to Jason's needs. Jason did not have difficulty separating from his parents, except for the beginning of the fifth session when he was not feeling well. He was easily engaged by the therapist and took delight in many of the activities. However, at the beginning, he attacked her a few times by hitting, scratching, and spitting. Each time she immediately stopped him, said firmly "No hurts," and diverted his attention to another activity. Jason needed frequent reminders to be gentle in his touch.

Parents came into the therapy room halfway through the fifth session, when they directly interacted with their son under the guidance of the therapists. Whenever Jason was aggressive to his parents, he was immediately stopped with a "No hurts" and a more appropriate action was modeled for him by the therapist. The therapists stressed structure and nurturing activities with Jason. He soon became more obedient, stopped his aggression, and was spontaneously affectionate with the therapist. After a half hour of Theraplay activities, parent counseling took place, as well as a debriefing of the Theraplay session. Home and day care progress was discussed, and the parents were encouraged to do Theraplay activities at home. The parents were advised to stop any aggression immediately in a consistent fashion and to do nurturing activities with him. Below is the agenda used in the fifth session (note that the parents observed for the first 5 to 10 minutes of this session and then came into the Theraplay room).

Agenda

Entrance (note that this entrance was modified, because Jason did not want to separate from his parents at the beginning of this session): Follow the leader

Hello song (for structure and a clear beginning to the session): "Hello, Jason, hello, Jason, hello, Jason, I'm glad you came to play."

Inventory (for self-esteem building) noting positive attributes of the child: "Jason, I see you have brought your sparkling eyes, shiny brown hair, rosy cheeks, and strong arms. Look at these hands!"

Lotioning of hurts (for nurturing): "Oh, oh, I see a boo-boo here. That needs looking after." The therapist proceeded to lotion all of the hurts on his hands.

Song (for engagement and body image): "Head and shoulders."

Activity (for engagement and body image): "Squeaky body parts." The therapist makes a funny noise as she presses different parts of his body—nose ("honk-honk"), chest ("erk!"), shoulders ("ohoo!"). The therapist makes up noises for different body parts and repeats them in sequence. (Jason laughs a lot during this activity).

Activity (for structure): Hopping from one side of the room to the other side.

Activity (preparing to engage parents): Rolling up in blanket pretending to be a hot-dog.

[The parents enter the room.]

Activity (for connecting to Jason and nurturing): Parents pretend to find Jason and then unroll the blanket with many delighted exclamations on having found him. (Jason wants this activity repeated, but the therapist moves on to the next activity.)

Activity (for nurturing): Jason is rocked in the blanket while adults sing "Rock-a-bye, Jason," and then is lifted up into a parent's arms. This is repeated with the other parent.

Activity (for nurturing): "Cotton-ball soothe." Therapist models gentle touch by moving a cotton ball on Jason's face, shoulders, arms, and hands. Parents imitate this with Jason and with each other.

Activity (for challenge): "Cotton-ball guess." Jason closes his eyes and guesses where his parents are touching him with the cotton ball.

Activity (for nurturing, structuring, and body image): "Body outline." Adults make an outline of Jason's body as he lies on a piece of paper. Everyone joins in, filling in the different body parts with colored crayons, with many positive comments.

Activity (for nurturing): Feeding of potato chips directly into the mouth of Jason by therapists and later by the parents. The therapists feed the parents as well. (Both parents needed nurturing, as well as the child.)

Activity (for definite ending and structure): "Good-bye song": "Good-bye, Jason, good-bye, Mommy, good-bye, Daddy, good-bye, Sue and Linda. We're glad you came today."

Big circle hug.

At this point one of the therapists took Jason into another room to play or do crafts while the parents remained with the other therapist for a counseling session and to focus on what had just happened in the Theraplay session.

Progress

Remarkably, Jason stopped biting children in his day care by the third Theraplay session. By the fifth session he had stopped being aggressive with his father, the chief caregiver (a stay-at-home dad), but was still swearing and spitting at his mother (who worked long hours during the night and did not come home until morning, when she went to sleep). By the seventh session, the neighborhood children were playing again with Jason and the cat did not hide from him. Theraplay was ended after the ninth session because most of the goals had been reached. The parents (especially the father) were relating to Jason in a positive, relaxed, but firm way. The mother still needed to be more directive with him, but he was much more obedient with her than previously. Four checkups were planned for the year, and the parents were advised to seek marital counseling.

Jason progressed well at home, at day care, and in the neighborhood for almost a year. Then the father started to use drugs again and accidently smashed his wife's car. She ordered him out of the house and hired a nanny. She also found a new boyfriend. The disruption in Jason's home life was a setback for him, and he started to be aggressive again. The mother asked for Theraplay again.

Theraplay was resumed, but this time it took place in the home with the hope that there would be better generalization of treatment effects, especially with the mother's interactions with her son. Again, Jason's behavior significantly improved. However, after treatment during checkup contact, it was noted that whenever the mother discontinued a relationship with a partner or hired a new nanny, Jason's behavior deteriorated. The treatment ended with a discussion on the importance of stability in Jason's home life. The mother agreed to strive for this. Individual psychotherapy was needed for the mother, but she was unable to afford this financially.

The prognosis was guarded for this family because of the frequent change of caregivers for Jason. However, at the end of both series of treatment, Theraplay had reduced Jason's aggression and had helped him to be a more cooperative, happier child, who was able to relate more positively to his parents, other adults, and peers.

CONCLUSIONS AND FUTURE DIRECTIONS

On a clinical level, Theraplay has a good reputation for being a highly effective treatment method, in a short period of time, that is cost-effective and particularly suited for infants and toddlers with its concrete, nonverbal, playfully engaging approach. Since Theraplay tries to replicate normal parent-child interactions, it is easily understood by parents and clinicians alike. It is often highly enjoyable for both parents and child as they find new ways of taking delight in each other. Parents become more attuned and responsive to their child's needs, while children usually become more

accepting of their parents' overtures. Attachments between parent and child are usually strengthened.

What is crucial for the acceptance of Theraplay is more evidence-based studies using randomly assigned control and treatment groups, as well as studies comparing Theraplay to well-validated treatment methods. For now and the future, this is a direction that Theraplay clinicians are well aware of and must continue to pursue. With cutting-edge research from psycho-biologists indicating that we need to pay more attention to nonverbal therapies and the importance of touch for children, it may be that treatment methods like Theraplay will soon be at the forefront of therapies widely used for helping children and their families form healthy relationships and/or attachments.

NOTE

1. More information about this area can be obtained directly from Barry Chaloner by e-mail: pals@frontier.net, or at www.pals4schools.com.

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