What is Theraplay?
An Overview Seminar for Professionals

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Table of Contents

An Overview of Theraplay 2
Basic Assumptions of Theraplay 3
Family Theraplay 4
Theraplay Dimensions 8
Practice Activities 9
The Core Concepts of Theraplay 10
What’s Behind These Theraplay Activities: 15
A Window into Attachment
Marschak Interaction Method 18
Working with Parents 19
The Use of Touch in Theraplay Treatment 20
How Theraplay Can Be Adapted for Traumatized Children 23
Theraplay For Children With Autism Spectrum Disorders 24
Theraplay Groups 26
Theraplay Research Summary 27
Recommended Readings 29
Use of Theraplay Service Mark 31
Evaluation 32
An Overview of Theraplay:
Helping Parents and Children Build Better Relationships Through Attachment-Based Play

Background
Theraplay® was developed in the late 1960’s by Dr. Ann Jernberg, a clinical psychologist, to meet the mental health needs of young children in the Head Start program in Chicago. Since that time, Theraplay has been used successfully in early intervention and parenting programs, day care and pre-schools, special and regular education programs, and residential, community mental health and private mental health practice. The typical age range of clients is from birth to 12 years, although the method has been adapted for teens and even for the elderly. The Theraplay Institute trains and certifies professionals in this method. It is now being practiced throughout the United States and also in Canada, Finland, Sweden, Germany, South Korea, United Kingdom, Australia, Japan, Israel, Spain and South Africa.

Parent-child relationships are the primary focus in Theraplay. We work to ensure that the connection between parents and children is firmly established or re-established following a loss, trauma, or separation. Because of its focus on attachment and relationship development, Theraplay has been used successfully for many years with foster and adoptive families. Theraplay is a useful therapeutic program for children with a variety of social and emotional difficulties. It also serves as a preventive program to strengthen the parent-child relationship in the presence of risk factors or the stresses of everyday life.

Distinctive Characteristics of Theraplay

- Theraplay is modeled on “good enough” parenting, the kind that leads to secure attachment.
- Treatment involves emotionally attuned, interactive, physical play.
- Nurturing touch is an integral part of the interaction.
- The focus is on the here-and-now, not on what happened in the past, interpretation of symbolic meanings or pretend games.
- Treatment is geared to the child’s emotional level and therefore often includes activities that might otherwise seem more appropriate for a younger child.
- The Theraplay therapist takes charge, carefully planning and structuring the sessions to meet the child’s needs.
- Parents are actively involved in the treatment to enable them to take home the new ways of interacting with their child.
- The therapist and parents work together to engage the child in a healthier relationship.

The goal is to enhance attachment, trust, self-esteem and joyful engagement and to empower parents to continue on their own the health promoting interactions of the treatment sessions.
The Basic Assumptions of Theraplay

From the beginning the Theraplay® approach shared many assumptions with interactional theories of development, particularly those of Self Psychology and Object Relations Theory. Over forty years of its clinical practice, an increasing body of research in the fields of child development, attachment theory, and brain research has given further support to many of Theraplay's tenets.

- The primary motivating force in human behavior is a drive toward relatedness. Personality development is essentially interpersonal. The early interaction between parent and child is the crucible in which the self and personality develop.

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

- When things do not go well, the child develops an inner representation
  - of herself as unlovable and incompetent;
  - of others as uncaring and untrustworthy; and
  - of the world as unsafe and full of threat.
In other words, within an insecure or disorganized attachment, the process of learning about one's self and the world becomes negative, full of shame, and hopeless. Many behavior problems of older children can be traced back to their beginnings in insecure or disorganized attachment and in the consequent negative views of themselves and the world.

- The playful, attuned responsiveness of caregivers is essential to the development of a secure attachment, which leads to the capacity for emotional self-regulation, the capacity to understand and empathize with others, and to feelings of self worth,

- The essential force for change lies in the creation of a more positive relationship between a child and his parents.

- Because the roots of the development of the self, of self-esteem, and of trust lie in the early years, it is essential to return to the stage at which the child's emotional development was derailed and provide the experience that can restart the healthy cycle of interaction. Parents are encouraged to respond empathically to their child's needs. The goal of treatment is to change the inner representation of the self and others from a negative to a more positive one.
FAMILY THERAPLAY®

Theraplay® is a structured play therapy for children and their parents. Its goal is to enhance attachment, self-esteem, trust in others and joyful engagement. The sessions are fun, physical, personal and interactive and replicate the natural, healthy interaction between parents and young children. Children have been referred for a wide variety of problems including withdrawn or depressed behavior, overactive-aggressive behavior, temper tantrums, phobias, and difficulty socializing and making friends. Children also are referred for various behavior and interpersonal problems resulting from learning disabilities, developmental delays, and pervasive developmental disorders. Because of its focus on attachment and relationship development, Theraplay has been used successfully for many years with foster and adoptive families. Please see the foster/adoptive treatment plan comments on page three.

With this method, family interaction patterns have changed and schools and pediatricians have reported improved behavior and reduced symptomatology in the child. Essentially the same treatment techniques extending over a longer period of time are used with children with developmental delays, pervasive developmental disorders, or autism. It has been our experience that even in the rare cases where parents/caregivers cannot be involved, Theraplay is still of benefit to the child.

Theraplay was first developed in 1967 at The Theraplay Institute in Chicago, IL. The method has been adapted for use in groups as well. It is used in many therapy, childcare and educational settings throughout the U.S. and abroad. The Theraplay Institute provides assessment and treatment to families, consultation to social service and child welfare organizations, and training in Theraplay for professionals.

Basic Treatment Plan

Families come to The Theraplay Institute for a series of 18-26 weekly sessions with four follow-up sessions at quarterly intervals over the next year. The first session is an information-gathering interview with the parents. The second and third appointments are observation sessions using the Marschak Interaction Method (MIM), in which the child and one parent perform a series of interactive tasks together. The interactions are videotaped and later analyzed by Institute staff in preparation for a fourth session with the parents. In that session the staff and parents discuss their observations of the interaction and together agree on a plan for treatment. In the next session the therapist demonstrates the activities to the parent and they discuss the purpose of the activities, the child’s potential reactions and the parent’s reflections.

Sessions six through twenty five involve direct Theraplay with the family, duplicating (regardless of age) the kind of playful behavior and fun games which parents and young children naturally engage in together. The interaction includes structuring, engaging, nurturing and challenging activities in combinations geared to the specific needs and problems of the individual child and his/her family. After every 3 family sessions a session is scheduled for the therapist(s) and the parents to meet without the child to discuss progress and goals.

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Parents observe all Theraplay sessions and eventually enter the room and join in Theraplay directly. We often have two therapists, one who interacts with the child and one who works with the parents. When two therapists are present, the parent therapist observes with the parents and discusses the rationale for the activities, e.g., encouraging the development of trust and self-esteem, building a sense of self as lovable, developing confidence, permitting pleasurable experiences, encouraging intimacy, developing a positive body image, strengthening perceptual motor-coordination. This discussion includes ways in which the parents can implement these ideas at home. If one therapist is present, these discussions take place with the parents at the end of each session, by phone, or at a separately scheduled time.

The final treatment session ends with a good-bye party. The parent-child interaction assessment and any standardized testing are re-administered and discussed with the parent to reflect on progress and make recommendations. Four follow-up sessions are scheduled at quarterly intervals, with parents and child, over the next twelve months. A typical Theraplay program is summarized below:
<table>
<thead>
<tr>
<th>Session</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Initial interview with mother and/or father. Administer Child Behavior Checklist or other appropriate standardized measures.</td>
</tr>
<tr>
<td>2</td>
<td>One parent and child participate in Marschak Interaction Method (MIM), a structured technique for intensive observations of the ways parent and child typically interact with one another. Theraplay staff members observe and videotape this interaction.</td>
</tr>
<tr>
<td>3</td>
<td>Same as 2, except that other parent participates.</td>
</tr>
<tr>
<td>4</td>
<td>Feedback session with mother and father.</td>
</tr>
<tr>
<td>5</td>
<td>Parent Theraplay demonstration session</td>
</tr>
<tr>
<td>6, 7, 8</td>
<td>The therapist interacts with child while parents watch. Explanations are given to parents ahead of time as to what will take place. Questions are answered after the session and parents are encouraged to try Theraplay techniques at home. Parents enter the session towards the middle or end of each session.</td>
</tr>
<tr>
<td>9</td>
<td>Meeting with parents only to go over videos of sessions/review progress/discuss issues with child at home</td>
</tr>
<tr>
<td>10-12</td>
<td>Same as 5-7, with parents gradually becoming the focus of interaction with child with therapist’s guidance.</td>
</tr>
<tr>
<td>13</td>
<td>Meeting with parents only to go over videos of sessions/review progress/discuss issues with child at home.</td>
</tr>
<tr>
<td>14-16</td>
<td>Same as 9-11, with parents gradually taking more of the lead role in interacting with child with therapist’s guidance.</td>
</tr>
<tr>
<td>17</td>
<td>Meeting with parents only to go over videos of sessions/review progress regarding therapy goals/discuss issues with child at home.</td>
</tr>
<tr>
<td>18-20</td>
<td>Same as 13-15, with parents gradually taking more of the lead role in interacting with child with therapist’s guidance.</td>
</tr>
<tr>
<td>21</td>
<td>Meeting with parents to evaluate therapy goals/decide on end date/refer for additional treatment</td>
</tr>
<tr>
<td>22-24</td>
<td>Theraplay session wherein parents are actively involved in planning and leading the sessions.</td>
</tr>
<tr>
<td>25</td>
<td>Final “goodbye Theraplay party” or additional sessions as needed Therapist re-administers CBCL/other objective measures</td>
</tr>
<tr>
<td>26</td>
<td>Re-administer MIM/ Final meeting with parents to review goals achieved and areas for future work if necessary. Schedule first follow up session</td>
</tr>
</tbody>
</table>
FAMILY THERAPLAY CONTINUED

Treatment Plan for Families Created Through Foster Care or Adoption

Different types of psychotherapy may be helpful to the child and family across the life span to deal with adoption/foster concerns. At the time of the initial information gathering and assessment, the focus will be on the child’s and family’s immediate needs and determination of the most appropriate treatment plan. These needs may be met at The Theraplay Institute, or appropriate referrals will be made. Theraplay may be an appropriate early treatment to work on strengthening relationships; this is especially true for children ages birth-7, but also may apply to older children. In recognition of the typically greater needs of children who have experienced separation, loss, trauma, multiple caregivers or institutional care, the treatment period is extended in length and intensity. Treatment may begin with the Theraplay plan as outlined above and gradually incorporate elements of processing the child’s history and adaptation to the current family. Sessions may be extended to 1.5 hours or scheduled twice weekly to allow for this processing. A treatment period of 9-18+ months is common. A significant aspect of the treatment is parent education/support in order to assist the parents in responding to the child and managing the child’s environment in therapeutic ways.
THERAPLAY TREATMENT: USING THE DIMENSIONS OF THE EARLY RELATIONSHIP AS COMPENSATION

STRUCTURE: Key concepts: Safety, Organization, Regulation
The fact that the adult is in charge is reassuring and creates safety. Warm and supportive adult leadership lends adult organization and regulation to the child, ultimately teaching the child self-control. Especially useful for children who are overactive, undirected, over-stimulated, or who need to be in control. Especially useful for parents who are poorly regulated/disorganized, have difficulty setting limits and/or being a confident leader, rely on verbal/cognitive structuring, or are over or under stimulating.

ENGAGEMENT: Key concepts: Connection, Optimal Arousal, Shared Joy
The child is focused on in an intensive, personal way in order to make an attuned connection. The goal is that the child feels “seen” and “felt.” Engaging activities offer pleasant stimulation, variety, and a fresh view of life, allowing a child to understand that surprises can be fun and new experiences enjoyable. Especially appropriate for children who are withdrawn, avoidant of contact, or anxious/rigidly structured. Very withdrawn or autistic children may experience engagement as uncomfortable. In response, the therapist slows the pace and monitors stimulation. Especially useful for parents who are disengaged, preoccupied, inattentive, out of sync with the child, rely primarily on verbal engagement, who do not enjoy the child.

NURTURE: Key concepts: Regulation, Secure Base, Self-worth, Empathy
Soothing, calming, quieting, caretaking activities that make the world feel safe, predictable, warm and secure, and reassure the child that the adult provides comfort and stability. Meets the child's unfulfilled younger needs; helps the child to be able to relax and allow herself/himself to be taken care of; builds the inner representation that the child is lovable and valued. Especially useful for children who are overactive, aggressive, anxious or pseudomature. Especially useful for parents who are dismissive, harsh, punitive or have difficulty with touch and/or displaying affection.

CHALLENGE: Key concepts: Competence/Mastery, Confidence, Support
Exploration Activities that are fun and require a partnership, not done alone. They help the child take a mild, age appropriate risk, and promote feelings of competence and confidence. Especially useful for withdrawn, timid, or rigid children; also used to deal with resistance. Especially useful for parents who have inappropriate developmental expectations, are competitive. All activities are conducted in an upbeat atmosphere of warmth, spontaneity, optimism, cheerfulness and fun.
Practice Activities

Pick a partner
Choose one activity from each dimension. Get your materials.
Lead your partner through the activities
Reverse roles, so that each partner has a turn as leader and as receiver

GOALS:
• To take the lead in engaging your partner
• To convey a sense of specialness, togetherness, and fun

STRUCTURE
• Trace your partner's hand on a piece of paper
• Make a stack of hands--up/down, fast/slow
• Hold hands and play row-row-row your boat

ENGAGEMENT
• Play patty cake
• Pop each other's cheeks
• Create a 4 part handshake

NURTURE
• Notice and care for a hurt or special spot on your partner
• Look at your partner carefully. Tell him/her two special things you notice.
• Pretend to “paint” a flower on your partner’s hand

CHALLENGE
• Teach your partner a clapping game
• Thumb wrestle with your partner
• Hold hands and stand up/sit down together

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THE CORE CONCEPTS OF THERAPLAY

Revised September 4, 2012

The Core Concepts of Theraplay are supported by extensive research about attachment, brain development, and the elements that lead to therapeutic change. See Circle chart.

The key elements are:

1. Interactive & Relationship Based
2. Direct Here and Now Experience
3. Guided by the Adult
4. Sensitive, Responsive and Reflective
5. Preverbal/Social/Right Brain Focus
6. Multi-sensory including Touch
7. Playful

Full descriptions and supporting research in chapter 2 of Theraplay, 3rd Edition 2010; pages noted below.

1. INTERACTIVE & RELATIONSHIP BASED (pp.42-47)

The focus of treatment is the parent-child relationship. Our model is the sensitive, responsive and playful give and take that occurs naturally between parents and their healthy young children and which leads to secure attachment and long term mental health.

“Loving connections and secure attachments build healthy and resilient brains, while neglectful and insecure attachments can result in brains vulnerable to stress, dysregulation, and illness.” (Cozolino, The Neuroscience of Psychotherapy, 2nd edition, 2010, p.180)

Healthy parent infant relationships are supported by two important innate drives that create both safety and connection:

A drive to stay close in order to be safe, and

A drive to share meaning and the joy of companionship.

Feeling safe is essential to the activation of the social engagement system which makes possible the sharing of meaning and companionship.

- The child who has experienced neglect, abuse and trauma is in a constant state of arousal.
- The impulse to seek companionship is deadened or lost.
- Theraplay helps parents create the safety that encourages the child to open up to new experiences of connection and shared companionship.

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It is important to understand what is involved in these instinctive impulses since we make use of them to create a new or healthier relationship.

- **Innate attachment behaviors: A drive to stay close and to feel safe**
  Babies signal their need for comfort and protection by crying and clinging: Adults respond with caregiving that protects and reassures their infant. The goal of Theraplay is to create a felt sense of safety for both parent and child.

- **Innate capacity for social interaction: A drive to share meaning and the joy of companionship.**
  The following overlapping elements support this drive and are basic to our Theraplay approach:
  - **Intersubjectivity:** Babies and their responsive parents naturally get in synchrony and together establish an intimate shared view of the world. They are present to each other, have matched vitality and congruent intentions. (Trevathan, Siegel, Hughes)
  - **Social Engagement System:** Well defined neural circuits, particularly the vagal system, support shared social engagement behaviors and the defensive strategies of fight/flight or freeze. The vagal nerve connects facial, throat, heart and stomach muscles involved in communication and emotional processing necessary for relationships. (Porges)
  - **Imitation & Mirror Neurons:** Our motor systems are primed to imitate other’s intentional actions, a “rehearsal” in the brain; helps us understand other’s intentions; links perception to action, making resonance and attunement possible (Iacoboni).
  - **Resonance, rhythm and synchrony:** The shared state of feelings and actions in a face-to-face human encounter (Trevathan & Aiken). Resonance behaviors occur when we unconsciously imitate others.
    - Activated neurons cause other neurons to fire within a brain or between brains; leads to connection with the emotional states of others (Siegel)
    - Observable in womb: fetus’ rhythmic response to sounds from outside womb (Trevathan)
    - Post birth synchrony with adult speech
  - **Affect attunement:** leads to dyadic regulation and a sense of sharing internal experiences and emotional connectedness (Stern) The Still Face: When the infant can’t establish connection with mother he becomes dysregulated. (Tronick)

- **The focus of Theraplay is always on what is going on in the relationship.**
  - Our simple games create shared, synchronous interactions between parent & child and intense “moments of meeting.”
  - We give parents a direct experience of Theraplay for themselves to help them understand their child’s experience and to provide missing experiences from their own childhoods.
  - Theraplay therapists make full use of their capacities to resonate, synchronize, regulate & read the intentions of our child and parent clients.

2. **DIRECT HERE AND NOW EXPERIENCE** (pp. 48-51)

Since neural circuits and attachment relationships are created in a “here and now” experience, we assume that in order to create mature emotional neural circuits and change negative internal working models for both parents and child, we must provide a direct, active emotional experience. Attention, care and nurturing build robust, resilient brains. By attuning with the child, we activate attachment processes, modulate fear and stress levels and create an optimal biochemical balance that develops plasticity.

- **Changing Procedural memory:** Attachment patterns, including IWMs, are stored in the procedural memory system, which is nonverbal and movement oriented. New procedural memories are formed in moments of shared, positive, affective experience. (Vicky Kelly)
• **Now moments**: Moments of intense connection and synchrony that lead to a major shift in internal organization & sense of self (Makela, Tronick). **The surprise of peek-a-boo, the shared belly laugh.**
  o Each microscopic present moment leaves its mark in microscopic changes in the neural circuits. (Hart)
• **Non-congruence**: The positive, accepting approach of Theraplay presents the child with an experience that is non-congruent with his negative view. Neural activation that does not match a previous experience exactly sparks a new process or experience, creates new neural connections leading to new learning and development (Hart).
• **Creating new meanings together**: Theraplay creates new meanings through shared experience rather than through thinking and talking about experience. True meanings are created through the sharing of bodily and emotional reality in dyadic states of preverbal consciousness (Makela).

### 3. GUIDED BY THE ADULT

Theraplay deliberately guides and co-regulates the session in order to create a safe, well-regulated experience for the child and parents. The following concepts and research support this aspect of our work:

• **Co-regulation**: Essential to the development of the capacity for self-regulation. **Parent calms the agitated baby, engages and arouses the quiet child.**
• **Clear expectations, leadership balanced with support**: Authoritative parenting had better outcomes than authoritarian, indulgent, or unininvolved (Baumrind).
• **Resiliency factors**: Most frequently cited external supports leading to resiliency were trusting relationships, structure and rules at home and strong role models (Grotberg).
• **Fears about fostering dependency**: Rather than creating dependency, adult guidance and secure relationships are the foundation for self-reliance. Autonomy grows out of attachment (Shahmoon-Shanok).

### 4. SENSITIVE, RESPONSIVE AND REFLECTIVE (pp. 54-62)

Theraplay treatment takes as its model the sensitive, attuned, reflective responsiveness of good parenting that leads to secure attachment and the development of a positive IWM. The Theraplay therapist responds in an attuned way to the parent and child and encourages the development of the parents’ capacity to reflect on their own and their child’s experience. Attunement, empathy and insight are essential to being able to respond sensitively to the child’s needs.

• **Attunement to vitality affects**: The ongoing experience of being together allows the sensitive parent to attune to the level and tone of the child’s emotion, or “vitality affect” (Stern). An infant learns about her own feelings by seeing them mirrored in her mother’s face (Winnicott). The parent makes it clear she is mirroring the child’s feeling and not expressing her own feelings: through exaggeration ( Fonagy) or cross modality matching (Stern).
• **Development of Empathy**: The affective attunement between a mother and baby makes it possible for the baby to understand the feelings of others (Stern).
• **Insight (Fearon), Reflective Function (Fonagy) or Mindfulness (Siegel)**: Refers to the parent’s ability to reflect on her own and the child’s internal states. The capacity for insight or reflection makes it possible to understand the link between behaviors and underlying mental states (Slade).

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The adult’s capacity to reflect on his/her own experience is characteristic of secure and earned secure adults (Main).

- “The mother’s ability to resonate with her infant’s emotional state and translate her feelings into words will eventually lead to the child’s ability to associate feelings with words.” (Coz, p. 181)

5. **PREVERBAL/SOCIAL/RIGHT BRAIN FOCUS (PP. 62-73)**

Theraplay provides experiences that can reorganize the brain, leading to affect regulation and changed patterns of interaction and expectations. In order to do this, we use the nonverbal language of the right brain—voice, facial expression, eye contact, movement, rhythm, rocking, singing, and touch to create the deep levels of neural integration that must be matured to make it possible to communicate on the mentalizing and narrative levels later on.

- **Experience dependent brain:** Rapid neuronal growth, especially in the right, social-emotional brain structures takes place in the first two years when attachment is being formed. Neurons are pruned via interactive experience with caregivers. The kind of brain the baby develops comes out of his experience with people (Gerhardt).

- **Hierarchical organization of brain:** The brain develops from the bottom up: brain stem>midbrain>limbic system>cortex; it requires appropriately timed and patterned responses at each stage of development. Treatment is geared to the child’s current state of arousal. Fight-flight-freeze responses to trauma come from the brain stem and override higher level thinking processes (Perry).

- **Primacy of right brain in early development:** The right brain limbic system along with the developing orbito-frontal cortex attunes to the social environment and regulates the internal state of the body. It stores the IWM of relationships and is the center for social cognition and understanding of others.

- **Co-regulation of physical & emotional states:** Brain research places affect regulation in the center of human development. The parent’s role is crucial in creating the child’s capacity to respond to positive and negative experiences without losing her sense of self. Dyadic failures of affect regulation result in developmental psychopathology (Schore).

- **Using brain development as a guide for treatment:** Therapeutic approaches must be rooted in an awareness of the centrality of early dyadic regulation, a thorough knowledge of right hemisphere emotional development, and a deep understanding of the dynamics of implicit procedural memory (Schore & Schore).

6. **MULTI-SENSORY INCLUDING TOUCH (PP. 73-78)**

Theraplay treatment contains multiple opportunities for safe and appropriate therapist-child and parent-child physical contact and stimulation of all the senses. The Theraplay therapist resonates with the child’s autonomic nervous system through body-communication and thus contributes to the child’s affective sense of self. Parents are encouraged to use touch to become their child’s source of comfort and calm. Aspects include:

- **Stimulating the body senses:** Tactile, vestibular & proprioceptive systems are involved in the sense of self and interaction ability (Williamson & Anzalone). Consider sensory issues in assessment & treatment planning and refer as needed (Dunn: Sensory Profile)
• **The importance of positive touch:** Touch is fundamental to human experience, first for survival and then for meaning (Brazelton).
  o Infants require the warmth of body contact to support their immature regulatory capacity.
  o Touch and warmth raise the levels of the hormone oxytocin, which is calming to adult and child.

• **Beneficial effects of touch:** Numerous animal and human studies include:
  o Social development of monkeys (Harlow).
  o Physiological & intellectual development of prematurely born infants (Field).
  o Management of stress: Babies touched during induced stress did better than untouched (Tronick).
  o Additional contact by surrogate carers can overcome genetic propensity to anxiety and irritability in rats and monkeys (Suomi).

Body Image: Human infants who are not touched and handled sufficiently at an early age may develop a distorted body image (Weiss).

More information in next section on touch in Theraplay

7. **PLAYFUL** (pp. 79-83)

Parents who meet their children with joy and interest generate a sympathetic arousal state in the child’s nervous system that promotes attachment formation. Without early experiences of high levels of positive affect co-regulated with an attuned caregiver, children cannot develop a sense of connectedness and empathy. The better the nervous system is at handling high arousal levels without disintegrating, the more flexible and resilient the child will become. Theraplay provides experiences of high arousal followed by experiences of calm and quiet and thus “trains” the vagus system to regulate arousal levels. Aspects are:

• **Optimal arousal, shared joy:** “High levels of activation correlate with increased production and availability of norepinephrin, endorphins, and dopamine, enhancing the child’s pleasure during positive experiences.” And creating the feeling of being alive, awake & full of energy.

• **Synchrony & healthy relationships:** Play episodes create affective synchrony, enhancing development of brain synapses (Hart). Play facilitates growth and health (Winnicott).

• **Stress reduction & regulation:** Repeated activation of adrenaline in childhood enables spontaneity, joy, awe and resilience in face of stress (Sunderland). Joy counteracts negative emotions (Panksepp).

• **Brain organization:** Play creates new neural connections via activation of a “fertilizer” Brain Derived Neurotrophic Factor; see increased gene expression of BDNF after play (Sunderland).

• **The harmful effects of lack of play:** Animals deprived of rough and tumble play when young develop social problems when adult (Brown). Children who don’t do socially interactive play will compensate by playing more roughly and at the wrong times, often labeled ADHD (Panksepp).
WHAT’S BEHIND THESE THERAPLAY ACTIVITIES: A WINDOW INTO ATTACHMENT
DAFNA LENDER, LCSW

Why is Theraplay effective for healing children’s attachment issues? The key is not the activities. The activities are just the vehicles that facilitate connection. The key is that we lend the child, and teach the parents to lend their child, our whole selves to help them organize into healthier, happier people. How does this happen?

Theraplay changes a child’s implicit relational knowing, which is a person’s non-conscious expectation of what will come from interacting with another human being. The patterns of interactions between a parent and child are established during infancy when a parent responds in an attuned way (or not) to the baby’s signals. These patterns turn into schemas that are neurologically “set” in the brain over the first three years. The more they are repeated, the more they are reinforced. These repeated schemas in the brain turn into a child’s internal working model in relation to attachment figures. Most of the children we work with have insecure attachment patterns. In Theraplay, we are giving the child interpersonal experiences that are non-congruent with their (insecure) internal working model, thereby challenging their brain to develop new, healthier implicit relational knowledge of what it’s like to be in a relationship. For example, when a child is struggling in a Theraplay session and pushes you away with his legs, you say “Boy you’ve got strong legs! I bet you can’t push me over with these legs on the count of three!” and then hold his feet two feet in the palms of your hands, count to three, the child pushes and you rock backwards with a big “OOOOHHHH” sound. When you come back up, you see the child’s face has changed from defensive fear to a moment of proud delight. What just happened? By reframing and organizing his resistance into a moment of reciprocal play, you have given the child an opportunity to experience himself as strong, clever and most importantly still connected to the adult rather than bad, rejected and isolated. You have given him new meaning for what it means to be him.

Right Brain Development in Early Childhood
The right brain is dominant in infants starting from the third trimester of pregnancy thru the third year of life. A parent’s emotional attunement (appropriate levels of touch, rocking, feeding, humming, changes of voice tone, tempo of movement, facial expressions) are the experiential food for the right hemisphere during early development, as well as in adult life. The reality of the right brain’s world is derived from information about the emotional states of others. While the left hemisphere is Logical, Linguistic, and Linear and slower in it’s processing, the right brain’s basic forms of conscious representations are: sensations and images. The left brain is inept at reading nonverbal social or emotional cues from others. Facial recognition centers are in the right brain. It is these right brain structures that are underdeveloped, damaged, or distorted in the children with whom we work.

Theraplay accesses these right brain structures by providing high levels of non-verbal, face to face emotional communications involving, rhythm, eye contact, attuned responses of pacing and intensity that lead to developing positive right brain structures.

Think of a parent whose baby is upset and crying: What does that parent do? She will hold the baby close, bounce him up and down in strong, rhythmic motions and hum or say “sh, sh, sh, sh” with the same level of energy as the infant is demonstrating in order to soothe him. The baby can feel the vibration of

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his mother’s chest as she hums and can feel her intention to help him through this experience. It is this type of behavior on the part of the parent that lends the infant’s immature nervous system the experiences it needs to learn to calm, organize, and soothe itself. But what if the parent were to hold the baby loosely, not bounce him, and not verbalize at all? The baby would likely not feel his parent’s presence and not feel soothed. If this happens chronically, he will not learn how to soothe himself and manage intense feelings, and he will also learn that no one can help him when he’s distressed. We see a lot of these children in our clinic when they’re older: they are the type who easily “lose it” (lack of self-regulation skills) and then they desperately try to keep you or their parents from getting close enough to help them.

What we do in Theraplay is to intervene at the appropriate physiologic level to connect with this type of child and capture the “attention” of his right brain. For example: grabbing a child’s hand and making a game of “ring around the rosy” out of a child who was previously running around the room chaotically, and then quickly placing him in your lap, facing out, and making finger prints in play dough or feeding him something chewy, is a common Theraplay sequence. What happened on a regulatory level is that the therapist met the child at his highly aroused level and helped to organize it, and then quickly provided both the structure and the engagement to help him calm down and focus his attention on a more soothing level, being ever mindful that because the child’s whole system is overstimulated and reactive, it is best not to insist on face to face contact but use body contact, which is less intense.

Vitality Affects
Keying in to and responding appropriately to a child’s vitality affects is our job: whether the goal is to down-regulate the child’s affect as illustrated above, or to match it (such as in the cotton ball hockey game, patty cake, etc), or amplify it (a child notices an interesting freckle on her hand and the therapist looks with interest and admires it further), we serve as guides in regulating the rhythm and intensity of the relationship. For example, if you’re doing a quiet “check up” with a child, it’s because you are attuned to her basic state of physiologic arousal and have judged that the child is able to sit still and focus long enough for you to capture her attention. If she becomes interested in the freckle you found and stares at it intently, you respond with a quiet, rich, energy filled voice: “Yeah, uh huh, neat freckle.” But if she were to stare off past you and look bored or disconnected, you would vary the activity or change it altogether in order to reestablish the connection.

Another unique attachment opportunity that a Theraplay session provides are the many moments of surprise: these are moments of increased intensity, where there is a sudden dynamic shift. We set up these opportunities for dynamic shift all the time in Theraplay. For example: You are quietly studying a child’s face in Theraplay and he reaches out to touch your nose and you make a resounding “BEEEEEEP” sound; the child is suddenly completely alert and, looking straight into your eyes, he giggles spontaneously at the surprising, funny shared event between the two of you, and you laugh in turn. The discrepancy between what the child expected and what actually happened is surprising. This element of surprise, so important in Theraplay, is the growing edge for a child to learn that new things can happen, but that these new things can be both fun/exciting and safe.

Now Moments
Related to the scenario described above, a now moment is when two people are sharing a dyadic state of consciousness. For those few seconds after you made the beep sound, you and the child are in a brand new, shared space created by the two of you, and you are intensely focused on each other. You each give meaning to the event as pleasant and the giggling both conveys and amplifies the moment. The more now moments occur, the more the child learns that it is pleasurable and safe to be completely caught up in a moment of shared joy or attention with another person. Once this has happened, there is no going back—a deeper sense of connection has been established between the two of you.

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Now moments can also be seen as trance-like or hypnotic states when the dyad is not aware of the passing of time, is not self-conscious and is intensely focused on the object of shared attention between the two people. This is a common experience for people when they are doing their favorite activity with another person such as playing music, dancing, etc. It is the common goal for many Theraplay activities that require reciprocity, such as pat-a-cake, peek a boo, beep and honk, cheek pop, etc.

**Positive Affect**

Finally, in Theraplay, positive affective states of interest/excitement, enjoyment/joy are tuned into and amplified in physical play that helps the child learn to share and expand joyful experiences and also to modulate them so that they do not become overwhelming (Think of a common parent behavior of throwing a baby in the air the appropriate amount of times, in the right rhythm and height so that she increasingly enjoys the experiences but does not spit up, start to cry or get aggressive from too much stimulation; that is what we are trying to achieve). Children crave vigorous, physical playfulness that involves body contact, and these activities not only help children expand and manage their positive feelings but they also help counteract negative emotions. Amplification and modulation of positive affect is one of the cornerstones of Theraplay: Pillow balance and jump, paper punch and throw, seed spitting contest all come to mind.

For all of the activities mentioned above, it is the fact of you and the child, or more importantly the parent and the child, *being together* in a connected way that achieves the goal of improved attachment capacities between parent and child.


Marschak Interaction Method

The Marschak Interaction Method (MIM) is a structured technique for observing and assessing the relationship between two individuals, for example, biological parent and child, foster or adoptive parent and child, teacher and child. It consists of a series of simple tasks designed to elicit a range of behaviors in four dimensions.

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

In addition to allowing a close look at problem areas in the relationship, the MIM provides a unique opportunity for observing the strengths of both adult and child and of their relationship. It is, therefore, a valuable tool in planning for treatment and in determining how to help families strengthen their relationships. The description of the relationship that results from this observation is a valuable aid in determining the appropriateness of custody arrangements, reunification, foster placement and/or adoption. While the MIM provides useful information about the way two people interact, it is important that other sources such as case management data, interviews and other types of assessments be taken into account when major decisions such as change of placement or permanent placement are being considered. The MIM is not a standardized instrument and is best used as a tool for describing parent-child interaction and planning treatment.

The MIM interaction takes from 30 to 60 minutes and is videotaped. Careful evaluation of the videotaped interaction precedes the preparation of the written report or feedback. Feedback includes showing parts of the videotape to demonstrate to the adult the most effective ways to engage and interact with the child. Individuals or agencies requesting this assessment may specify either a written report, personal feedback or both.
Working With Parents

A. Giving parents a more positive, empathic view of their child
   Observations
   Guided Observations
   Role Playing the Child’s Part

B. Steps leading to competence in using the Theraplay approach
   Discussion
   Modeling
   Guided
   Practice Home
   Work Role
   Playing
   Taking Charge

C. Teaching parents about developmental issues and how to handle behavior problems
   Teaching appropriate developmental expectations
   Teaching the concept of inner representations
   Consulting about behavior management

D. Meeting Parents’ Unmet Needs
   Parent support
   Theraplay for parents
   Dealing with parent’s own issues
   Refer for individual or marital work when needed

A resource for assisting parents in examining their own history and beliefs:
STATEMENT ABOUT THE USE OF TOUCH IN THERAPLAY® TREATMENT

Theraplay® is a child and family treatment for enhancing attachment, self-esteem, trust in others, and joyful engagement. It is based on the natural patterns of healthy interaction between parent and child, and is personal, physical, and fun. Theraplay interactions focus on four essential qualities found in parent-child relationships: Structure, Engagement, Nurture, and Challenge. Theraplay sessions create an active and affective connection between the child and parents, resulting in a changed view of the self as worthy and lovable and of relationships as positive and rewarding.

Touch is a normal, healthy part of all parent-child interaction. There is a growing body of literature demonstrating the positive impact of healthy physical contact on people of all ages. Physical touch can relieve stress, decrease anxiety and depression and increase comfort (Barnard & Brazelton, 1990, Field, 1993). “Loving touch [produces] oxytocin and releases endogenous opioids, which are known to solidify infant-mother bonds” (Panksepp, 2001, p.151).

Various kinds of touch are essential to Theraplay treatment. Theraplay touch is organizing and modulating in the structuring activities; it is playful and engaging as seen in many of the surprising and delightful activities; it is nurturing in the care giving activities; it is used to assist or guide the child in the challenging activities. At all times our goal is to maintain the safety and meet the developmental needs of the child.

The following is an explanation of how we use touch in Theraplay.

**Structuring Touch**
Theraplay sessions often begin with a playful, interactive entrance activity that incorporates touch, such as, wheelbarrow walking or holding hands and taking steps into the room together. The therapist helps the child or child and parent sit comfortably on cushions on the floor or on a couch in a relatively close and face to face position. Activities usually have components of coordinated movement, touch, and sensory experiences, such as popping bubbles or feeling a touch with a cotton ball. Active and quieter games are alternated; within activities there are opportunities for modulation of movement, sound and energy.

**Challenging** activities usually are physically active and are carried out cooperatively rather than competitively; the therapist often gives physical assistance or guidance to help the activity turn out successfully.

**Engaging Touch**
The Theraplay therapist plans to touch the child because touch is an important modality for creating relationships and communicating safety, acceptance, playfulness and empathy. Activities that naturally require touch are used to make a connection with the child, such as hand clapping games or making a hand stack. The Theraplay therapist is attuned to the child’s reaction and finds ways to make the touch acceptable to an anxious or touch aversive child. Withholding touch because of a fear of inappropriate touch can be as damaging to the growing child as inappropriate touch (See Harlow studies). It is important that children experience gentle, kind, loving, and safe touch.

**Nurturing Touch**
Feeding, bathing, taking care of hurts, cuddling, and rocking, are essential and natural parts of healthy parent-child interaction. They are important interactions that help the child develop the capacity eventually to soothe and calm himself. Nurturing touch in Theraplay includes noticing the child’s scratches/bruises and taking care of them with lotion or bandaid, feeding and singing to the child, and putting an arm around the child’s shoulder or rocking and comforting a child who is anxious or needing to be reassured. Most children welcome these
kinds of touch. If a child resists being touched, the Theraplay therapist will find another way of getting close and providing the nurturing, calming experience needed by the child. Nurturing touch is never coercive.

**Calming/Containing Touch**

While we focus our efforts on helping a child to interact in a calm and well regulated manner, it is not always possible to avoid having a child escalate to a point where it is necessary to contain her in order to protect her from harming herself or others. If a child is angry, dysregulated or out of control in a session and has not responded to other efforts to calm her, the Theraplay therapist and parents stay with and contain the child in some way; this may involve cradling the child on the lap of the adult, an arm around the child, or close, soothing physical contact. If the parents are able, they contain the child with support from the therapist. As soon as the child settles, the containment stops and the adult continues her interaction with the child. Containment in Theraplay is done in reaction to the child's dysregulated behaviors; the therapist never provokes the child in order to contain the child. The model for this type of containment is that of a parent who holds an over tired, over stimulated, or frightened toddler in order to calm him.

**Note: Theraplay is not a “holding therapy”**

- Containment is a response to a highly dysregulated child, not a planned event
- It only lasts until the child is calmer
- We do not deliberately provoke anger
- We do not share our feelings of frustration
- We do not use periods of containment to process earlier experiences

See more about calming touch and non-touch methods in the resistance handout.

**Working With Children Who Have Experienced Trauma**

If a child has been physically or sexually abused, we reduce our physical contact and proceed slowly. We continue to provide the Theraplay experience, but focus more on the safety provided by good Structure, or the confidence building provided by Challenge, while using less physical forms of Engagement and Nurture until a relationship is developed.

While the focus in most Theraplay sessions is on the here and now, a child who has experienced trauma may need us to identify not only the intense feelings he is experiencing at the moment, but also the past source of the feelings. For example, “It’s hard for you to let your Mom cuddle you like this because it reminds you of all the times when you were left alone in your crib when you were a baby. But we will make sure that you are safe right now. We can hold you and help you handle these feelings that come up. We can help you get used to your Mom taking good care of you.”

We concur with the statement about touch made by The Association for Play Therapy (2001): “The use of touch is not automatically excluded because a child has experienced trauma regarding bad touch but the therapist needs to be even more vigilant in monitoring and managing the child’s perception and experience of being touched. The symptoms and maladaptive coping strategies the child develops may be appropriately treated with touch. A conscientious play therapist is ever vigilant not to re-traumatize a child and understands that the child, in order to heal, may need to experience safe, good touch. As always, the use of touch is integrated into the treatment plan.”

In Theraplay, the goal is to touch carefully and respectfully, to touch only to meet the needs of the child, and with a full recognition of the effect that touch has on the child. We at The Theraplay Institute are not aware of any child ever being harmed by the physical contact of Theraplay sessions.
Touch and Working with Parents
Parents always are active participants in Theraplay treatment. Our goal is that parents be able to provide the touch, nurture and regulation that their child needs. However, at the beginning of treatment, the Theraplay therapist will be the more active member of the team and initiate these interactions, for the following reasons:

• To provide a model for a new way of interacting for this particular parent and child
• To get past the child’s initial resistance so that the parent’s first experience with the new kind of interaction is positive
• To help parents who are unsure of themselves or uncomfortable with touch to gain confidence.

We want parents, as soon as possible, to carry on the attuned, playful interaction at home. We therefore carefully assess the parent’s capacity to do this safely, particularly all aspects of appropriate touch. We do not embark on Theraplay treatment with parents who are abusing substances or who intentionally hurt their children.

If parents question the reason for physical contact or have difficulty touching or appropriately containing the child, we, again, move very slowly until we develop a relationship with them and better understand their interaction with the child.

References:
How Theraplay® Can Be Adapted For Traumatized Children

Treatment Needs Of Traumatized Children
Need to feel safe and be comforted by a trusted caretaker
Need to understand and resolve issues related to Trauma
Need to reestablish trust
Need to modulate affect
Need to change self-image from negative to positive
Need to be empowered to stand up for self. Need to experience good touch
Need to repair the disrupted attachment relationship
Need to teach both parents and child to play together

Adapting Theraplay for Traumatized Children
- While maintaining a comfortable, self-assured stance, increase your sensitivity to child's response. If child seems uncomfortable, acknowledge his discomfort and try another approach.
- If the child is fearful, acknowledge that you see he is frightened and that you think this must be because he has been hurt in the past, but that his new caretakers and you are going to make sure that he is safe.
- Have trusted caretakers in the room. Have them make the initial physical contact with a particularly frightened child.
- Avoid a tentative, questioning approach that implies that the child might not be safe with you.
- Slow down, talk softly, and make sure the child is not overwhelmed.
- Use touch that is matter-of-fact, non-threatening, soothing, and calming. Include safe touch in many activities.
- Empower the child to say no. Engage the child in activities that give her a chance to feel her strength, to use her body to push you away, to be assertive.
- If child has been taught that people must ask permission to touch her, affirm that that is a very good rule to protect her from people who do not respect her. Her parents and her therapist respect her very much and will help her learn how to accept good touch from them.
- Above all, be playful and engaging. Convey the message that the child is a delightful, strong, interesting person and that you are a trustworthy, fun loving and caring adult.

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Theraplay For Children With Autism Spectrum Disorders
Susan Bundy-Myrow, Ph.D., Private Practice, West Seneca, New York
Sandra L. Lindaman, M.A., M.S.W., The Theraplay Institute, Chicago, Illinois


How can Theraplay help my child with Autism Spectrum Disorder (ASD)?

Regardless of age and developmental level, a child with ASD needs ways to engage with others in pleasurable, social interactions. Neurological problems including severe sensory reactivity and processing difficulties interfere with the child’s ability to engage in reciprocal social interactions. He has difficulty sending out signals to which others can respond, and then has trouble receiving information; i.e., comprehending social cues, and learning from experience. Theraplay is a focused way to play with the child. It gives the child experience interacting with another, and gives the parents tools for engaging a child who may find it more comfortable to withdraw.

What actually happens in a session?

The therapist and child usually sit on the floor across from one another, to allow maximum eye contact and physical interaction. The therapist leads the child through a series of engaging, playful activities such as blowing and popping bubbles, squishing soap-foam balls, pulling slippery lotioned hands, catching a bean bag dropped off the head, playing a push-me-over, pull-me-up game, guiding the child through a song with hand motions, rocking in a blanket, or feeding the child a treat. Parents join the session and are encouraged and coached to complete the same activities.

My child would prefer to play alone or with certain toys; is it good to force her to play this different way?

Most children with ASD are distressed at first when we attempt to interact with them and guide their play. We believe that allowing them to withdraw only deepens their isolation and gives them less experience with others. Theraplay therapists are very sensitive to the child’s reactions. When a child is upset, we soothe and gently encourage her. We have found that if we are persistent and playful as we try to engage the child, he will show brief signs of enjoying the interaction even during the first session and usually overcomes his discomfort within a few sessions.

Is Theraplay a kind of behavior modification?

Theraplay does attempt to change behavior, but in a more social way than many behavior analysis programs. Theraplay goals include: increasing eye contact, increasing attending and turn-taking, adjusting to transitions, finding ways to soothe and comfort the child, determining the optimal level of arousal to promote engagement, and stimulating communication. A behavioral specialist who worked with several children after they attended Theraplay sessions commented that these children were more ready to work with her than children who had not attended Theraplay.

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My child attends many different therapies, how does Theraplay differ from them?

Children with ASD usually receive various kinds of special assistance including speech-language therapy, occupational therapy, sensory integration treatment, tailored educational services, and behavior modification programs. These programs have their own important goals, but may not focus as directly as Theraplay on social interaction. The skills that Theraplay treatment focuses on are necessary for participation and success in other kinds of treatments. Children may receive Theraplay as their first kind of treatment: they may receive Theraplay at the same time as other services with all treatments carefully coordinated; or children may come to Theraplay later when parents and other specialists realize that social skills are not progressing adequately.

What evidence do you have that Theraplay works?

Theraplay has been used with children with ASD since its development thirty years ago and we have a great deal of positive clinical experience. There have been published accounts of single case studies and a recent controlled study of parent-child Theraplay in Korea. Currently, research data on Theraplay is being collected across the U.S., in Canada, and in Finland. Parents, therapists and teachers regularly report significant progress made by children when Theraplay is introduced; for example, special education teachers have reported that children who had received Theraplay in their primary school-aged class the previous year entered their new class better able to adjust to routines, “bond” with the teachers, and be cooperative with peers.

Is Theraplay ever done in a group or at school?

Direct work with the child and her parents has the greatest impact and usually is conducted first.

As Theraplay progresses, sometimes siblings participate in treatment sessions to help them interact more effectively and have more fun with their brother or sister with ASD. As you can imagine, other children usually are “natural” Theraplay therapists. As the child with ASD increasingly becomes aware of self and others and predictably finds comfort and pleasure in the structure of his environment, goals may extend to include peers through Group Theraplay. Theraplay for groups of older children can offer the opportunity to give and receive in a safe, accepting setting, increase comprehension of social conventions, and practice social competence in a fun, friendship-enhancing context. Theraplay for children with ASD has been conducted in private practice, community based centers, and public schools by psychologists, social workers, counselors and teachers trained in the Theraplay method.
Theraplay Groups

What is a Theraplay Group?

A Theraplay Group is an adult-directed, structured play group in which all the participants, adults included, are actively involved together in pleasant, enjoyable activities. Through the use of cooperative and often nurturing games, a Theraplay Group fosters a child's self-esteem, the sense of belonging, the ability to care for oneself and others and the opportunity to develop increased trust. The four rules of a Theraplay Group -- NO HURTS, STICK TOGETHER, HAVE FUN, and THE ADULT IS IN CHARGE -- provide the framework for group experiences that are structuring, challenging, engaging, nurturing and playful. Within this atmosphere of fun, caring, acceptance, and encouragement, children are able to grow socially, emotionally, and often intellectually as well.

Which Children are Appropriate for a Theraplay Group?

Theraplay Groups are for children who have unmet emotional needs: children who are withdrawn or quiet, overactive-aggressive or bossy, frightened or shy, compulsive or rigid. Children with learning problems, speech-language problems, intellectual deficits, and/or academic problems may also have associated emotional problems. Coming from broken homes or with working parents, and under growing pressure to achieve and perform, modern-day children can benefit from the experience of being appreciated not for what they accomplish, but just because they ARE.

What are the Benefits of a Theraplay Group?

Theraplay is a DOING rather than a talking experience. It is important to attend to not only what the children SAY, but to what they DO. When the needs of children for structure, engagement, nurture and challenge are attended to, the children begin to internalize this experience and extend it toward others spontaneously. Rather than using external controls, a Theraplay Group promotes internal self-control and the desire to relate appropriately. Instead of being suppressed, problems are allowed to surface so that the leader and group members can help children take in the positive experiences offered. Because a Theraplay Group is playful and upbeat, it appeals to children. It also can be a way to "teach" social and communication skills to older children. Finally, it is an excellent way to bring fun and exuberance into the lives of all children.

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Theraplay Research Update July 2011

Theraplay achieved evidence-based status December 2009
Theraplay has been rated as demonstrating “promising research evidence” by The California Evidence-Based Clearinghouse. Its rating of 3 on a 5-point scale means that Theraplay meets the following standards:
1. No empirical or theoretical evidence exists that Theraplay has a substantial risk of harming clients as compared to its possible benefits.
3. Two peer-reviewed studies utilizing some form of control have been published.
4. The outcome data support the benefits of Theraplay.

Published research in peer-reviewed journals:

Other research pending publication:
• Howard, A. R., An evaluation of Theraplay using a sample of children diagnosed with Pervasive Developmental Disorder (PDD) of mild to moderate autism. TCU Institute of Child Development, Department of Psychology, Texas Christian University.
• Salo, S., Makela, J., Flykt, M., Biringen, Z. Does Theraplay increase emotional availability among substance-abusing mothers and their infants?
• Weir, K., Whole family Theraplay for adoptive families. California State University at Fresno (submitted for publication).
Other publications:

The Theraplay Institute is committed to research
The Theraplay Institute is committed to supporting research in Theraplay. This includes Individual/Family Theraplay, Group Theraplay, and Whole Family Theraplay. We support research in multiple ways: Providing Theraplay and MIM training to therapists involved in research projects. Providing Theraplay and MIM supervision to therapists and onsite supervisors. Providing funds toward worthy studies. Providing consultation in the development of research projects on Theraplay.

We invite clinicians, researchers and graduate students studying attachment and attachment therapies to contact us at gayle@theraplay.org.
Recommended Readings about Theraplay


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The Use of Theraplay®
A Service Mark of The Theraplay Institute

Theraplay® is a registered service mark of The Theraplay Institute. A service mark is a word used by an entity to identify and distinguish its services from the services of others and to indicate the source of those services. Thus, The Theraplay Institute owns the rights to the service mark Theraplay® and therefore has the right to control its use. What follows is a description of appropriate ways to use the Theraplay® service mark.

First, any reference to Theraplay®, whether describing the activities, training, or theory of the Theraplay® model, should include an indication that it is a registered service mark of The Theraplay Institute. This can be accomplished by including the letter R enclosed in a circle, thus ®, next to Theraplay. In addition, the following phrase should be included (possibly as a footnote): "A registered service mark of The Theraplay Institute 1840 Oak Avenue Suite 320 Evanston, IL 60201."

Second, we encourage those who attend Theraplay workshops, to use the Theraplay principles and techniques in their own setting.

- After attending one or two Theraplay workshops they can describe what they are doing as based on Theraplay® principles, but cannot say that they are doing Theraplay or conducting Theraplay sessions.
- If they are in the process of the supervised practicum, they can say that they are working toward certification as a Theraplay® therapist.
- After completing the supervised practicum and all other requirements for Certification, they can call themselves Certified Theraplay® Therapists and refer to their practice as Theraplay®.

Once trainees become Certified, they can use the Theraplay® name in written statements about their practice. Reference to Theraplay in written statements in agency brochures, business cards, private practice advertising, and other published material should be followed by the service mark registration notice symbol ® and footnoted with the following phrase: "A registered service mark of The Theraplay Institute, 1840 Oak Avenue Suite 320 Evanston, IL 60201."
Presentation Objectives & Evaluation

*Circle the number to indicate your level of agreement/disagreement with the degree to which the presentation objectives were met:*

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<thead>
<tr>
<th>Objectives</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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<td>1. Knowledge of the Theraplay model and its roots in attachment theory</td>
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<td>2. Knowledge of how the Theraplay dimensions of Structure, Engagement,</td>
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<td>Nurture and Challenge are used to meet children’s needs and address</td>
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<td>behavior problems.</td>
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<td>3. Knowledge of how Theraplay interactions are conducted with</td>
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<td>preschool and school age children, and children with attachment,</td>
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<td>regulatory, and developmental problems.</td>
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<td>4. Knowledge of how parents are guided as they participate in Theraplay</td>
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<td>5. Introduction to use of Theraplay in groups.</td>
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