Whole Family Theraplay: Integrating Family Systems Theory and Theraplay to Treat Adoptive Families

Kyle N. Weir\textsuperscript{a}, Song Lee\textsuperscript{a}, Pablo Canosa\textsuperscript{a}, Nayantara Rodrigues\textsuperscript{a}, Michelle McWilliams\textsuperscript{a} & Lisa Parker\textsuperscript{a}

\textsuperscript{a} California State University–Fresno, Fresno, California, USA

Published online: 18 Nov 2013.

To cite this article: Kyle N. Weir, Song Lee, Pablo Canosa, Nayantara Rodrigues, Michelle McWilliams & Lisa Parker (2013) Whole Family Theraplay: Integrating Family Systems Theory and Theraplay to Treat Adoptive Families, Adoption Quarterly, 16:3-4, 175-200, DOI: 10.1080/10926755.2013.844216

To link to this article: http://dx.doi.org/10.1080/10926755.2013.844216

PLEASE SCROLL DOWN FOR ARTICLE
Whole Family Theraplay: Integrating Family Systems Theory and Theraplay to Treat Adoptive Families

KYLE N. WEIR, SONG LEE, PABLO CANOSA, NAYANTARA RODRIGUES, MICHELLE McWILLIAMS, and LISA PARKER

California State University–Fresno, Fresno, California, USA

This article regarding the effectiveness of Theraplay for the clinical treatment of adoptive families both outlines a model for integrating family systems theory with Theraplay to create a new approach entitled Whole Family Theraplay (WFT), as well as provides a preliminary report of a pilot study demonstrating the efficacy of that model. WFT integrates Theraplay with family systems approaches (Structural and Experiential Family Therapies) to treat parents and all the siblings within adoptive families. The findings indicate that WFT treatment may lead to statistically significant benefits in regard to family communication, adults’ interpersonal relationships, and children’s overall behavioral functioning.

KEYWORDS adoption, play therapy, family systems, Theraplay, integration, clinical efficacy

Family therapy and play therapy are two treatment modalities that both have histories of demonstrated efficacy (Bratton, Ray, Rhine, & Jones, 2005; Carr, 2000a, 2000b; Charles, 2001; Cottrell & Boston, 2002; Crane & Hafen, 2002; Holder, 2008; Larner, 2004; Murphy Jones & Landreth, 2002; Pinsoff & Wynne, 2005; Weir, 2013).
Each approach contains numerous models of treatment that have a record of usefulness for a variety of clinical issues with which adoptive families present in clinical settings. For example, Structural Family Therapy (SFT), Bowenian Family Systems Therapy, Narrative Family Therapy, multiple Behavioral Family Therapy approaches including Parent-Child Interaction Therapy (PCIT), and Solution-Oriented Family Therapy have all had studies indicating that these models are effective in the systemic treatment of adoptive families (Barth, Crea, John, Thoburn, & Quinton, 2005; Becker, Carson, Seto, & Becker, 2002; Cattanach, 2008; Doherty & McDaniel, 2010; Nims & Duba, 2011; Timmer et al., 2006; Weir, 2003, 2007, 2011a, 2011b). Additionally, multiple models of play therapy such as Filial Family Play Therapy (FFPT), Dyadic Developmental Psychotherapy (DDP), and Theraplay have been shown to be effective with adoptive families (Becker-Weidman, 2006; Booth & Jernberg, 2010; Hughes, 1997; Hughes, 2007; Ryan & Madsen, 2007; Van Fleet, 1994; Van Fleet, Ryan, & Smith, 2005; Weir, 2007, 2011a, 2011b).

Lebow (1997) has called the integration of theories of therapy treatments the “zeitgeist of our time.” Mostly, such focus on integration has had to do with family therapy theories in general (e.g., integrating Solution-Oriented or Brief Family Therapy integrated with Strategic Family Therapy to form “Brief Strategic Family Therapy,” Santisteban, Suarez-Morales, Robbins, & Szapocznik, 2006) and couples therapies in particular (e.g., Integrative Behavioral Couple Therapy, Christensen, Jacobson, & Babcock, 1995; Emotionally Focused Couple Therapy [EFT], Johnson et al., 2005; and Collaborative Attachment Systems Therapy, Weir, 2012). Only recently have we seen a significant interest in integrating family therapy with play therapy models to develop more effective treatment approaches for families of all types regardless of their adoption status, in general (Dermer, Olund, & Sori, 2006; Early, 1994; Gil, 1994, 2006; Gil & Sobol, 2000; Poole, 2006; Sori, 2006; Weir, 2011a; Wittenborn, Faber, Harvey, & Thomas, 2006) and for adoptive families, in particular (Cattanach, 2008; Gil, 2006; Weir, 2007, 2011a) in the contemporary literature. The integration of family therapy and play therapy has wide practical applications for clinicians in the counseling, marriage and family therapy (MFT), psychology, and social work fields who specialize in working with adoptive families. One study (Weir, Fife, Whiting, & Blazewick, 2008) found that master’s-level, accredited training programs in counseling, MFT, and social work provided very little specific coursework in adoption or foster care services to their students (despite that a range of nearly 14% to 26% of the graduates of these programs are estimated to work in child welfare careers after graduation). The counseling and MFT accredited programs did have statistically significant greater amounts of coursework in child development and practicum experiences in child welfare (leading one to consider the possibility that in some ways counselors and MFT professionals may be better trained for these positions
Because adoptive families may disproportionately experience issues relating to attachment (Levy & Orlans, 2000), non-coercive attachment-based treatments logically offer promise for clinical efficacy. Barth et al. (2005) argue against using attachment therapies for attachment-disordered children in preference of behavioral and other evidenced-based models. Their study, however, narrowly defines attachment therapies as the coercive disreputable treatments that can be harmful to a child (such as holding or rebirthing therapies): treatments that all ethical clinicians should avoid. In their article, Barth et al. (2005) do not address the value of non-coercive attachment-based models (such as Theraplay and Dyadic Developmental Psychotherapy) that are appropriate, effective treatments for children with attachment issues. Despite this omission, Barth et al. (2005) highlight some of the positive, beneficial behavioral models (and other similar evidence-based approaches) that can be effective in children with attachment concerns. These include the Incredible Years (Webster-Stratton & Hammond, 1997), Parent Management Training (Reid & Kavanagh, 1985), Multisystemic Therapy (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), Parent Child Interaction Therapy (Eyberg et al., 2001; Chaffin et al., 2004), and Functional Family Therapy (Alexander & Parsons, 1997) as effective intervention strategies. Behavioral approaches and other similar treatment models utilize systems of rewards and punishments, praise and (re-)direction, clear expectations, and several other effective training mechanisms, inducements, incentives, and consequences to modify the child’s behavior and effect desired changes. For the most part, these approaches work well with children without attachment disorders and even can be successful with some who do struggle to form healthy attachments. But for some attachment-disordered children (particularly the ones who have been traumatized by significant abuse and neglect of various types), behavioral approaches may have the effect of exacerbating the problem and the children might not respond to the rewards and punishments of behavior modification systems as desired. Some of the children do not fully grasp the reward portions of behavioral approaches and disproportionately focus on the punishment aspects of behaviorism. It is almost analogous to a “cognitive distortion” in which the child personalizes the consequences or punishment aspects of the behavior modification system in an exclusively relational way. They see the behavioral system through the “lens” or perspective of hurtful relationships and faulty attachments and therefore focus on the behaviorally imposed consequences and misattribute the punishment portions to relationship deficits rather than the need for changes in their behavior (Weir, 2011a, 2011b). For example, an adopted or foster child with reactive attachment disorder who receives a consequence for misbehavior is more likely to think, “I hate my (foster) mom”
instead of thinking “I shouldn’t have done that” in response to their consequence. Because children with reactive attachment disorder have difficulties with relationships, problem solving, and responses to discipline (Hughes, 1997, 2007; Weir, 2011b), these children misjudge the motives of the caregiver and assume the discipline is a sign of a bad relationship rather than an instructive gesture or opportunity to correct their behavior. Therefore, it is critical that treatments of adopted or foster children with significant attachment issues include an appropriate, non-coercive attachment treatment basis.

It is important to distinguish among the various attachment-based treatment approaches the disreputable ones (which are coercive) and the reputable non-coercive models and to select from among the non-coercive models an approach that can be integrated with family therapy. Coercive attachment therapy models may be termed Holding Therapy, Rebirthing Therapy, or simply Attachment Therapy; they have been controversial models of treatment, in some cases have led to the harm or death of children, and have been warned against in the ethical guidelines of many major mental health professional associations (American Psychiatric Association, 2002; ATTACH, 2007; Weir, 2006). Speltz (2002), Mercer (2002), and Mercer (2005) provide an excellent history and critique of coercive attachment theories.

Among the non-coercive attachment-based play therapies, Filial Family Play Therapy (FFPT), Dyadic Developmental Psychotherapy (DDP), and Theraplay have been the most studied (Becker-Weidman, 2006; Booth & Jernberg, 2010; Hughes, 1997, 2007; Rubin, Lender, & Mroz, 2009; Ryan & Madsen, 2007; Van Fleet, 1994; Van Fleet et al., 2005; Weir 2007, 2011a, 2011b; Wetting, Franke, & Fjordbak, 2006). Each of these three models warrants consideration in the treatment of adoptive and foster families. Brief descriptions of each ensue.

According to Ryan and Madsen (2007), FFPT is a non-directive form of play therapy developed by Bernard and Louise Guerney in which parents are taught to conduct child-centered play therapy with their children:

> With the goal of increasing parent-child relationship satisfaction, filial family play therapy (FFPT) was created in the early 1960s to train birth parents to conduct child-centered play therapy sessions with their children. The purpose of FFPT was to allow the parent and child to experience each other differently through this unique relationship working through issues in a nondirective, empathic methodology. (pp. 112–113)

DDP was developed by Daniel Hughes in the 1990s out of his work with foster and adopted children on the East Coast of the United States. DDP involves a keenly attuned relationship among the therapist, caregiver, and child. Hughes (2007) identifies the posture that therapists take toward children with the acronym “PACE.” PACE stands for playfulness, acceptance,
curiosity, and empathy. For parents or caregivers, Hughes (2007) adds the dimension of love to form the acronym “PLACE.” One article describes the central component of DDP as:

Dyadic Developmental Psychotherapy has as its core, or central therapeutic mechanism and as essential for treatment success, the maintenance of a contingent collaborative and affectively attuned relationship between therapist and child, between caregiver and child, and between therapist and caregiver. (Becker-Weidman, 2006, p. 148)

Theraplay was developed by Ann Jernberg in 1971. “Theraplay is an active, playful, short-term (about 12-week period of therapy sessions) treatment method that uses attachment-based play to create better relationships between parents and their children” (Booth & Koller, 1998, p. 308). Theraplay integrates interpersonal theories of human development, object relations theory, and the attachment theories of Bowlby and Ainsworth (Booth & Lindaman, 2000).

Theraplay helps to improve attachment by engaging a parent and child in playful activities. In adopted children, Theraplay helps to reduce some of the internal attachment models they gained in their previous abusive environments and helps them to produce new healthy internal attachment models with their adoptive families. Additionally, Theraplay builds attachment by replicating healthy parenting patterns that foster secure attachment, such as understanding the importance of the parent-child relationship, recognizing patterns of attachment, and including parents in treatment (Jernberg & Booth, 1999, p. 12). Theraplay follows the premise that children excel and thrive in the context of secure attachments to their caregivers. When parents and children interact in playful ways that balance four key dimensions of attachment, children and parents will develop more secure attachments leading to several beneficial outcomes (including better affect regulation and behavior). The four key dimensions to building such healthy attachments through play are structure, engagement, nurturing, and challenge (SENC). Brief descriptions of each dimension are given here:

Structure: The goal of structure is to assure the child that the parent is in charge and the child is safe with them being in charge. Structure helps children listen to and follow directions, providing them with a sense of security because they know they are being protected and guided. As children are regulated in a caring but structured manner, their ability to co-regulate their emotions will increase.

Engagement: The goal of engagement is to connect with the child in a very intense and personal way, allowing the child to know that surprises can be fun and safe. Engagement involves paying attention to the child, making good eye contact, being upbeat, being playful, and
communicating that the child is of worth through the adult’s attunement with the child. Often attunement begets affect regulation.

**Nurture:** The goal of nurture is to produce an environment for the child that is caring, calming, and predictable; this gives the child a feeling of comfort and stability. This dimension (along with the other three dimensions) assists a child with affect regulation by meeting the child’s emotional needs where they are developmentally. Nurturance provides opportunities for tenderness, parent-child affection, and healing.

**Challenge:** The goal of challenge is to give a child a challenge, but not to make that challenge undoable; this promotes a child’s self-esteem and promotes feelings of competence. As adults and children face and overcome challenges together, such cooperation enhances attachment. Also, as children experience some minimal frustration in facing and overcoming challenges, their frustration tolerance will grow and their affect regulation will increase.

Affect regulation and attachment enhancement are consistently improved through Theraplay (Lindaman & Lender, 2009). Nida and Pierce (2000) indicate that emotional regulation within a child’s socioemotional developmental growth stems, in part, from healthy parent-child attachment patterns and that a child’s increased capacity to respond well to co-regulation of affect leads to improved behavioral regulation. It is, therefore, by improving the parents’ capacity to parent in attachment-savvy and affect–co-regulating ways (Laakso, 2009) that the child’s behavioral regulation may be best served. This “backdoor” approach to behavioral regulation, through strengthening attachment relationships and then enhancing co-regulation of affect, represents a potential equifinal path to improving a child’s behavior. Booth and Koller (1998) best describe the goal of Theraplay by saying:

The goal is to empower parents to continue on their own the health-promoting interactions of the treatments sessions. Training parents to be therapists for their children was a natural development of the Theraplay method. It is the parent, not the child’s therapist, who must live with the child 24 hours a day; thus, the parent has the greatest opportunity to influence the child for good or ill. (Booth & Koller, 1998, p. 308)

While FFPT, DDP, and Theraplay all have efficacy for working with adopted and foster children (Becker-Weidman, 2006; Booth & Jernberg, 2010; Hughes, 2007; Ryan & Madsen, 2007; Van Fleet, 1994; Van Fleet et al., 2005; Weir, 2007, 2011a, 2011b), Theraplay was chosen as the best model to integrate with family therapy models for three primary reasons: First, the directive nature of Theraplay is more conducive to the directive posture of classical family systems models (compared to FFPT). Due to the directive nature of many of the family systems models (particularly Structural Family
Therapy and Experiential Family Therapy), the directive style of Theraplay seemed the best theoretical fit to integrate family counseling and play therapy approaches. Particularly, the use of the “self-of-the-therapist” as the direct instrument for family change in both Theraplay and Structural and Experiential Family Therapy appeared to have a theoretical and practical affinity. Second, Theraplay has a longer history of treatment and slightly longer history of empirical testing for efficacy than DDP. Finally, the primary investigator of this study had prior training in Theraplay and had formed a collaborative relationship with the Theraplay Institute and was designated by them as a “university-based Theraplay researcher.”

In developing an integrative model of family systems and Theraplay, it was necessary to be clear about the different kinds of uses of play so as to be prepared for the larger family systemic contexts. In traditional Theraplay, one or two parents interact with just one child. In developing WFT, we anticipated working with parents, the adopted child, their siblings, and anyone else residing in the home (foster children, grandparents, etc.) who is part of the family system. This caused us to think about how to play in a larger family system. We drew upon traditional Theraplay (Booth & Jernberg, 2010), group Theraplay (Rubin & Tregay, 1989), Parten’s (1932) descriptions of preschool children’s play, and several models of family systems theory (particularly, Structural Family Therapy, Experiential Family Therapy, and Object Relations/Attachment Theory; Minuchin, 1974; Napier & Whitaker, 1988; Nichols, 2009), noting the different types of playful interaction (and the exponentially increasing number of interactions in the room) among whole families.

In a landmark study, Parten (1932) identified six types of play among preschool children: unoccupied, onlooker, solitary independent play, parallel play, associative group play, and cooperative group play. As we began examining how families could play the Theraplay games and activities, it became apparent that some activities and games would lend themselves to a whole-group interactive process akin to Parten’s (1932) associative group play or cooperative group play. These types of activities included things like: zoom-erk, weather report, pass a touch, hand-stacking, and keep-the-balloon-in-the-air. Other activities required parents and co-therapists to pair off with a child so that the parent-child interaction could be more one on one. This was more akin to the parallel play Parten (1932) described. A child and therapist might be engaged in the same activity as a sibling and parent might be doing (e.g., imaginary face-painting, feeding M&Ms, or mirroring), which descriptively is more like parallel play.

We also needed to clinically address family systems issues due to having larger families in session. Some of the ways WFT addressed those systemic issues drew from Structural Family Therapy and Experiential Family Therapy models by focusing on unhooking the identified patient, observing the impact of marital conflicts on children, balancing or resolving sibling rivalries,
increasing family openness and authenticity, and supporting the hierarchical structure of the executive subsystem (parents) over the sibling subsystem (children) (Weir, 2011a).

Such inclusion of family systems concepts included a variety of family systems theories and methods. The directive style of WFT and the dimensions of attachment (especially the Structure and Engagement dimensions) fits well with the Structural Family Therapy (Minuchin, 1974) goals of directive use of the “self-of-the-therapist” to facilitate change. The student-trainees reported that using Theraplay helped them better understand such Structural Family Therapy concepts as hierarchy, boundaries, coalitions, scapegoating, and enmeshment/disengagement. Likewise, using WFT helped the students-trainees see theoretical and methodological affinity with the Experiential Family Therapy goals of the “here-and-now” temporal focus (Nichols & Schwartz, 2006), being attuned to the family’s emotional needs (Napier & Whitaker, 1978), and understanding the roles individuals play in families (Satir, 1988). Additionally, because Theraplay seeks to identify dimensions where the family may be weak in its attachments (i.e., too much or not enough structure, engagement, nurture, or challenge), WFT integrates the concept of “corrective emotional experience” from Experiential Family Therapy. We strive to create for the parent-child relationship right there in the room the emotional experience of attaching to one another that they seem weak or incapable of doing on their own. As they experience activities that facilitate their emotional attachment, they realize they are capable of loving and connecting with one another. It is the experiencing of such attachment bonds that leads to further attachment. Furthermore, Experiential Family Therapy (more so than Structural Family Therapy or Object Relations) has at its core the flexibility to be playful (sometimes even silly or zany) and spontaneous when that is what is most needed by a family in treatment. In this way, the playfulness of the Theraplay therapist and the Experiential therapist are integrated into one.

Integrating all of the literature, clinical considerations, theories, and modalities, we developed the following central research questions for this study:

- Can Theraplay be modified to accommodate whole families either with one child or more than one child in treatment?
- What are the principles involved with such modifications for larger families?
- How does family systems theory (specifically Structural Family Therapy and Experiential Therapy), including the role of sibling relationships, inform the practice of Theraplay with whole families?
- Would a modified Theraplay model demonstrate empirical support (or at least the potential promise of empirically supported clinical efficacy)?
- Further, is such a modified Theraplay model effective with a particular population, namely adoptive families?
METHOD

Sample

The sample consisted of 12 adoptive families from the local community. Of the 12 families, 23 parents participated and 30 children participated in the WFT sessions \( (n = 53) \). The parents of the 12 families participated in the WFT sessions with their spouses or partners with one exception (in one family the father worked out of town during the week and was not available to participate in sessions, but the mother attended with her children). We had 8 married couples, 1 lesbian couple, 2 cohabitating heterosexual couples, and 1 married woman (whose husband was unavailable due to work) participate in the study. Notably, all 12 families completed at least 12 sessions of WFT treatment. None dropped out of the treatment, lending support to the assertion that they found value in the therapy modality and regarded the treatment approach as helpful for their family’s needs.

There were 5 biological children (meaning biologically related to their parents in therapy with them) and 25 adopted children in the sample. The number of children in these adoptive families ranged from 1 to 6. The average number of children in a family in this sample was 2.5 and the modal number of children in the family was 1 (4 families with 1 child, 3 families with 2 children, 3 families with 3 children, 1 family with 5 children, and 1 family with 6 children). The average age for the children in this sample was 8.64 years. The average age of the biological children was 13.3 years and the average age for the adopted children was 7.52 years in this sample. In every instance (except one) in this sample the biological children were older than the adopted children. In the one exceptional case, the youngest of three biological children was 12 and was supplanted in birth order by a 14-year-old adopted child and a 12-year-old adopted child the same age (but a couple of months older than the biological 12-year-old in the family).

The gender of the children included in this sample was 16 female and 14 male. Among the biological children there were 2 girls and 3 boys. In the adoptive subset there were 14 girls and 11 boys. Thus, the female gender percentage of adopted children in this sample (56%) is slightly elevated from the number of females adopted from the public child welfare systems of the United States (49% as reported by the most recent Adoption and Foster Care Analysis and Reporting System report; see U.S. Department of Health & Human Services, 2011). Unfortunately, the researcher did not gather information about the length of placement in the home or the age at placement of the adopted children in the home. This oversight will be corrected in future studies.

The ethnic make-up of the children in the sample included 7 Latino children, 8 mixed Latino/Caucasian children, 9 Caucasian children, and 6 African American children. The ethnicities of the parents were 3 Latino, 1 mixed Latino/Caucasian, 15 Caucasian, 3 African American, and 1 Southeast...
Asian (India). Of the 12 families, 8 were families in which multiple ethnicities were present (i.e., cross-ethnic or transracial adoptions), and 4 families were all of the same race or ethnic heritage (1 Latino, 2 Caucasian, and 1 African American).

Of the 25 adopted children in this sample, 23 were adopted from public child welfare services agencies in the local community (a small urban city surrounded by several rural and agricultural communities in the region). Two of the adopted children were adopted through private adoption agencies. The high number of public adoptions was likely due to recruitment procedures.

Recruitment of Participants

Adoptive families from the community were invited to participate in this study primarily through advertising through local public child welfare agencies (e.g., the county’s Child Protective Services department) and private foster and adoption agencies (e.g., religious adoption agencies, foster family agencies with foster/adopt programs, and nonsectarian private adoption agencies). The university’s student training clinic, Fresno Family Counseling Center, operated by the students and faculty of our Council for the Accreditation of Counseling and Related Educational Programs–accredited counselor education program (MFT option) generously agreed to allow families to receive WFT for free to facilitate the project. This seemed to help in the recruitment of families from the public child welfare agencies in the communities nearby.

Training and Supervision

Students from the MFT program enrolled in a course taught by the lead author. The students would participate in the study for one semester and then new students would be recruited and trained each new semester. Two graduate assistants and co-authors of this study also attended the trainings and provided continuity throughout each semester by assisting in the training and modeling of Theraplay to the other students. Prior to each semester, the Theraplay Institute provided a certified Theraplay trainer/supervisor to conduct a 3-day training in Theraplay with the lead author and his students. Students were paired into partnerships that they would work with throughout the semester as co-therapists. As part of the training, co-therapist teams would practice providing Theraplay through role plays.

Once the semester commenced, students would conduct WFT sessions under the local supervision of the lead author, who is a licensed marriage and family therapist and a university-based Theraplay researcher. Sessions were recorded, burned onto compact discs, and provided to the Theraplay Institute for supervision to ensure reliability and validity verification that the sessions met the Theraplay Institute standards.
Instruments and Study Design

The design of this study was a pre-test/post-test quasi-experimental design using four key instruments: the McMaster Family Assessment Device (FAD), the Outcome Questionnaire-45 (OQ), the Youth Outcome Questionnaire 2.01 (Y-OQ), and the age-appropriate (depending on the age of the child) Achenbach Child Behavior Checklist (CBCL). The FAD was used as an overall measure of the family’s systemic functioning. It has seven subscales: Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control, and General Functioning. The OQ was used to measure the parents’ outcomes through treatment on three aspects: Symptom Distress, Interpersonal Relations, and Social Role. The Y-OQ and the CBCL were used to measure the outcomes for the children. In particular, the Y-OQ has six subscales: Intrapersonal Distress, Somatic, Interpersonal Relations, Critical Items, Social Problem, and Behavior Dysfunction. The CBCL has eight scales: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior.

Reliability and validity scores for the FAD, OQ, Y-OQ, and CBCL are all acceptable or high. The FAD subscales’ reliability scores (as measured by Cronbach’s alpha) ranges from 0.72 to 0.90 (Epstein, Baldwin, & Bishop, 1983; Miller, Bishop, Epstein, & Keitner, 1985). According to Ellsworth, Lambert, and Johnson (2006); Wells, Burlingame, Lambert, Hoag, and Hope (1996); and Lambert and Finch (1999), the reliability score for the OQ is 0.93, with the subscales ranging from 0.70 to 0.93. Similarly, the internal consistency reliability scores from the Y-OQ range from 0.74 to 0.93 for the subscales (Wells et al., 1996), with a very high total scale estimate of 0.97 (Wells, Burlingame, & Lambert, 1999). The Achenbach CBCL reliability is 0.88 (Achenbach, 1999). Similarly, various forms of validity testing have been thoroughly conducted on each of these four instruments all were found to be valid at acceptable or high levels (Achenbach, 1999; Ellsworth et al., 2006; Epstein et al., 1983; Miller et al., 1985; Lambert & Finch, 1999; Wells et al., 1999; Wells et al., 1996).

Families completed the assessment instruments prior to commencing the WFT treatment sessions and again at the conclusion of the treatment. Parents were to complete 1 FAD for their family, 1 OQ for each spouse or partner, 1 Y-OQ for each child in their family, and 1 age-appropriate CBCL for each child in their family. In all cases, the mothers completed the FAD and Y-OQ questionnaires for the families, although sometimes a father may have expressed an opinion or gave input. Each adult completed their own OQ assessment. The CBCL was completed by a few mothers in the beginning, but its length became a deterrent in getting the completed assessments at the end of the study. Student-trainees were available to assist the families if they had questions, but most families chose to take the instruments home and
return them the next week. This created problems for getting the post-test data. Of the 12 families, only 2 families completed all four instruments for all their family members, and 7 families had complete pre-test and post-test assessment data sets for the FAD, OQ, and Y-OQ (but not the CBCL). The other 5 families had pre-test assessment data sets but had gaps or missing data in some of their post-test assessment data sets to the point that we could not report accurately with integrity despite the fact that no families dropped out of treatment in this study. It became obvious that the length (and different age-appropriate versions for differing children) of the Achenbach CBCL was a significant barrier to families completing the assessments upon termination. As this was a pilot study, this identification of an assessment barrier was useful information to make modifications for the WFT Project’s future studies. We determined to discard the data on the CBCL and focus on the 7 complete data sets of the FAD, OQ, and Y-OQ.

After completing the pre-test assessment data sets, families engaged in a modified version of the Marshak Interaction Method (MIM) simplified and adapted to just five tasks to accommodate larger families. The modified MIM assessment was only utilized in the first session of treatment as sort of a subjective clinical diagnostic tool to determine the attachment themes, strengths, weaknesses, and patterns in the adoptive families. Afterward, the family received 12 to 15 weekly sessions of WFT with a wide variety of treatment games and activities based on what was learned from the WFT’s modified MIM throughout a 16-week semester and then completed the assessment instruments upon termination.

Clinical Procedures
Families contacted the lead author via phone or e-mail to be screened for appropriateness of the study. Screening factors included the following: at least one child in the family had to be adopted or in adoption placement, the adopted child had to be between the ages of 3 and 12, and the parents had to be willing to attend and bring the other children living in their home (whole family) during the available hours allocated by the clinic for these sessions. Once the family passed the screening process, appointments were scheduled at the beginning of the semester to complete the assessment forms, conduct the WFT MIM (on the first session only), and begin treatment sessions with the student-trainees for the remainder of the semester. In addition, families signed both a research informed consent form and a clinical informed consent form. The research was approved by the Human Subjects Committee/Institutional Review Board at California State University-Fresno. Families were also given the policy regarding the privacy practices of medical information as required by the Health Insurance Portability and Accountability Act.
The WFT MIM used in this study during the first session with the family differs from the original MIM assessment in that it is simplified to accommodate large numbers of children playing and interacting in their family. During the first session, families were given cards with specific directions on tasks to play with their child along with a bag of materials needed to accomplish the tasks. Families performed the tasks in the treatment room while the student-trainees observed the WFT MIM session from a monitoring room. The student-trainees looked for strengths and weaknesses in the four dimensions of attachment outlined by Theraplay: structure, engagement, nurture, and challenge (SENC). There were just five tasks families were asked to do during this initial, subjective assessment:

1. Play with hats with your child or children.
2. Play a familiar game with your family.
3. Play a game of stacking hands. Be sure to lead the family in going up and down, fast and slow.
4. Lotion your child or children.
5. Feed your child or children a snack.

Hats, lotion, and a snack such as M&Ms, fish crackers, or raisins were provided to the parents (after checking with the parents for allergies and dietary restrictions).

The WFT MIM generally took families between 20 and 30 minutes to complete. The remaining part of the first session, the student-trainees returned to the treatment room with the family. One student-trainee spent some time with the parents to explore their interests in therapy and informed them about Theraplay and its purpose. Meanwhile the other student-trainee engaged in play with the children.

After the WFT MIM initial session, the assigned two student-trainees, acting as co-therapists, would begin using WFT based on what they learned about the family’s attachment strengths and weaknesses from the WFT MIM and emphasizing different activities from the four dimensions of Theraplay (SENC) in subsequent weekly sessions. Subsequent WFT sessions lasted for 30 to 35 minutes of family play and 15 to 20 minutes of debriefing (totaling 50 minutes of treatment sessions). During the 30 to 35 minutes, both co-therapists would engage in a wide range of attachment-based Theraplay activities with the entire family. During the remaining 15 to 20 minutes of the session, one co-therapist would sit in a corner of the room and debrief or talk with the parents about the games and activities, answering their questions about the activities, emphasizing their purpose, and instructing the parents how they can be successful in playing those games and activities at home. They would also use the time to briefly talk about progress their children were making regarding any emotional and/or behavioral issues the parents saw at home. During this same 15 to 20 minute time period, the
other co-therapist would continue to play with the child or children. This play was not specifically aimed at any particular treatment issues (and no particular play therapy model was implemented), but it did allow for the children to be cared for in a fun way with someone they trusted while the parents and other co-therapist talked.

Student-trainees also contacted the families at a prearranged time throughout the week either by phone or e-mail. This “midweek communication” was essential to allow parents to discuss items with the student-trainee out of the hearing of the children because we were concerned children might overhear some of the discussion during the debriefing period at the end of each session. This confidential midweek communication also allowed for more coaching on the WFT games and activities and gave parents the opportunity to ask detailed questions about their child’s or children’s behaviors and attachment needs.

The family received 12 to 15 WFT weekly sessions throughout the semester. The reason for the variation of 12 sessions to 15 sessions was due to attendance and occasional holidays disrupting the schedule. Post-test assessments were handed out to the families on the penultimate scheduled session, allowing them to take them home and return them on the last session. In the event families did not return with the assessments, we encouraged them to return them in person or by mail by a certain date. We also engaged in follow-up phone calls to obtain the post-test assessments. Due to the missing data, we intend to change that structure in future studies and have scheduled time for the families to complete the assessments at the clinic to ensure we obtain the needed data.

Termination sessions were celebratory in nature. Children chose and played their favorite games and activities that they most enjoyed throughout the treatment. Families often brought food such as a cake or pizza to create a festive party atmosphere for the children. Silly party hats were typically worn, and the upbeat power of play was emphasized. Parents, children, and co-therapists also discussed the progress they have seen in the family.

Analysis

Utilizing $t$-tests comparing pre-test and post-test responses on the assessment instruments, we looked for statistically significant improvement from Time 1 (pre-test) to Time 2 (post-test). In our analysis of the FAD we looked at the seven subscales (Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control, and General Functioning) as well as overall total scores on the FAD. The FAD served as a systemic measure of the family system. One FAD was filled out by the mother (often with some input by the father) for the whole family. Essentially, this tells us her perspective of the family’s systemic functioning.
We also did t-test comparisons on the OQ for each parent from Time 1 to Time 2. We examined the change over time at both the subscale level (Symptom Distress, Interpersonal Relations, and Social Role) and the overall total OQ score. The OQ was used to measure the impact WFT sessions had on the parents. Each parent filled out their own OQ.

Finally, we examined t-test comparisons of Time 1 and Time 2 for each child on the Y-OQ. The Y-OQ has six subscales (Intrapersonal Distress, Somatic, Interpersonal Relations, Critical Items, Social Problem, and Behavior Dysfunction). We ran t-tests for each subscale and the overall total score on the Y-OQ from the data from Time 1 to Time 2. Children, regardless of their adoptive or biological status, were included in the analysis. Given that 25 out of the 30 children were adopted and that only 3 of the 12 families had biological children, we determined to review the analysis from a family systemic perspective. Rather then targeting a specific identified patient, we sought to determine how all children in the family system fared. Thus the Y-OQ scores for all children were examined rather than distinguishing any subsets of biological versus adopted children. We did not conduct any analysis of the Achenbach CBCL because so few of these assessments were returned. Because multiple t-tests were utilized, we also conducted Bonferroni tests to add statistical rigor to our analysis.

RESULTS

Despite several measures showing the possibility that WFT was helpful to adoptive families, very few items from these measures were statistically significant. Although it is possible that many measures in this study were not statistically significant for a wide variety of reasons (i.e., the treatment is not effective in those areas, the assessments were not filled out correctly, the sample size is too small, sampling error is present, or the protocol did not measure what the researchers intended it to measure, among an assortment of available reasons), the researchers still felt that a future study with a much larger sample size may provide better information. Despite the small sample size, lack of a control group, and the failure to use mixed methods that would have strengthened this study (thus the inability to draw firm conclusions in a inferential manner from these findings due to these and other limitations discussed later), three items showed statistically significant favorable improvement at the $p \leq .05$ level: the FAD Communication subscale, the OQ Interpersonal Relations subscale, and the overall total score of the children on the Y-OQ. This leads our research team to believe that WFT did show promising results and is worth further study with an improved research design. The statistical results are presented in Table 1.

These findings suggest that family systemic functioning did not show a statistically significant change after WFT treatment in terms of the total
TABLE 1  Paired t-Test Findings From the Whole Family Theraplay Project Pilot Study: Family Assessment Device—Total Score and Subscale Scores Results

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>SE</th>
<th>t</th>
<th>df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAD_Total</td>
<td>−2.143</td>
<td>16.263</td>
<td>6.147</td>
<td>0.349</td>
<td>6</td>
<td>0.739</td>
</tr>
<tr>
<td>FAD_Problem Solving</td>
<td>2.145</td>
<td>3.078</td>
<td>1.164</td>
<td>1.842</td>
<td>6</td>
<td>0.115</td>
</tr>
<tr>
<td>FAD_Communication</td>
<td>−2.00</td>
<td>1.83</td>
<td>0.69</td>
<td>−2.90</td>
<td>6</td>
<td>0.027*</td>
</tr>
<tr>
<td>FAD.Roles</td>
<td>1.43</td>
<td>3.237</td>
<td>1.223</td>
<td>0.117</td>
<td>6</td>
<td>0.911</td>
</tr>
<tr>
<td>FAD_Affective Involvement</td>
<td>0.857</td>
<td>5.080</td>
<td>1.920</td>
<td>0.446</td>
<td>6</td>
<td>0.671</td>
</tr>
<tr>
<td>FAD_General Functioning</td>
<td>0.143</td>
<td>4.670</td>
<td>1.765</td>
<td>0.081</td>
<td>6</td>
<td>0.938</td>
</tr>
</tbody>
</table>

*p ≤ .05.

score or in the subscale measures, except for the family communication subscale. FAD_Communication did improve and is statistically significant at the p < .027 level. This subscale measures family communication with statements to which the respondent agrees or disagrees on a four point Likert scale. Such statements include: “When someone is upset the others know why,” “You can’t tell how a person is feeling from what they are saying,” “People come right out and say things instead of hinting at them,” “We are frank with each other,” “We don’t talk to each other when we are angry,” and “When we don’t like what someone has done, we tell them.” The findings indicate that WFT treatment improved family communication patterns.

The adult parents were also assessed using the Outcome Questionnaire. The results are presented in Table 2. The results from the Outcome Questionnaire (OQ) indicate that adult parents did not show any statistically significant improvement in their overall functioning (OQ_Total) or in the subscales pertaining to symptom distress (e.g., statements measuring feelings of worthlessness, feeling tired, unhappiness, feeling anxious, having sore muscles, having headaches, having disturbing thoughts they cannot get rid of, troubling sleeping, and other indicators of mental or emotional distress) or their social role (e.g., feeling stressed at work/school, not enjoying their spare time, not feeling satisfied with relationships, and other similar indicators). The results from the study do indicate that adults/parents report

TABLE 2  Paired t-Test Findings From the Whole Family Theraplay Project Pilot Study: Outcome Questionnaire (Adults/Parents)—Total Score and Subscale Scores Results

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>SE</th>
<th>t</th>
<th>df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>OQ_Total (Mothers)</td>
<td>1.429</td>
<td>9.914</td>
<td>3.747</td>
<td>0.381</td>
<td>6</td>
<td>0.716</td>
</tr>
<tr>
<td>OQ_Total (Fathers)</td>
<td>7.143</td>
<td>8.745</td>
<td>3.305</td>
<td>2.161</td>
<td>6</td>
<td>0.074</td>
</tr>
<tr>
<td>OQ_Symptom Distress</td>
<td>3.286</td>
<td>5.880</td>
<td>2.222</td>
<td>1.478</td>
<td>6</td>
<td>0.190</td>
</tr>
<tr>
<td>OQ_Interpersonal Relations</td>
<td>3.14</td>
<td>3.19</td>
<td>1.20</td>
<td>2.61</td>
<td>6</td>
<td>0.040*</td>
</tr>
<tr>
<td>OQ_Social Role</td>
<td>−1.571</td>
<td>3.867</td>
<td>1.462</td>
<td>−1.075</td>
<td>6</td>
<td>0.324</td>
</tr>
</tbody>
</table>

*p ≤ .05.
that their interpersonal relations improved. The OQInterpersonal Relations scores were statistically significant at the \( p < .04 \) level. This subscale measures an adult’s interpersonal relations with statements on a 5-point Likert scale with a range of never, rarely, sometimes, frequently, and almost always. Examples of such statements include “I get along well with others,” “I feel unhappy in my marriage/significant relationship,” “I am concerned about family troubles,” “I have an unfulfilling sex life,” “I feel loved and wanted,” “I have frequent arguments,” and “I am satisfied with my relationships with others.” This finding of statistically significant, enhanced interpersonal relations on the part of the parents is remarkable given that marital issues (such as their sex life and other relational aspects with their spouse or partner) and other interpersonal aspects pertaining to their adult life were not directly addressed in WFT treatment (although one couple did receive marital counseling separate from WFT sessions).

The results presented in Table 3 from the Y-OQ indicate that WFT treatments made a statistically significant difference in the “overall condition,” “behavioral functioning,” and positive “subjective experiences” in the lives of the children who participated in this study (Burlingame & Lambert, 2007, pp. 5–8). The Y-OQ Total score has a \( p \) value of 0.026, the most statistically significant finding in the study.

After discovering the three statistically significant findings, we then examined the \( p \) values using a Bonferroni test. Although three of the \( p \) values (FADCommunication, OQInterpersonal Relations, and Y-OQTotal) were significant at the .05 alpha level in our initial analysis, none of the 18 \( p \) values reported in this study met the more rigorous standard of \( .00278 (\alpha/\text{n or .05/18}) \) required by Bonferroni corrections. Despite these disappointing Bonferroni test results, we cite Perneger (1998), who argues against using Bonferroni adjustments in certain circumstances due to their propensity to perpetuate Type II errors and thereby unnecessarily nullify practical and useful approaches that may be of value when the alternative of accepting the null hypothesis and doing nothing may be harmful to the patient/client in need. Given the exploratory
nature of this study, the practical needs of adoptive families to receive some useful therapeutic assistance, and the arguments Perneger (1998) makes, we surmise that Bonferroni corrections may not be the best measure to ultimately evaluate these findings, at least not yet. Future studies with larger samples and better controls will be necessary to determine whether such a standard can be met by this treatment approach.

DISCUSSION

These initial findings indicate that WFT is a practice model that shows promising potential, and tentatively, we can say that it might have some level of clinical efficacy in at least three key areas: improving family communication within adoptive family systems, enhancing adult parents’ interpersonal relational skills, and assisting children in adoptive families to have better overall clinical outcomes.

As both researchers and clinicians, our team found it interesting that although Theraplay does not explicitly focus on verbalization in its form of play, the study found that WFT did significantly improve family communication. Perhaps families found that coming together and playing (both in session and at home) facilitated more emotional openings and thereby led to more opportunities to communicate authentically as attachment improved and secure relationships were enhanced. It is possible that as whole families more frequently engaged in playful postures, they grew more comfortable being together as a whole system. This new comfort level might have allowed more open dialogue at home in the presence of others instead of seeking to communicate more privately (wherein such private methods of communication may naturally lead to more structural coalitions and alliances).

The finding that the parents’ interpersonal relations (as measured by the OQIR subscale) improved leads us to consider that WFT may effectively assist adults in enhancing their interpersonal skills. We find it curious that WFT had a significant beneficial role on the adults’ interpersonal relationships with others. Future waves of research with this study will include assessment instruments concerning couples and marital relationships to learn whether we can determine whether WFT has any positive effect on the parents’ couple/marital relationship.

The most important finding of this study is that the Y-OQ total scores for children in adoptive homes improved with treatment. The implementation guidelines that accompany the OQ and Y-OQ state: “the most reliable and valid quantitative measure of the child/adolescent’s condition is the total score” (Burlingame & Lambert, 2007, p. 8). The finding that adopted children’s overall “behavioral functioning and subjective experience” (Burlingame & Lambert, 2007, p. 5) were improved as indicated by
a statistically significant amount as a result of participating in a short-term course of WFT treatment is promising. In terms of clinical efficacy WFT demonstrates signs of merit, or at least the promise of merit, and further studies are warranted.

Descriptively, it is clear that Theraplay can effectively be modified to accommodate whole families with either one child or multiple children in treatment together. This article is valuable because it describes the modification of Theraplay into WFT. WFT involves the integration of family systems models (most notably Structural and Experiential Family Therapy), careful attention to Parten’s (1932) types of play, and traditional Theraplay. By including the siblings and other family members of the adopted child’s family system, parents are able to learn how to play in attachment-savvy ways with their children that are more natural to their family context and therefore more conducive to successful implementation at home.

From a theoretical perspective, integrating Theraplay with family systems approaches is exciting. Lebow’s (1997) description of integrative frameworks helped the researchers to conceptualize integrating Structural Family Therapy, Experiential Family Therapy, and Theraplay. All three models have as strategies a “here-and-now focus,” use the “self-of-the-therapist” as an instrument of change, use a directive posture to facilitate change in the family system, correct emotional/attachment weaknesses, and maintain a relational context. By expanding traditional Theraplay (where the focus is on one child) to include the entire family system, we were able to help the adoptive family integrate therapeutic play into the natural context of the entirety of the family. At the theory level, boundaries, systems and subsystems, sibling dynamics, parental-child coalitions, family roles, non-summativity, and circular causality all become added dimensions to the therapeutic power of Theraplay when the whole family participates. Techniques or interventions that draw from Theraplay and Group Theraplay are modified according to Parten’s (1932) model to draw in the many children and family members of the system. Specifically, we had to be clear about which games, activities, and interventions need to be done in a group process with the whole family or in parallel play with the adults in the treatment room (both parents and therapists) pairing up with a child. Counselor and MFT educators would benefit from examining this model of integration in their theory instruction (particularly for courses relating to theories of play therapy). For practitioners, WFT proffers the benefits of an integrated form of treatment for families that combines the benefits of both family systems approaches with traditional Theraplay. Moreover, it has begun to demonstrate clinical efficacy with one population: adoptive families.

We also note, with deep appreciation to the families who participated in the study, that families remained in therapy throughout the entire course of treatment. The fact that none of the families dropped out and all the families utilized the services offered through at least 12 sessions says much,
anecdotally, about the usefulness and benefit that they ascribed to WFT in their lives.

There are some important limitations to note about this study. The study lacks a control group. Every adoptive family who participated in the study received treatment from the WFT approach. In future studies, we intend to include a control group who receive FFPT or DDP. The study would have been enhanced if we had used mixed methods and included analysis of qualitative data. Unfortunately, we did not consider that prior to the commencement of the study and our informed consent (which the families signed) did not include the use of the videos to be analyzed in that manner (they only agreed to allow videos to be used for supervision purposes). To be ethical, we could not go back and revisit such qualitative data for that purpose. Second, the sample size is small. Future renditions of this study will expand to include a larger sample size. One of the main limitations of this study was our inability to extrapolate these findings to other adoptive families (or other populations of families) due to our small sample size. Our intent is to explore the usefulness of WFT with both adoptive and foster families, hoping to acquire a much larger sample size in the process. Third, our data gathering for Time 2 assessments was less than ideal. We trusted the subjects to fill out assessments at home (because of the number and length of the assessments) and return forms. We did not get back the critical Time 2 data we needed on 5 of the families. In comparing completers to non-completers (e.g., on the FAD we looked at the Total Scores and the subscales: Problem Solving, Behavioral Control, or General Functioning), no clear picture emerged that would indicate why some families completed the tests and returned them where others failed to. Non-completers were not any more likely to score poorly in these areas that would measure some level of disorganization or lack of follow-through on their part. Nor was the average number of children in each family much different between the groups. Non-completers averaged 2.4 children and completer families averaged 2.57 children per family, so on average each group had to fill out assessments on roughly the same number of children (and the two largest families with the most children completed both sets of assessments). We are only left to believe that some families simply chose to make returning the assessments a priority and others (due to the busy nature of their lives, their forgetfulness, or some other reason not known) did not. In future versions of this study, we will be certain to have the families fill out the Time 2 assessments on site. We will also seek to get post-treatment data at 3- and 6-month follow-up intervals to determine sustainability of improvement and relapse prevention.

In addition to continuing the use of the FAD, OQ, and Y-OQ, future renditions of this study will also include the Revised Dyadic Adjustment Scale (Busby, Crane, Larson, & Christensen, 1995) and the Disturbances of Attachment Interview (Smyke & Zeanah, 1999; Smyke, Dumitrescu, &
Zeanah, 2002). We hope to determine what types of couples/marital impact a family systems based Theraplay approach, such as WFT, might have on marriages and hope the Revised Dyadic Adjustment Scale will give us useful information on that subject. We also desire to have an assessment that more precisely measures attachment issues in children, and the Disturbances of Attachment Interview appears to offer the promise of that result.

CONCLUSION

In summary, WFT is an integrative model developed to work with adoptive families by including siblings and other members of the family system in a holistic, systemic context. By integrating family systems theory with Theraplay, WFT enhances quality parent-child attachment and sibling relations and improves overall behavioral functioning and subjective emotional experiences of the children within the adoptive family system. It also appears to improve family communication and the interpersonal role of the adults. By integrating family systems theory with Theraplay, WFT also provides counselors and marriage and family therapists with a powerful model for assisting adoptive families. Such a model shows great promise for clinical efficacy and warrants further research.

NOTES

1. See the appendix of Booth and Jernberg (2010) for full descriptions of Theraplay activities and games.
2. Note that this argument is not the extreme position of permitting any unexamined gimmick or therapy method with zero evidence basis to be utilized because “anything is better than nothing.” Rather this is a moderate position that when one finds statistically significant findings that a treatment works, the added cautionary posture of Bonferroni might be too rigorous when the alternative to the treatment is to do nothing for a patient, client, or family in need. There is a “window” between statistically significant findings of effective treatments and the increased desirable position that Bonferroni affords of near certainty. Apparently, these findings fall within that window and can be useful information until such time as a better-designed study with enhanced controls can be attempted and reported.

REFERENCES


