Theraplay: A Therapeutic Intervention for Children and their Caregivers

by

Michelle Gerretsen

A practicum submitted to the Faculty of Graduate Studies

in partial fulfillment of the requirements for the degree of

Master of Social Work

Social Work

University of Manitoba

Winnipeg, Manitoba

© July 2003

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FACULTY OF GRADUATE STUDIES

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ABSTRACT

Theraplay is a short-term, goal oriented treatment model used to work with children and their caregivers for a wide range of difficulties seen in the parent-child relationship. This model primarily focuses on how to enhance the interactions and the relationship between the child and caregiver through attachment-based play (Jernberg & Booth, 1999). Theraplay is not considered a "talk therapy" as it primarily focuses on attachment building/interactive activities between the parent and child. The caregiver plays a large role in the therapeutic sessions and is actively involved during the entire treatment process. Through play the theraplay model places emphasis on the importance of the child's health and strengths while also focusing on the healthy parent/child relationship (Booth & Koller, 1998).

This practicum was conducted at the Elizabeth Hill Counselling Centre and consisted of employing the theraplay model with 6 family systems. Each family was seen for an average of 12 sessions. Standardized measures the Child Behavior Checklist (Achenbach, 1991) and the Parenting Stress Index (Abidin, 1995) were used pre- and post-test to assist in measuring the effectiveness of the intervention. Overall, the results of the measures did not indicate significant changes as a result of the intervention. Case studies are presented in order to explain the process and to illustrate the strengths and limitations of the model.

ACKNOWLEDGEMENTS

This practicum report could not have occurred without the support and assistance of a great number of people. Each person contributed at different points in the process with their own unique perspective. I am especially grateful to Linda Perry who provided insightful and thoughtful supervision throughout my practicum. Her involvement as a co-therapist was an invaluable part of this experience for my learning. Also, Diane Hiebert-Murphy provided guidance through the entire process and provided good, constructive feedback in putting this report together. Furthermore, I would like to thank Lynne Pinterics who took the time to be a part of my practicum committee and the entire staff at the Elizabeth Hill Counselling Centre for providing a warm and supportive work environment.

Thank you also to my friends and family who took the time to read portions of this practicum report at various stages of the process. The extra sets of eyes were extremely helpful in picking up my oversights.

Most importantly, I want to thank the children and their caregivers who faithfully attended and were ready to play. Their participation greatly enriched my learning experience.

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INTRODUCTION

I began this practicum with the goal of developing clinical skills in working with children and their families. The theory of attachment and the implications of this theory for children and their family systems are of particular interest to me. Prior to beginning the Master of Social Work program at the University of Manitoba, I had worked in the field of child welfare for a couple of years. This experience initiated my understanding of the importance of the parent-child relationship and the impact that this relationship has on the future development of the child.

The primary aim of this practicum was to intervene with both children and their caregivers. The goal of the therapeutic process was to increase the positive interactions within the family system, thereby strengthening the relationships of the family members. The Theraplay model of therapeutic intervention was the primary model used for this practicum. However, it should be noted that various interventions were employed depending on the individual needs of the clients while acknowledging the various systems that they interact with in their daily lives. In the following section I will discuss the rationale for working with the family system and the objectives of this practicum.

Rationale and Objectives

The quality of the relationship between a parent and a child is important for the child's emotional, physical, and social development (Fahlberg, 1991). The

development of an attachment to a caregiver is important since it will play a role in how an individual is able to form future relationships, feel a degree of trust and stability within those relationships as well as develop a sense of her/his own self concept and self esteem (Booth & Koller, 1998). A healthy parent-child relationship provides the child with a secure attachment, which will result in an increase in the child's levels of resilience, independence, empathy, and social competence (Fahlberg, 1991). Furthermore, this relationship allows the child to learn basic trust and reciprocity in forming relationships. Through the process of attachment children also develop the ability to "self-regulate" which occurs when the child is able to effectively manage her/his impulses and emotions (Levy & Orlans, 1998). Children who have an insecure attachment will often show behaviours that are impulsive, oppositional, aggressive, and lack empathy; they may also be unable to give and receive love and affection (Levy & Orlans, 2000).

The importance of the parent-child relationship has been well documented in the literature. According to Fahlberg (1991), numerous studies of children raised in institutions indicate that physical care alone is not adequate for a child's overall physical and psychological development. Children require that both their physical and emotional needs be met; this can occur when there is a primary caregiver who is attuned to the needs of the child (Fahlberg, 1991). Furthermore, Levy and Orlans (1998) state that studies have indicated that children who are cared for without physical touch and nurturance have been shown to have abnormally high levels of stress hormones in the brain, which may impact on their growth and development.

An attachment is a bond that both a primary caregiver and the child "create" together in an ongoing reciprocal relationship (Levy & Orlans, 1998). This relationship is often called a "mutually regulatory system" where the infant and caregiver influence one another over time (Levy & Orlans, 1998). The reciprocal behaviours that a child and caregiver engage in form the basis of the attachment relationship. When a child has difficulties forming a secure relationship to a caregiver, she/he is at a greater risk of reduced learning during her/his formative years of life (Fahlberg, 1991). The learning that occurs during the first years of a child's life is dependent on the life experiences the parent can give the child (Fahlberg, 1991). Strengthening and fostering a healthy relationship between a child and her/his caregiver(s) is considered important for the child's overall development and functioning.

A child's level of attachment can be affected by a number of different factors. These may include loss or death of a caregiver; abuse or neglect by a caregiver; physical or psychological illness of a caregiver; and physical, psychological, or developmental limitations of children that inhibit their ability to respond to their caregivers (Booth & Koller, 1998). The parent-child relationship itself is influenced by a number of societal/contextual factors. Poverty, unemployment, lack of social support, and isolation are examples of external factors that can cause parental stress. This parental stress may affect the care that is given to the child, which in turn will impact on the quality of the parent-child relationship.

According to Luster and Okagaki (1993), a parent's level of social support, the level of parental stress, and the quality of the marital relationship have been found

to be predictive of attachment levels. Furthermore, individual differences in parenting behaviour are influenced by a combination of personality characteristics, skills, maturity, values, and child rearing beliefs (Luster & Okagaki, 1993). It is the interrelatedness of these factors that can impact on the care a child will receive. Therefore, understanding how these factors interrelate and how they can impact on the parent-child system is important to clinical practice with families.

Social workers attempt to assist parents and children by intervening with individuals, families, and the various systems to which they are connected. A primary theory, which guides social work practice, is the ecological systems theory. The ecological approach holds that an individual must be understood within the context of her/his environment and that a large part of an individual's environment is her/his family (Greene, 1999). According to Boyd Webb (1996), there is the interplay of many different influences in the lives of children, that is, their "...biological/temperamental/developmental status, the familial/cultural context, and the physical and social environment..." (p. 4). All of these factors will impact on their growth and development. When working with children, these influences must all be considered in order to employ the most appropriate interventions.

This primary focus of this practicum was to employ the Theraplay model of intervention when working with children and their caregivers. This model is a good fit for a social work perspective as it views the family and their interactions as the primary focus for intervention. Historically, the profession of social work

has placed a high value on understanding and working with the family unit in order to bring about change. The roots of social work as a profession saw the family as a main focus of attention and intervention (Hartman & Laird, 1983). At the turn of the century, Mary Richmond in her book *Social Diagnosis,* identified the strong need for social worker to provide treatment to the entire family and emphasized that when understanding the family they should not be isolated from the context of their environment (Nichols & Schwartz, 1998). It was her view that the relationships family members have is essential for their survival and well-being, and therefore, the family must be considered as its own unit (Nichols & Schwartz, 1998). It has been the prevailing view in social work that the individual is best understood within the context of the systems she/he is apart of; the family is considered a very important system (Hartman & Laird, 1983). Over the course of time, the profession of social work has shifted its focus of intervention from the family to the individual at various times depending on the political climate and philosophy of the time (Hartman & Laird, 1983). However, from a systems viewpoint the family is a very necessary unit to understand when assessing the needs of the individual and family to determine appropriate interventions.

The model of Theraplay is based on the interactions of the healthy parent-child relationship (Jernberg & Booth, 1999); and therefore, this model places emphasis on the interactions of the members of the family unit. Theraplay is a model that fits with the social work perspective, as the child is not seen in isolation but with her/his parents who are an integral part of the therapeutic process. The emphasis

is placed on the functioning of the family members through increasing the positive and playful interactions. A number of play therapy models focus solely on interventions with the child. With the child as the primary focus there is the risk of pathologizing the child. The Theraplay model takes a greater systems focus, which allows for a better fit with social work values and practice.

Gaining an understanding of the types of interactions that occur between a parent and her/his child, and the impact of these interactions on the relationship, will assist in developing and implementing appropriate interventions that may best meet the needs of the client system. According to Fahlberg (1991),

> An understanding of how child and parent behave when there is normal attachment and bonding between them is the basis for an assessment of the strengths and weaknesses of family relationships. Social workers need to be able to facilitate the development of stronger intrafamilial relationships (p.19).

One must also acknowledge that attachment is formed within the context of many interrelated systems that affect the family's system (Levy & Orlans, 1998). Therefore, other systems such as the child's immediate and extended family, the community, and society will influence the relationship between the caregiver and child. In order to strengthen the parent-child relationship, interventions must be aimed at various systemic levels so that effective change may occur.

The objectives of this practicum have been organized into two categories. The first set of objectives are client-focused, that is, they relate directly to what the

practicum and intervention hoped to offer the client. The second set of objectives relate to my development in the area of clinical social work.

Client-focused objectives.

1. To create a safe and supportive environment for children and their caregivers within the context of a therapeutic setting.
2. To provide a safe, nurturing, and playful setting for the child so that she/he would experience the benefits of play.
3. To provide a supportive and a non-threatening environment for caregivers so that they would gain a better understanding of the emotional, social, and physical needs of their children.
4. To assist in the strengthening of the caregiver-child relationship through the incorporation of the principles of the therapeutic model of theraplay.
5. To provide a broad range of interventions that would depend on the needs of the family, thereby, acknowledging the many different systems that may affect and impact on their functioning.
6. To provide a positive adult role model to children and their caregivers.

Personal objectives.

1. To gain a better understanding of the needs of children and their caregivers in the context of the therapeutic relationship.
2. To develop clinical skills when working with children and families.
3. To gain a better understanding of the theoretical knowledge associated with providing clinical service to children and their families.

4. To provide effective service to children and their caregivers in order to enhance the caregiver-child relationship.
5. To evaluate the effectiveness of the Theraplay intervention model by utilizing various research methods.

LITERATURE REVIEW

The Importance of Play

Play is an important and necessary element in the lives of children, as it impacts on their emotional, social, and physical development. Play is pleasurable, spontaneous, voluntary, and usually with no ending or goal (Reid, 2001). It is the primary and most significant way a child learns (Nickerson & O'Laughlin, 1983). Children require a wide range of play experiences in order to foster areas of healthy development (Oppenheim, 1984). When children engage in play they are learning about their immediate environment, which in turn influences their perception of the world (Oaklander, 1988). Oaklander states (1988), "Through the safety of play every child can try out his own new ways of being" (p. 160). According to O'Connor (2000), engaging in play serves a number of different purposes for the child in her/his development. Play gives the child an environment to learn basic skills, expends energy, which facilitates relaxation, and allows the child the opportunity to become aware of her/his own affect as well as responding to the affect of others (O'Connor, 2000). Furthermore, the process of play allows infants to learn muscle control and coordination, which will also build on their successes and sense of competence as they move through the developmental stages of life (Oppenheim, 1984).

For children who are between the ages of 3 and 5, play is an important part of their life experience as it serves to develop both their verbal and representational

skills (O'Connor, 2000). Play also assists children in developing conflict resolution skills, empathy, and moral values (O'Connor, 2000). For infants, play is seen as a process that allows infants to cope with anxiety that is produced when the child is discovering her/his independence and separate identity in the world (McMahon, 1992). In this sense, play is seen as a "safe refuge" for the child as she/he can engage in playful interactions while relying less heavily on verbal interactions (Boyd-Webb, 1991).

Play is also considered a part of exploration, which assists children in developing understanding and competencies about themselves and their environment (Howe, Dooley, & Hinings, 2000; McMahon, 1992). Through engagement in play the child is able to explore her/his own strengths, and competencies and gain a sense of mastery (McMahon, 1992). When a child is able to learn and gain a sense of self-esteem and self-respect this will be reflected in relationships and understanding of the external world (Axline, 1964).

In the area of clinical work with children, play serves a function as it is often used by therapists to build rapport and begin a therapeutic relationship with the child (Boyd-Webb, 1991). Play is interactive and it allows the therapist to engage the child in an interaction with which the child is typically familiar. Play can serve as an initial vehicle that allows the adult and child to connect and build rapport, which in turn assists in facilitating a therapeutic relationship.

Play Therapy

As with other therapeutic models, the initial model of play therapy evolved out of Freud's psychoanalytic model (O'Connor, 2000). Since the 1920's, Anna Freud began to incorporate the use of games and toys into her therapy sessions in an effort to assist in establishing a relationship with her child clients (Boyd-Webb, 1991). The work of Anna Freud and Melanie Klein produced the theory and clinical practice of psychoanalytic play therapy (Gil, 1991). Play therapy has undergone many transformations and a number of different theoretical models have evolved and adapted based on their theories. Play therapy is based on both psychodynamic and developmental principles (Boyd-Webb, 1991). Play therapy is used to help children relieve distress or stress by incorporating a variety of imaginative and expressive play materials (Boyd-Webb, 1991) and is based on the relationship and interactions between the therapist and the child.

According to O'Connor (2000), there are four core models of play therapy, namely: psychoanalytic, humanistic, cognitive-behavioral, and developmental. O'Connor acknowledges that over the past few decades there has been an influx in the number of theoretical play therapy models and that most of these fall into these four categories (O'Connor, 2000).

Psychoanalytic play therapy evolved from Freud's psychoanalytic model. This model places a great deal of emphasis on the individual and the various theories of personality. According to this model, "pathology" occurs for an individual based on conflicts that occur within her/his personality (O'Connor, 2000). This approach relies heavily on verbal interactions between the therapist and client and

is highly insight oriented (O'Connor, 2000). It is the therapist's role to offer insight and interpretation to the client and in theory this insight will bring changes in behaviour. Play is used to engage the child in a therapeutic relationship and it is also used as a medium in order to analyze and interpret the child's thoughts and feelings (O'Connor, 2000).

Humanistic play therapies include child centered play therapy and filial therapy. Both evolved out of the work of Carl Rogers who was breaking away from ideologies of the psychoanalytical model (O'Connor, 2000). The humanistic approach tends to view the individual as a product of vast and diverse experiences that occur throughout her/his life (Axline, 1964).

Virginia Axline developed child-centered play therapy from the principles of Carl Rogers. This approach sees the environment as playing a major role in the shaping of the individual. The therapist sees the environment as the cause of any problematic/symptomatic behaviours (O'Connor, 2000). This approach takes the position that if the environment is meeting the needs of the child, she/he is able to strive for self-actualization and will not likely engage in problematic behaviour. Adults are seen as responsible for providing an environment that enables the child to achieve self-actualization (O'Connor, 2000). This approach believes that children are constantly moving towards growth, independence, mental health, and autonomy, which all together form self-actualization (Landreth & Sweeney, 1997). The goal is to provide the child with an optimal environment through play therapy sessions. This is a non-directive approach that focuses on following the child's play, engaging in verbal and play interactions, reflecting back to the child

her/his behaviour and emotions, providing empathetic responses, and setting appropriate limits within the therapeutic environment (O'Connor, 2000). The goal of the therapist is to provide the child with a healthy atmosphere while engaging the child with warmth and empathy. The therapist does not engage in judging or evaluating the child's behaviour but rather in accepting and respecting the child for who she/he is (Landreth & Sweeny, 1997).

Filial therapy is an extension of the child-centered approach developed by Virginia Axline. The difference in this type of therapy is that the parents/caregivers of the child as well as the child him/herself play a role in the therapeutic process. The parents are taught the child-centered therapy approach so that they may replicate this type of interaction with the child in their home environment (Guerney, 1997). A great deal of emphasis is placed on the principles of empathy and acceptance and working with the child always takes priority (Guerney, 1997).

Cognitive-behavioural play therapy is an example of a model that falls into the behavioural category. This therapeutic approach looks at the interaction of an individual's cognitions, emotions, behaviours, and environment (O'Connor, 2000). Cognitive-behavioural play therapy incorporates cognitive and behavioural interventions within a play therapy context (Knell, 1997). This approach does not rely on a personality theory but focuses on "psychopathology" and attempts to change the factors that may be causing problems (Knell, 1997). Any disturbances or disruptions in behaviour are thought to be caused by "maladaptive" thoughts (Knell, 1997). Therefore, the goal for therapy is to

identify the "maladaptive" thoughts and restructure them. This approach takes the position that it is the individual's cognitions that will determine her/his experience (Knell, 1997). Reinforcement is a key element and behaviour problems are thought to arise due to inconsistent patterns of reinforcement by the significant people in the child's life (O'Connor, 2000).

Cognitive-behavioural play therapy can be characterized as being brief, structured, directive, and problem-oriented (Knell, 1997). One of the therapist's roles is that of being an educator (Knell, 1997). The use of play activities and props are often used in an effort to communicate with the child, which may be direct or indirect (Knell, 1997). This type of therapy relies heavily on verbal interactions between the child and therapist and language is seen as an important mediator of the child's behaviour (O'Connor, 2000).

Developmental approaches include Viola Brody's developmental play therapy and Ann Jernberg's Theraplay model. The Theraplay approach will be explored at greater length in upcoming sections. Both of these models are considered to be brief, directive, and structured. The use of physical contact and a re-creation of healthy parent-child interactions take the form of play therapy (O'Connor, 2000). It is the position of the Theraplay model that recreating the healthy interactions of the parent and child will impact positively on the child's mental health (O'Connor, 2000).

Eco-systemic play therapy has been created by integrating different principles and techniques of existing theoretical models in order to view the child within the context of her/his eco-system (O'Connor, 2000). This perspective emphasizes a

developmental approach by viewing a child's developmental level as an important element to take into consideration when providing interventions. It assumes that a child is affected by a number of different systems in her/his life and that the impact of these systems needs to be acknowledged and worked with in order to bring about change (O'Connor, 2000). According to this perspective, any difficulty that may occur with the child is dependent on the quality of interactions she/he has with others who are part of the systems in her/his life (O'Connor, 1997).

The goal of eco-systemic play therapy, as with other models, is to ensure that the child's needs are being met. However, this is done by assessing and intervening in the systems that affect the child's life (O'Connor, 1997). This can also take the form of the child understanding her/his life situation from alternative perspectives (O'Connor, 1997). Therefore, interventions may not necessarily be directed entirely to the child client but with other systems that may be impacting on the child, including the family and the school.

This section has provided a brief overview of the different theoretical models of play therapy. Later sections will explore the Theraplay model of therapy in greater detail and the benefits it has to offer particularly in strengthening the parent-child relationship.

Critique of Play Therapy

A criticism of the wide range of play therapy models is that they tend to focus on interventions with the individual child with relatively little attention given to

the other elements or systems that are a part of the child's life. By therapy or interventions focusing solely on the child there is the risk of "pathologizing" the child when other more effective interventions may lie within the other areas of the child's life. According to O'Connor (2000), one of the major developments in the field of mental health over the past couple of decades is that more often clients are not seen to exist in isolation but as a part of a larger system. O'Connor (2000) states, "...the systemic unit thought to change as a result of treatment varies from the dyad, to the family, to the social network, to the community, to some broader network of interlocking systems" (p. 58). Although there is an acknowledgement of viewing the client within the context of multiple systems, typically clinical interventions are primarily focused on the individual rather than using a systems approach. Incorporating an ecological-systems perspective when working with clients allows for an acknowledgement of the various and diverse systems that may impact on an individual and the family system. Furthermore, by adopting a system's perspective there is the belief that changes in one system will have an impact on other systems that are involved in the life of the individual.

Social work practice is in large part guided by the ecological systems theory. According to Greene (1999), an ecological approach is an extension of contemporary social work as the profession's concern is both the interests of the individual and her/his environment. Urie Bronfenbrenner pioneered the ecology-based theory, which emphasizes the importance of the individual's interactions with her/his environment as necessary for human development (Garbarino, 1983). The primary assumption of this theory is that a person and her/his environment

are considered inseparable and in order to be understood must be considered jointly (Greene, 1999). Bronfenbrenner created a model that explores the parents' capacity to meet the developmental needs of their children by examining external factors that influence their lives such as quality of social support, quality of the community's resources, quality of child care, and workplace stresses (Jack, 2000). This theory takes into account the many different transactions individuals have in their environment that impact on their lives. According to Bronfenbrenner, the interaction between the individual and her/his environment is reciprocal in that both impact each other (Garbarino, 1983) and reciprocally shape each other (Greene, 1999). Therefore, this theory implies that not only does the environment impact the individual but also the individual restructures her/his environment depending on these interactions (Garbarino, 1983). In order to promote healthy development for children there needs to be positive interactions not only with the family system but also in the larger community and social systems.

The play therapy models discussed in the previous section on the whole do not fit well with an ecological-systems and social work perspective. However, Kevin O'Connor's ecosystemic play therapy model is a closer fit to a social work perspective as there is the acknowledgment and the development of interventions that are aimed at the broad range of systems in the child's life (i.e. family, school, community).

When working with children and their families it is important to incorporate interventions that have an ecological systems perspective. As there are many contextual factors that impact on the family and the parent-child relationship,

interventions that take into account the diverse systems in a family's life are essential in order to best meet the needs of the client.

The following sections will take a closer look at the Theraplay model of working with children and their caregivers. This model takes a broader approach as the child as a client is not seen in isolation from her/his family system. Since the family is the primary support system for the child it is important to incorporate the family into the therapeutic intervention. Furthermore, depending on the needs of the family, further interventions at the family level must also be considered.

Origins of Theraplay

Theraplay was created and developed by Ann Jernberg in the late 1960's as a response to the challenges that resulted in providing psychological treatment to pre-school children in Chicago's Head Start Program (Koller & Booth, 1997). At that time, Jernberg was the clinical director of the Head Start Program where many children had been identified for psychological treatment and were in need of services (Myrow, 2000). During that time, Jernberg began to formulate the strategies that would eventually become known as Theraplay. This approach took a model of the healthy parent-child interaction and the elements of what is now known as developmental play therapy to form the Theraplay model (Jernberg & Booth, 1999).

Theraplay is considered to be one type of developmental play therapy that evolved out of the earlier work of Austin Des Lauriers and Viola Brody. Viola Brody was a colleague of Ann Jernberg and initially introduced the model of

developmental play therapy. Developmental play therapy is considered a "close cousin" of Theraplay, in which sessions are structured while emphasizing physical contact and touch between the therapist and client (O'Connor, 2000). Touch is a central component of developmental play therapy and is considered a core element in the relationship between mother and child (Brody, 1997). The work of Des Lauriers impacted the Theraplay model since he placed a great deal of emphasis on the "here-and-now" in the therapist-client relationship and incorporated the physical and intrusive approach to the therapeutic process (Booth & Koller, 1998).

Theraplay

Theraplay is a short-term, goal oriented treatment model used to work with children and their caregivers. This model primarily focuses on how to enhance the interactions and the relationship between the child and caregiver through attachment-based play (Jernberg & Booth, 1999). Theraplay is not considered a "talk therapy" as it primarily focuses on attachment building/interactive activities between the parent and child. The caregiver plays a large role in the therapeutic sessions and is actively involved during the entire treatment process. Through play the Theraplay model places emphasis on the importance of the child's health and strengths while also focusing on the healthy parent/child relationship (Booth & Koller, 1998).

The Theraplay therapist emphasizes creating and increasing positive interactions within sessions that are playful, interactive, fun, and energetic

(Jernberg & Booth, 1999). The focus of treatment is on structured and directed play activities by the therapist (Jernberg & Booth, 1999). While traditional forms of play therapy focus on the child's feelings and level of understanding of events that have occurred in her/his life, the Theraplay model focuses on developing stronger relationships with relevant others. Proponents of this model advocate that this focus will assist the child in her/his emotional development and ability to form lasting relationships (Jernberg & Booth, 1999).

One goal of the Theraplay model is to assist parents in understanding the issues that may impact a child. The parents being more attuned to their child's needs will assist in improving the quality of the relationship between the parent and child (Booth & Koller, 1998). Other goals of this treatment model are to enhance attachment, self-esteem, and trust in the child and caregiver; and to empower caregivers to implement the activities and interactions into their daily routines (Jernberg & Booth, 1999). Providing parents with the tools to interact with their children in a positive way is an important element of the Theraplay model. The Theraplay model is based on the interactions between parent and child that lead to healthy development. This theory assumes that interaction between a parent and a child is reciprocal and that the behaviours of both participants influence the other (Booth & Koller, 1998). It does not matter who initiates the behaviour. According to Booth and Koller (1998), this is an important element as it takes blame away from the problem and gives the caregiver(s) the power to change the situation.

The next two sections will discuss the contributions of attachment theory and as well as a critique that emphasizes the impact of contextual factors on the parent-child relationship. A discussion of attachment theory is important since the Theraplay model has its roots within this theory. As well, understanding the impact of contextual factors is important in addressing the limitations of Theraplay and is the basis for the eco-systemic approach taken in this practicum.

Attachment Theory

The Theraplay model relies heavily on attachment theory and the research and information it has contributed to the area of child development (Booth & Koller, 1998). Vera Fahlberg (1991) in her book A Child's Journey Through Placement provides a definition of attachment as "an affectionate bond between two individuals that endures through space and time and serves to join them emotionally" (p. 20). The development of an attachment to a primary caregiver is an important part of a child's developmental process. Literature on the theory of attachment indicates that children who experience safety and security with a responsive and available caregiver are more likely to be autonomous as they develop (Levy & Orlans, 1998).

John Bowlby pioneered the notion of attachment in the 1950's. It was his studies of homeless children and children with severe emotional problems that led him to believe that a child's relationship with her/his mother was essential to her/his psychological and social development (Levy & Orlans, 1998). Bowlby was one of the first psychiatrists of his time to emphasize and acknowledge that

humans have an instinctive need to be close with others (Myrow, 2000) and that this need is on the same level as physical needs such as food, shelter, etc. (Howe, 1997). Bowlby (1982) described this as humans having a number of behavior systems that promote survival. As infants are young and vulnerable they have a natural instinct to be protected and will seek this from a primary adult figure (Bowlby, 1982). His view that familial interactions were important to a child's emotional development was considered controversial at the time when the prevailing view was that children's individual experiences formed the basis for how they saw themselves and the world (Goldberg, 2000).

Bowlby believed that the early relationship a child has with a caregiver provides the basis for a prototype for subsequent relationships. He introduced the notion of an "internal working model", which is developed at a young age through the experiences and interactions a child has with a caregiver (Booth & Koller, 1998). These "internal working models" serve as templates for children to process information and help them make sense of their environment (Howe, 1997). The internal working model is considered an unconscious representation of how they perceived their attachment figure (Bolen, 2000). There has been great debate amongst attachment researchers and mental health professionals as to how fixed or flexible these internal working models are as the child grows older. It is believed that the working models are changed and revised through the experiences the individual has (Bolen, 2000; Goldberg, 2000).

Mary Ainsworth took Bowlby's influential work on attachment a step further by introducing the concept of a "secure base". Ainsworth believed that in order

for a child to develop a secure attachment she/he must have one caregiver who is a "secure base". Having an individual who is considered a "secure base" allows the child to explore her/his environment independently and without anxiety knowing that the caregiver will be there on her/his return (Levy & Orlans, 1998).

According to Levy and Orlans (1998), Ainsworth outlined five phases of attachment that will occur during the first year of a child's life. The first phase is called *Undiscriminating* where the infant does not show any discrimination amongst caregivers and will respond and engage with any individual; the second phase is *Differential Responsiveness* where the child will react to and prefer her/his primary caregiver; the third phase is *Separation Anxiety* where the child will cry when her/his caregiver leaves and is comforted upon her/his return; the fourth phase is *Active Initiation* where the child is upset when separated from her/his caregiver and will actively approach and follow upon her/his return; and the final stage is *Strange Anxiety* where between the ages of 6 to 8 months the child will show discomfort with strangers (Levy & Orlans, 1998).

The roots of a child's level of attachment with her/his caregiver are learned and developed during the first 3 years of the child's life (Levy & Orlans, 1998) and the period between the age of 6 months and 3 years considered the optimal time for children to form attachments (Golombok, 2000). However, it should be noted that more recent thinking has acknowledged that attachment continues to develop throughout life and is not fixed (Golombok, 2000). Furthermore, it is no longer thought that the mother must be the child's main attachment figure but that the primary attachment will be the individual most involved in caring for the child

(Golombok, 2000). According to Golombok (2000), it is now widely believed that children can attach to more than one person but that there is a "clear order of preference" for the child depending on who interacts and meets the needs of the infant the most.

An infant will develop trust and a secure attachment through the gratification of basic needs. Bowlby (1982) identified the following five patterns of behaviour that assist in the formation of the attachment process: sucking, clinging, following, crying, and smiling (Bowlby, 1982). It is through these behaviours and the caregiver's responses that the attachment between caregiver and child is formed. Levy and Orlans (1998) describe a number of specific behaviours in which a child and her/his caregiver engage in order to promote the level of attachment and bonding between the two that occurs during the first year. They are as follows:

1. Eye contact between the child and caregiver is essential as it promotes intimacy and closeness.
2. Touch and holding are essential for the child's physical and emotional development.
3. A smile is a powerful action as this engages the caregiver when the infant smiles and when the caregiver reciprocates this smile, it provides the infant with feelings of safety and security.
4. Movement also promotes attachment, as actions such as rocking are effective in calming and soothing the infant.

5. Responding to feeding cues also promotes attachment, as this is a basic survival need for the child (Levy & Orlans, 1998).

Levy and Orlans (1998) state that by having a consistent and stable caregiver the child is able to explore her/his environment with more confidence and less anxiety, resulting in enhanced self-esteem and stronger self-concept. Cooperation, caring, and empathy are all learned behaviours, which develop when a child has a secure attachment to a primary caregiver (Levy & Orlans, 1998).

Disruptions in a child's attachment can develop if children perceive their primary caretakers as unavailable and unresponsive to their needs (Jernberg & Booth, 1999). According to Howe (1997), a child's attachment level is dependent upon "…the physical and emotional availability, sensitivity, reliability, predictability, and responsiveness of the parent" (p. 8). A parent's inability to meet her/his child's needs may be due to a number of factors, such as stressful family and environmental circumstances, overwhelming health problems, or an inability to parent adequately due to the parent's own childhood experiences (Jernberg & Booth, 1999). Attachment behaviours form as a way of adapting to and coping with relationships the child has with others (Howe et al., 2000). Children will continually seek ways to adapt to and cope with the environment in which they live.

Through the work conducted by Mary Ainsworth, four categories of attachment have been identified; namely, secure, ambivalent, avoidant, and disorganized. It was through her research using what is now known as the Ainsworth Strange Situation procedure that an empirical base of knowledge began

for assessing parent-child interactions (Erickson, Sroufe, & Egeland, 1985). Ainsworth believed that attachment behaviour in a child would become more intense when there was a separation from her/his caregiver (Ainsworth, Blehar, Waters, & Wall, 1978). That is, the child would initially protest the separation and then actively seek out the caregiver (Ainsworth et al., 1978). Through observing the responses of the children to the separations, the four categories of attachment were identified.

A child who has a secure attachment typically has one caregiver who is warm, affectionate, consistent, and responsive to the child's needs (Jernberg & Booth, 1999). These children develop into infants who are affectionate and can be easily comforted and calmed when in distress. By the time they reach school age, securely attached children will demonstrate characteristics of flexibility, curiosity, social competence, and assertion (Jernberg & Booth, 1999). They also tend to be resilient, independent, and empathetic (Fahlberg, 1991). In the face of stressful situations, children who have a secure attachment will handle situations effectively or will request help from others in order to obtain a satisfactory resolution (Fahlberg, 1991). Children who have insecure attachments may have had caregivers who were unresponsive, unavailable, or hurtful (Levy & Orlans, 1998).

Avoidant attachments may occur after a child has experienced an environment that is chronically hostile and where a caregiver has been rejecting the attachment behaviours of the child (Howe et al., 2000). In response to this environment the child may adopt coping strategies where she/he will minimize the feelings of

distress and anger. These children have learned to behave in one manner while feeling another (Howe et al., 2000). Furthermore, avoidant attachments are characterized by the child seeking little physical contact, not responding to comforting, and displaying anger easily (Myrow, 2000). By the time these children reach school age they continue to avoid physical contact; they have little enthusiasm for relationships, and may become isolated (Myrow, 2000).

Children who have ambivalent attachments can be characterized as being anxious and clingy, and as having difficulty with brief separations from adults. As these children reach school age they continue to have difficulties being separated from adult caregivers and typically do not form friendships easily amongst their peers (Myrow, 2000). The caregivers of children who have ambivalent attachments have tended to be inattentive, unpredictable, and unaware of their child's needs (Myrow, 2000). There appears to be a lack of synchronicity between the child and her/his caregiver in terms of responding to and meeting the needs of the child (Howe et al., 2000).

Children who have disorganized attachments typically do not display a consistent coping style (Myrow, 2000). These children will behave in a disorganized manner. Sometimes they will be clingy and anxious with their caregiver and at other times they will behave ambivalently towards them (Myrow, 2000). Children with disorganized attachments have typically experienced significant trauma in their lives (Delaney, 1998).

Jernberg and Booth (1999) in their book Theraplay: Helping Parents and Children Build Better Relationships Through Attachment-Based Play, outline the

following typical behaviours that are associated with children which may indicate a disruption in their attachment level. They include:

1. *Problems relating to people* – children with attachment issues often have difficulties interacting with others. They are unable to get close to other people or they will show indiscriminate affection. Typically, these children have poor peer relationships and cannot maintain long-term friendships.
2. *Problems accepting care* – children who have attachment problems may have difficulty accepting care and nurturance from others; they may also be accident prone and engage in reckless behaviour.
3. *Problems with transitions* – change and transitions are extremely difficult for children who have attachment problems. Often the child's experiences with others has not been constant or predictable; therefore, the child will take comfort in her/his own routines in order to gain a sense of security and stability. Disruptions in these routines can upset the child.
4. *Lack of conscience* – children with attachment difficulties can engage in behaviours that appear to lack a sense of conscience. Cruelty to animals and people as well as stealing and lying are not uncommon behaviours amongst these children. Often there is a lack of empathy shown when engaging in aggressive behaviours.
5. *Emotional immaturity* – children with attachment difficulties may appear to be emotionally immature. They may engage in impulsive and aggressive

behaviors and will lack an awareness of other's needs. They may show explosive anger, which is often related to the insecure attachment.

6. *Problems with trust and self-esteem* – some children will have little confidence and trust in their environments and are clingy and immature while other children will show maturity and independence that is not typical for a child of her/his chronological age.

Children who have been identified as having a disruption in their attachment can also be superficially charming, engaging, and/or overly compliant (Levy & Orlans, 1998). The child may act in a passive manner and will comply rather than express her/his true needs and feelings. This is done in an attempt to avoid what may be perceived by the child as further conflict and, therefore, this is done to protect her/himself from traumatic experiences (Levy & Orlans, 1998). However, it should be noted that these behaviours can occur as a result of a variety of other factors or experiences that the child has had, such as trauma.

There are a number of developmental tasks that children need to accomplish as they grow. Children who have secure attachments tend to have greater success at achieving these tasks which include, for example, developing intimacy and reciprocity that will assist in healthy future relationships; developing a sense of identity that includes feelings of self-worth as well as a balance of needing dependency and autonomy; and developing healthy coping strategies in the face of stresses that promotes resilience and resourcefulness (Levy & Orlans, 2000). Longitudinal studies have indicated that securely attached children tend to do

better in life in the areas of self-esteem, peer relationships, empathy and compassion, impulse control, trust, and intimacy (Levy & Orlans, 2000).

Inge Bretherton's (1985) *Attachment Theory: Retrospect and Prospect* provides a good overview of the theory of attachment and relevant research. Bretherton (1985) indicates that some studies have reported correlations between attachment security and cognitive development in children. Bretherton (1985) indicates that a study conducted by Main (1973) concluded that toddlers who were identified as securely attached had longer attention spans and showed greater positive affect during play. Furthermore, Bretherton (1985) discusses a study conducted by Matas, Arend, and Sroufe (1978) that found children who had a secure attachment at 12 and/or 18 months were able to confidently attempt to solve a "tool-using task" or would seek their mother for support when they were challenged. This study also found that insecurely attached 2 year olds were easily frustrated and whiney when trying to solve problems and would not seek the assistance of their mothers (Bretherton, 1985).

Sroufe (1988) cites a number of different studies in which attachment has been the focus of attention. The Minnesota Pre-School Project is an example of a study that sought to look at the issue of attachment and the relationship it has to children's self-confidence as well as their relationships with peers and teachers (Sroufe, 1988). The results of this study indicated that there were many differences between securely attached children and insecurely attached children in two specific areas. Children who were considered to have avoidant attachments did not engage in any "fantasy play" that involved people (Sroufe, 1988).

Furthermore, children who were identified as having insecure attachments encountered a great deal of conflictual themes in their play with peers and were not effective in resolving the conflict (Sroufe, 1988). On the other hand, children who were identified as having secure attachments were able to resolve conflicts that arose in their play. Overall the study showed that children who were identified as having a secure attachment tended to make friends easily and maintained relationships with their peers; they were positive and empathetic, and tended not to victimize or become a victim when engaging in interactions with their peers (Sroufe, 1988). The study also indicated that children who had avoidant attachments were more likely to victimize their peers whereas children with anxious/resistant attachments were more likely to be victimized by peers (Sroufe, 1988).

Erickson, Sroufe, and Egeland (1985) conducted a study that sought to test the hypothesis that children who are identified as having an anxious attachment are more likely to have behaviour problems in pre-school. This was a longitudinal study that included observations of children and parents at different stages of the child's life from 12 months to 5 years (Erickson et al., 1985). The sample of participants was taken from a health clinic that began with a sample of pregnant mothers who were considered at risk for later caretaking problems (i.e., low educational level, high level of stress, age, lack of support etc.). The mothers and their children were seen at different stages over a four- year span. The results of this study indicated that children who were anxiously attached to a caregiver functioned poorly in school and were observed to be highly dependent, non-

compliant and lacked social skills when interacting with their peers (Erickson et al., 1985). Furthermore, teachers described these children as being hostile, impulsive, withdrawn and gave up easily when challenged (Erickson et al., 1985).

The need for attachment and positive relationships continues to be a necessity that is fostered throughout life (Booth & Koller, 1998). Studies have been conducted that indicate that adolescents who are considered to be securely attached to a caregiver report higher levels of self-esteem than adolescents who have an insecure attachment (Booth & Koller, 1998). The development of attachment continues throughout life and takes a different form depending on the individual's stage of development.

Critique of Attachment Theory

The theory of attachment has greatly contributed to the understanding of child development and functioning; however, the theory does have some limitations in its ability to account for the influence of societal and contextual factors on the parent-child relationship. Bolen (2000) authored an article entitled *Validity of Attachment Theory* that provides a good overview of attachment theory and critique of the research. One limitation of attachment theory is that it minimizes the impact of the current social environment on family functioning and on the parent's ability to care for her/his children (Olds, 1997); that is, the theory does not account for any social contextual issues that may impact on the coping abilities of an individual parent. Economic, social, and environmental factors all impact on the family's resources, which in turn affect the positive outcomes for

children (Einzig, 1999). Attachment theory's main aim is to view the micro relationship of the parent and child and often fails to take an ecological perspective that looks at contextual factors that may influence this relationship (Belsky, Rosenberger, & Crnic, 1995). Furthermore, attachment theory fails to acknowledge that these contextual factors may also directly affect a child's development (Bolen, 2000). Belsky et al. (1995) indicate that by adopting an ecological approach to attachment theory it will enrich the theory by building on its existing contributions.

Contextual factors are an important consideration as many families in society today are faced with a number of external stressors such as low-income and poverty, work pressures and unemployment/underemployment, and government cutbacks in community and social services. All of these may have an impact on the support the family is able to receive and their overall functioning (Demo & Cox, 2000). There are many contextual factors that have an impact on the parent-child relationship and the family's ability to function in society. Increasingly, poverty and unemployment are major issues for families, which may have a significant impact on parenting.

Economic deprivation challenges the coping resources of the individual, family, and the community (Garbarino & Kostelny, 1993). According to Braun (1997), poverty challenges a parent's ability to access social and community services and resources for health and welfare. Therefore, economic and social conditions can often put stresses on children and families leaving them at the risk of developing difficulties in their relationship (Bolger, Thomas, & Eckenrode,

1997). According to Bolger et al. (1997), when a family experiences difficulty in regards to economic and social circumstances, these can be seen as predictors of child abuse and neglect.

These contextual factors are important to take into consideration when looking at the formation of attachment because they have an impact on the family's ability to function. McKay, Pickens, and Stewart (1996) indicate that there is a link between parental stress and the parent-child relationship. A study conducted by McKay et al. (1996) indicated that higher levels of stress were found in single parent homes and that this is most likely due to a lack of availability of financial, economic, and social support in comparison to families with two parents.

Demo and Cox (2000) state that more research is needed in order to take into account the impact of contextual factors on the family. They argue that most of the research on attachment that has been conducted up to this point has been with middle class American samples, which has provided little understanding as to how social and cultural factors impact on attachment security (Demo & Cox, 2000). According to Bolen (2000) the research that has been completed has indicated that the categories of attachment differ from culture to culture. Bolen (2000) states that this suggests that attachment is based on the interaction of the parent and child as well as that of the "mores" of that particular culture.

Another limitation of attachment theory is the lack of acknowledgement of the individual differences each child has and how this impacts on or influences parental behaviour (Olds, 1997). Belsky et al. (1995) state that a child's temperament will not determine his/her level of attachment to a caregiver but may

be one factor along with others that may impact on the quality of the relationship. The hypothesis is that if a child's temperament does not match her/his caregiver's temperament and the caregiver's coping mechanisms, this may lead to conflict, which may have an impact on the formation of a secure attachment.

The psychological health of a caregiver is one indicator of the type of care a child may receive and this may have an impact on attachment. Psychological health is often influenced by the amount of social support the caregiver has in her/his social network. Studies have indicted that parents who have increased amounts of social support are psychologically healthier. This is positively related to their functioning as a parent (Belsky et al., 1995; Ptacek, 1996). Therefore, the amount and nature of social support a parent receives may affect interactions between the parent and child (Belsky et al., 1995). According to Ptacek (1996), social support can be a characterized by the available resources in the environment along with the individual's perception of the available support. Braun (1997) states that parenting has increasingly become unsupported and isolated. Due to an increase in mothers and fathers who are working this makes social support more challenging to organize at the neighbourhood and community level. Furthermore, there has been increasing individual responsibility for children and less community and society responsibility, which further isolates parents (Braun, 1997).

Belsky et al. (1995) cite a study conducted by Lyons-Ruth, Connell, and Grunebaum that looked at two groups of "economically disadvantaged and often depressed mothers" where one group had the intervention of a family visitor who

offered emotional and concrete support regarding the needs of infants and the mothers and the other group did not. The results of this study indicated that the group that received the social support of the family visitor had fewer infants who were insecure (Belsky et al., 1995). Furthermore, a study by Crockenberg indicated that parents who had a good social support network tended to be more sensitive to the needs of their children then parents who lacked those supports (Bolger et al., 1997).

Belsky (1999) cites conflicting studies regarding the issue of social support and attachment. However, he does state that we cannot rule out the link between attachment and social support. Belsky (1999) advocates that one factor in isolation will not determine a child's level of attachment; however, a combination of risk factors such as the parent's personality, marital quality, infant temperament, social support, occupational stressors, and socio-economic circumstances will have an impact on the parent-child relationship.

Attachment theory tends to put a great deal of attention on the responsibility of the mother for her role in her child's developing a secure attachment. This focus on the mother's role fails to recognize the importance of the role of the family as a system (Demo & Cox, 2000) and from the community and society as a whole. Attachment theory also neglects to acknowledge "...parental motivation for change in caregiving" (Olds, 1997, p. 145). That is, the theory can be interpreted as taking a stance at placing the blame on the caregiver for the parent-child relationship. The theory does not take into consideration contextual factors or the parent's attempts to change caregiver practices.

Demo and Cox (2000) cite that there has been little research conducted on the long-term implications of the categories of attachment and whether they are fixed or flexible categories. A major criticism of attachment theory is the deterministic nature in which it is presented. Theraplay as a therapeutic model takes the stance that there is the opportunity for change and learning new ways of interacting in order to promote attachment between a child and her/his caregiver. There is the acknowledgement that this process is easier to develop in a child's formative years, however, there is the ability to foster attachment behaviours later in life (Jernberg & Booth, 1999).

The limitation of the theory in acknowledging contextual factors that impact on the parent/child relationship is an important consideration for practice. There are a number of contextual factors such as poverty, lack of social support and community resources, mental health of the caregiver etc. that will have an impact on the family's ability to function and cope. A limitation of the Theraplay model is the lack of attention the literature plays to the importance of other systems outside of the family. Incorporating the Theraplay model within an ecological perspective is one way to address this shortcoming. It is important for clinicians to acknowledge and be aware of broader contextual issues and the impact they may have on the family if practice is to be effective.

Elements of the Theraplay Model

Theraplay incorporates four elements into its model. These elements are based on interactions in a healthy parent-child relationship (Booth & Koller, 1998). These elements are: structure, challenge, engagement, and nurture.

1. *Structure* – Structure is an important element in the parent/child relationship. Through structure the parent is able to put limits on the child in order to provide safety and to meet the child's needs. It is this element that reinforces to the child that the adult is in charge. Structure is incorporated into the therapeutic relationship with the therapist "taking charge" of the direction and activities of the session. This can be accomplished by clearly stating safety rules and by structuring activities that have a beginning, middle, and an end. This element is especially "…important for children who are overactive, unfocused, or overstimulated, or who have an anxious need to be in control" (Koller & Booth, 1997, p. 205). Examples of activities that promote structure are the following: tracing hands or doing body drawings, mother/father may I?, red light green light, three-legged walk etc.
2. *Challenge* – The concept of challenge is incorporated into the therapeutic relationship by the therapist introducing activities that encourage the child to take age appropriate risks in order to promote feelings of competence and confidence (Koller & Booth, 1997). This element is helpful for children who are withdrawn, anxious, or timid. By providing positive reinforcement/praise this allows the child to build self-esteem. Examples of activities that incorporate the element of challenge are: balloon tennis, balancing activities, straight face challenge, etc.

3. *Engagement* – Activities are introduced in order to engage the child in playful interaction, which is essential in the parent/child relationship. The activities are spontaneous, stimulating, and joyful for the child. Activities are always age appropriate and may include games such as row, row, row your boat; hand clapping games; hide and seek, etc. The activities should be playful and enjoyable for the child in order to promote a sense of adventure and stimulation (Koller & Booth, 1997).
4. *Nurture* – Activities that are nurturing are an integral element of the parent-child relationship. These actions and activities help sooth, calm, and reassure the child and are necessary in order to promote stability, consistency, and predictability in the child's environment. These activities usually incorporate the use of touch since this is an important element when interacting with children. Activities many include using lotion, feeding etc.

The therapy sessions are organized to incorporate a mixture of activities that fall into these four categories in order to provide the child with a wide variety of experiences (Koller & Booth, 1997).

Marshack Interaction Method

The Marschak Interaction Method (MIM) is a tool commonly used by therapists when employing the principles and techniques of the Theraplay model. The MIM is used as an assessment tool in order to gain an understanding of the needs of the client and in formulating treatment goals. Marianne Marschak created this tool in order to measure specific aspects relating to the quality and

nature of the interaction between parents and their children (DiPasquale, 2000). The MIM was created through Marschak's work of observing and documenting the interactions of parents and their children in the home setting while participating in structured activities. Furthermore, Marschak was interested in observing how each child responded to, identified with, and imitated each parent (Marshack, 1960). It should be noted that the MIM is not a standardized measurement tool and is based on the subjective view of the individuals observing the interaction of the parent and child.

In relation to the Theraplay model, the MIM is used at the beginning of treatment in order to assist in the assessment of the issues that may be impacting the family as well as the planning of the treatment process. The MIM session typically follows the intake session and is the first time the parent and child are seen together. The caregiver and child are left alone in the playroom with approximately 7-10 cards where each card outlines a task/activity for the parent and child to engage in (DiPasquale, 2000). The tasks are taken from each of the four dimensions of Theraplay: structure, nurture, challenge, and engagement. The tasks are arranged so that there is a mixture and a balance from each of the dimensions to allow the parent and child to engage in (Booth & Koller, 1998). Common examples of tasks are: "Adult teaches child something child doesn't know"; "Adult leaves the room for one minute without child"; "Play a game that is familiar to both of you"; "Adult and child feed each other" (Jernberg & Booth, 1999). All of the materials/supplies are provided for the parent and child in order for them to engage in the activities/tasks.

While the family is participating in the activities the therapist observes the interactions and notes the verbal and non-verbal exchanges that occur by each person upon the initiation and during the task. The MIM utilizes a format for recording these observations, which includes documenting the verbatim responses each participant has made as well as symbols that indicate non-verbal communication (DiPasquale, 2000). Observations of specific non-verbal communication are noted such as smiles, frowns, physical touch, pulling away, leaning towards, etc. According to DiPasquale (2000), "...the ability of the parent to provide empathy, stress reduction and playfulness is also observed" (p. 31).

Following the completion of the tasks, there is a debriefing interview where the caregivers is given the opportunity to discuss her/his reactions to the initial session (DiPasquale, 2000). Furthermore, the parent is asked to identify his/her favorite activity and to identify what she/he believe was the favorite activity of his/her child. This information gives some insight as to how attuned the parent is to his/her child.

The MIM can also be used at the conclusion of therapy in order to measure the effectiveness of treatment. The MIM with the same order of tasks can be used at the beginning and at termination of the therapeutic process. A comparison of the two MIM's will assist in determining whether any change has occurred over the course of treatment (DiPasquale, 2000).

Features of the Theraplay Model

The therapeutic session is structured so that the first half hour is spent with the child engaging in Theraplay activities and the following second half hour is spent with the caregiver(s) in parent counselling. The structure of the Theraplay treatment ideally has two therapists who work with the child and caregiver(s). One therapist works directly with the child while the other therapist interprets the session to the parent while observing through a one-way mirror (Jernberg & Booth, 1999). However, if it is not possible to have two therapists, the work conducted with the child can be videotaped and then reviewed with the caregiver (Myrow, 2000).

The Theraplay model is considered to be most effective when the primary caregiver(s) of the child participates in the therapeutic process so that she/he can carry on with the work that the therapist has begun with the child (Jernberg & Booth, 1999). By including the caregiver(s) into the process there is a greater inclusion of the child's system into the therapeutic process. Typically, the caregiver(s) will begin to participate directly in the therapy sessions around the fourth session. Up until the fourth session the caregiver(s) observe behind a one-way mirror. Observing the session allows the parents/caregivers the opportunity to gain a positive and empathetic view of their children as they watch their children respond to the planned activities and the interactions with the therapist.

In order to incorporate the four elements into the therapy session, the therapist "takes charge" of the session by pre-planning activities to meet the child's needs rather than allowing the child to direct the play (Jernberg & Booth, 1999). The

therapeutic process is geared towards developing a relationship with the child. Activities are incorporated into the sessions that emphasize "nurturing touch" as this is seen as an integral part of the interaction. Treatment involves active, physical, and interactive play. There is no symbolic play or discussion of feelings. The activities are geared to the emotional level of the child. Initially, the therapist will step into the role of the parent in order to model different ways of interacting with the child. Beginning at around the fourth sessions the parent joins the therapist and child. The caregiver is invited to participate in the activities so that she/he may practice the interactions in a safe environment (Jernberg & Booth, 1999).

This model acknowledges that attachment building is most effective when the child is young but promotes the view that change is always possible and that it is never too late to create a new experience for a child so that she/he may develop healthier relationships (Jernberg & Booth, 1999). Therefore, Theraplay can be adapted to work with children of a variety of ages.

Working with the Child

Working directly with the child requires the Theraplay therapist to be energetic and enthusiastic in order to engage the child in spontaneous and playful activities. In structuring the half hour Theraplay sessions, the therapist creates a "session proper" which is a schedule of activities for the session. This includes a list of approximately 12 activities that are chosen to reflect the treatment goals. Typically, the first and last activities are songs that welcome the child to the

session and at its conclusion say goodbye. This allows for structure as it provides the child with a clear beginning and an ending to the session. The remainder of the activities reflect the treatment goals and there is always an incorporation of nurturing activities (e.g. feeding, physical touch). An example of a "session proper" where the goals are to strengthen the parent-child relationship in the areas of structure and nurture may look like this:

1. Hello Song (beginning)
2. Check-up (engagement)
3. Push me over, Pull me up (challenge/engagement)
4. Three Legged Walk (structure)
5. Mother/Father May I? (structure)
6. Toilet Paper Bust Out (structure)
7. Stack of Hands (structure/nurture)
8. Shave (nurture)
9. X-Marks the Spot (engagement/nurture)
10. Lotioning Hurts (nurture)
11. Feeding (nurture)
12. Goodbye Song (ending)

These activities are playful and interactive in nature. The list incorporates a number of nurturing and structuring activities as well as engaging ones for the child. Although the sessions are highly structured, the therapist must be

constantly assessing the child's needs and be acutely aware of her/his responses to treatment (Booth & Koller, 1998).

According to Jernberg and Booth (1999), the child will typically go through six phases during the entire course of the treatment process. The length of time the child will stay in each phase is dependent on the individual and her/his needs (Jernberg & Booth, 1999). The phases include the following: introduction, exploration, tentative acceptance, negative reaction, growing and trusting, and termination.

1. *Introduction* – This phase occurs at the beginning of the therapeutic process with the therapist introducing the activities to the child, directing the play while engaging the child with enthusiasm and spontaneity. This is the phase where the therapist sets the tone of being in charge.
2. *Exploration* – This phase occurs where the child and therapist get to know each other through exploration activities. The child is able to explore the environment and the therapist in the context of engaging activities. The therapist is acknowledging the unique features of the child in a playful and interactive way. At the same time, the therapist is making an impression on the child that she/he is valuable and interesting.
3. *Tentative acceptance* – This phase may begin in the first session and be followed into subsequent sessions. The child may also display a level of apprehension in her/his interactions with the therapist. This phase may have the child engaging and participating in the activities but she/he may be displaying tentative acceptance of the activities and the therapist. At this point, the child is not

relaxed enough to genuinely accept the activities and interactions of the therapist. Therefore, the acceptance that is given may be tentative and superficial.

4. *Negative reaction* – The child may become resistant to activities that promote further intimacy between her/himself and the therapist. This behaviour may be a result of the child's past experiences of trusting an adult. This reaction may occur because the child is beginning to test the commitment level of the therapist. It is important for the therapist to stay with the child during this phase, thereby sending the message that there is a commitment. This phase is important to the treatment as it is teaching the child that an adult will stay with her/him even when he/she are being pushed away.
5. *Growing and trusting* – Once past the negative reaction phase the child will begin to develop confidence and trust in the caregiver. The child will become more of a partner in the play which features reciprocal interactions and laughter. This would be the stage when relevant caregivers are introduced into the Theraplay sessions for the last half of each session.
6. *Termination* – Preparation of the child for termination of the therapeutic relationship is typically introduced three sessions prior to the final meeting. This allows the child to be prepared for the ending. At this phase, the parent is participating in the sessions and incorporating what has been learned during the sessions into the interactions with her/his child. The final session should be marked by a celebration of the play that has been done.

The parents are usually introduced into the session once the child has entered the growing and trusting stage. It is important that the child has gone through the

phases with the Theraplay therapist before the parents are introduced into the room. The six stages described above focus on the reactions of the child. Interestingly, there is little information in the literature that describes the reactions of the parents to treatment, which can have an impact on the therapeutic process and would be important information for therapists to have.

Working with the Caregiver

The caregiver's participation in the Theraplay process is essential since this is the person who resides with her/his child on a full-time basis. During the initial stages of the therapeutic process, the caregiver watches the activities between her/his child and the Theraplay therapist. These activities and possible interpretations of the child's reactions are described to the parents by the interpreting therapist (Jernberg & Booth, 1999). The main goal of having the caregiver observe her/his child during the therapeutic process is to allow the caregiver to see her/his child in a different way and to increase the amount of empathy the caregiver has for her/his child (Jernberg & Booth, 1999). It is important for the interpreting therapist to prepare the caregiver for the phases that the child may go through during the sessions. When the caregiver begins to participate in the sessions and appears to feel comfortable with the activities, it is important to provide the family with tasks in order to reinforce what has been learned during the sessions into their home life (Jernberg & Booth, 1989).

Another important aspect of working with the caregiver is for the therapist to provide support, respect, and empathy. All of the caregiver's needs and concerns

may not be addressed in the Theraplay sessions. Therefore, it is helpful to provide individual sessions of supportive counselling to the parent in order to validate her/his progress, to reduce any distress or anxiety, and to assist in strengthening her/his coping skills (Mahy & MacQuarrie, 2000). Supportive counselling for the caregiver during this process is important as it allows the therapist to work from a strengths perspective in validating the work that has been accomplished (Mahy & MacQuarrie, 2000).

Research

The Theraplay model relies heavily on the research that has been completed in the area of attachment (Jernberg & Booth, 1999). Over the years there have been many studies conducted that indicate the importance of children developing an attachment and the implication that this has on their future development. There continues to be a need for more research in determining the effectiveness of the theraplay model. However, studies that have been completed suggest that the model may have a positive impact. A study conducted by Evangeline Munns on 25 children using pre- and post- scores on the Achenbach Child Behavior Checklist indicated that the aggression scores decreased following an intervention of theraplay (Munns, 2000). Furthermore, observations by teachers, parents, and therapists indicated a decrease in aggressive behaviour by the children (Munns, 2000). A study conducted by Morgan (1989) indicated that two-thirds of her participants improved in the areas of self-confidence, self-control, self-esteem, and trust following Theraplay treatment (Munns, 2000). However, more research

will need to be conducted in order to gain an understanding of what part of the therapy is creating the change and to determine if there are possible external factors that may be contributing to the change in behaviour.

Limitations of the Theraplay Model

The Theraplay model is designed to treat many behaviour problems that are a result of a failure to meet a child's basic emotional needs. Theraplay is not a recommended treatment for children who have recently experienced traumas such as sexual or physical abuse (Jernberg & Booth, 1999). In situations of recent abuse, more traditional forms of play therapy that assist the child in verbalizing her/his feelings and understanding what has happened are more appropriate (Jernberg & Booth, 1999). Theraplay may be a useful treatment if there is a need to strengthen the child's relationship to a caregiver. For example, Theraplay may be considered an effective choice of therapy for a child in a new adoptive home, as this treatment will facilitate the development of an attachment to a new caregiver (Jernberg & Booth, 1999).

The literature currently available on the Theraplay model places a great deal of attention on the work that is to be done with the child. Although this is an integral part to the model, there appears to be a lack of information on the individual sessions/parent counselling that are conducted between the therapist and caregiver. Despite the fact that the role of the caregiver is seen as an important element when implementing this treatment model, there is, unfortunately, a lack of information regarding this part of the process.

PRACTICUM PROCESS

Overview

The intervention for this practicum was the use of the Theraplay model in working with children and their families. The previous section went into detail regarding the techniques of the Theraplay model and how they can be implemented. This theoretical model places a great deal of emphasis on engaging families in playful interactions that are aimed at strengthening the relationship between a caregiver and a child. It should be noted that assessing for attachment related difficulties was not the goal of this practicum; the focus was on enhancing the parent-child relationship in an effort to alleviate any conflicts or difficulties that may have developed within the family system. This practicum focused primarily on using the Theraplay model with individual caregiver/child systems, as opposed to using Theraplay with groups of caregivers and children.

Along with working from a Theraplay approach, this practicum also acknowledged and incorporated other interventions that were seen as appropriate in order to best meet the needs of the family. As previously discussed, there are many contextual factors that impact the parent-child relationship. Therefore, it is important in clinical practice to take other factors into consideration when assessing and incorporating appropriate interventions.

Setting

This practicum was conducted at the Elizabeth Hill Counselling Centre, located at 321 McDermott Avenue, Winnipeg, MB. The Elizabeth Hill

Counselling Centre is operated by the Faculty of Social Work of the University of Manitoba and allows for social work and psychology graduate and undergraduate students of the university to participate in clinical training. The centre is located in Winnipeg's inner city and offers clinical services to all clients free of charge. The centre has a number of therapy rooms including two play rooms, each of which has one-way observation mirror. This was an important feature for the Theraplay model because it allowed the caregiver to observe the interactions between the therapist and her/his child.

The centre also has extensive video equipment for each of the therapy rooms. Video taping each session is required as it allows the student to obtain clinical supervision and self-evaluation on the work that has been conducted. Furthermore, videotaping sessions complements the Theraplay model especially if there is only one therapist available. Both the caregiver(s) and the therapist can review the videotape in order to discuss and explain what has taken place during the session. The videotape is considered a useful tool as the caregiver(s) can see firsthand the child's interactions during the sessions.

Practicum Committee

The practicum committee consisted of three members. The first member of this committee was Diane Hiebert-Murphy who is a social work faculty member at the University of Manitoba and is the faculty advisor for this practicum. The second member of the committee was Linda Perry who is a Program Manager of the Parent-Child Program at the Elizabeth Hill Counselling Centre. The third

member was Lynne Pinterics who is in private practice in Winnipeg, MB and has employed the Theraplay model in her practice with children and their families. For this practicum, Ms. Perry provided myself with direct clinical supervision with these families and Dr. Hiebert-Murphy provided case consultation.

Intervention

This focus of this practicum was to apply the Theraplay model of therapeutic intervention when working with children and their caregiver(s). The clients for this practicum were obtained through the referral process of the Elizabeth Hill Counselling Centre. The Centre accepts self-referrals from individuals and families in the community as well as referrals from professionals regarding their clients. The clients included in this practicum consisted of children and their caregiver(s) who were experiencing difficulties in their relationship and other problems that could be addressed by the Theraplay model.

As the Theraplay model uses a co-therapy approach this allowed me the opportunity to work with Linda Perry, the Manager of the Parent/Child Program at the Elizabeth Hill Counselling Centre. Of the six families seen, I was in the role of Theraplay therapist for five families and the interpreting therapist for one family.

The course of treatment for each family included an intake session with the caregiver(s), a Marshack Interaction Method (MIM) session with the child and caregiver(s) and the Theraplay sessions with the child and caregiver(s). The intake session included the caregiver(s) and both therapists. In the intake session

information regarding the caregiver's perception of the presenting difficulties and the developmental history of the child was obtained. As well, the Child Behavior Checklist (CBCL) and the Parenting Stress Index (PSI) were explained to each caregiver and it was requested that they complete the measures by the next session.

The MIM was administered by the second session. Five out of the six families participated in the MIM. One family was not assessed by using the MIM as it was felt that this would be too stressful for the mother and son. Treatment goals for each family were formulated from the observations of the MIM, the results of the CBCL and PSI, and through a discussion with the caregivers. In the first parent counselling session, caregivers were given feedback, which included highlighting the strengths seen in the MIM as well as a discussion of possible areas to strengthen during the Theraplay sessions. Furthermore, segments of the videotape were shown to the caregivers to highlight the feedback. With all of the families an initial contract for eight Theraplay sessions was made. This was extended depending on the individual needs of each family.

The Clients

The original goal of this practicum was to see approximately six to eight client systems initially contracting for eight weekly sessions. However, this time frame was flexible in order to best meet the individual needs of the client. A total of six families were seen for this practicum: four families were headed by a single mother; one by a single father; and one by two parents. Two of the families had

the involvement of Winnipeg Child and Family Services and were referred by professionals currently involved with the families (one family was a foster family and the other was a mother and son in the process of reunifying). Two of the families had heard about the Theraplay services at the Elizabeth Hill Counselling Centre through community professionals and were self-referred. The remaining two families contacted the Centre looking for services to assist in managing their child's behaviour. All of the children were male and ranged in age from six to nine years. The length of treatment for each family varied between eight to twenty sessions; however, the average length was approximately 12 sessions. The length of the therapeutic intervention depended on the individual needs of the family and this was assessed throughout the course of treatment.

The following will give a brief description of the six families seen in this practicum. The first three family systems listed will be discussed in greater detail in the following chapter. It should be noted that the names and identifying information of the clients in the following case studies have been altered in order to protect their identity.

Sharon and Jack.

Sharon was a single parent to eight year old Jack. Sharon referred her son Jack for counselling as she was concerned about the amount of anger she was seeing in her child and due to Jack's increasingly aggressive behaviour. Sharon and Jack consistently attended 8 Theraplay sessions in addition to the intake and MIM sessions. As will be discussed in the next chapter, it appeared as though this intervention was helpful for this mother and son.

Maria and Ben.

Maria was a foster parent to six year old Ben. The presenting concerns were Ben's attachment difficulties and the significant aggressive and violent behaviour he engaged in. This family had a Winnipeg Child and Family Services Support Worker involved who participated in the treatment as well. In total this family attended 11 sessions in addition to an intake and MIM session. Evaluation of the intervention suggests that this model was not entirely effective for this family; it made gains in some areas but not on the whole.

Jane, Steve and Dave.

Jane and Steve were the parents to eight-year-old Dave who was their only child. Jane referred Dave for counselling due to concerns of acting out behaviour. Jane and Steve had recently reconciled after a three year separation. This family attended 11 Theraplay sessions in addition to intake and MIM sessions. It appears as though this intervention was helpful for this family.

Bill and Scott.

Bill was a single father to nine-year-old Scott and eight-year-old Paul. Bill referred Scott for counselling as he was concerned about increasing defiance seen at home and at school as well as concerns regarding regressive behaviour. This father and son came for 20 Theraplay sessions in addition to intake and MIM sessions. On the whole, this model was not seen as effective for this father and son based on our clinical observations and the results of the PSI and CBCL. Scott responded well to the Theraplay activities and clearly enjoyed the individual attention and nurturing he received. The initial Theraplay goals for this father and

son focused on strengthening the areas of structure and nurture in their relationship. As the course of treatment progressed it became apparent that the goal of nurture was of significant importance. Scott appeared to need more nurturing interactions than he was receiving from the adults in his life. Over the course of treatment, however, there was a deterioration in Scott's behaviour specifically at school. Additional interventions were incorporated into the Theraplay sessions to focus on the expression of feelings and to work on issues of grief and loss. It appeared as though Scott was struggling with the lack of consistent contact with his mother. Interventions were attempted to work on these issues with little success. On the whole, the parent counselling component of this treatment model was not effective with this father. Bill appeared to have a great deal of difficulty making the shift to understanding or being attuned to the needs of Scott. This may have been due to a combination of my lack of experience in a therapeutic role and the individual needs of Bill as he appeared to be struggling with a number of parenting stresses and losses in his life. Following the completion of Theraplay, Scott attended some individual play therapy sessions because it was felt that the Theraplay intervention had reached its limits at that particular stage.

Karen and Josh.

Karen was a single parent to six-year-old Josh and two-year-old Mandy. Karen referred herself and Josh for counselling as she was concerned about Josh becoming increasingly sad and physically aggressive. This mother and son came for a total of 11 sessions in addition to an intake and a MIM session. Linda Perry

was the Theraplay therapist and facilitated the parent counselling with Karen and I was in the role of interpreting therapist. Based on clinical observations, Theraplay appeared to be an effective model of treatment for this mother and son. As treatment progressed, Karen and Josh appeared to enjoy the play activities as it allowed for the mother and son to spend time together engaging in fun activities. Further interventions were used in addition to the Theraplay model in order to facilitate Josh's feelings of sadness, grief and loss over the absence of his father. The parent counselling was reported as being an effective component to treatment as it allowed Karen to explore and process her feelings and stresses related to parenting.

Shannon and Mark.

Shannon was a single parent to nine-year-old Mark and one-year-old Bobby. Mark was in foster care and had been out of his mother's care for approximately one year. This mother and son were referred by their Winnipeg Child and Family Services Social Worker as there was the possibility of Mark returning to his mother's care. This mother and son attended 8 Theraplay session in addition to an intake session. A MIM session did not occur for this family as it was felt it may be too anxiety producing for both Shannon and Mark. The mother and son were not living together and it was assessed that observing them engaging in activities may be overwhelming for them. On the whole, this intervention was not entirely successful. There was a good number of missed and rescheduled appointments, which had an impact on the flow of treatment. Shannon herself appeared to be struggling with a number of parenting stresses (i.e., caring for an

infant, being a single parent, struggling with feelings that she may not be able to care for Mark) that may have impacted her ability to attend or commit to treatment at that time. For the sessions this mother and son attended, there did appear to be some slight changes in the level of gentle affection Shannon showed Mark. At the beginning of treatment, there was a level of harshness in Shannon's reactions to Mark and this continued to some degree throughout the course of treatment.

Evaluation

The evaluation of this practicum consisted of a combination of two standardized measures and a consumer satisfaction/feedback questionnaire. This allowed quantitative and qualitative data to be obtained from the clients who received counselling services. The two standardized measures that were used were the *Child Behavior Checklist* (CBCL; Achenbach, 1992) and the *Parenting Stress Index* (PSI; Abidin, 1995). The evaluation design of this practicum consisted of pre- and post- intervention tests for each parent at which time the two standardized questionnaires were administered. The *consumer satisfaction/feedback questionnaire* was given to the parent upon termination of therapy so that they were able to provide me with their thoughts and feelings regarding the service they received. The caregiver of each family completed the CBCL and the PSI at the intake session and at the termination session.

Child Behavior Checklist.

The CBCL is a measurement tool that has been designed to empirically measure a child's behavioural/emotional difficulties and social competencies (Achenbach, 1992). The tool consists of 118 items that are related to a child's behaviour problems and an additional 20 items that are related to a child's level of social competence (Freeman, 1985). Some items assist in identifying overt behaviour of children, while other items request that the parent make inferences regarding the thoughts and feelings of her/his child (Kelley, 1985). These items are rated on a three-point likert scale that includes 0 = not true, 1 = somewhat or sometimes true, and 2 = very true or often true. This standardized measure has versions that are completed by people who are able to observe the child's behaviour in a number of different settings (i.e., parent, teacher) (Achenbach, 1992). Additional scales have been created in order to obtain information from teachers and adolescents. The Teacher's Report Form (TRF) was designed in an effort to obtain information from the child's teacher in addition to the CBCL that is completed by the child's parent (Freeman, 1985). Similarly, the Youth Self-Report (YSR) was designed as a measurement tool to obtain self-reported information for adolescents between the ages of 11 and 18. Typically, the individual completing the scale will take into account the child's behaviour over the past two months for children ages 2-3 and over the past six months for children ages 4-18 (Achenbach, 1992). The difference in time periods is due to the significant changes that occur in a child between their second and third year of life (Achenbach, 1992).

According to Achenbach (1992) the CBCL can be completed by anyone with a 5th grade education. If an individual is having difficulty reading the questionnaire, another person can administer it by reading the statements out loud and recording the responses (Achenbach, 1992). The instrument can be easily scored by hand.

The CBCL has been empirically tested and been shown to have strong psychometric properties. According to Achenbach (1992), the CBCL as a mean test-retest reliability of .85. Kelley (1985) indicates that the CBCL has mean scores of above .90 for test-retest reliability, interparent agreement, and inter-interviewer relationship. Furthermore, Kelley (1985) reports that several studies have indicated good construct and criterion validity of the CBCL.

The CBCL and the supplemental forms have been reviewed extensively and a strength of the measure is that it allows for the collection of information from multiple sources, which allows for a "multiaxial assessment approach" (Christenson, 1992). Christenson (1992) states that multiple forms of this measurement allows information to be obtained from a variety of sources and enhances the measurement's ecological approach. Furthermore, this measurement tool allows for the individual who is collecting the data to achieve an "assessment-to-intervention link" (Christenson, 1992). That is, the data that is obtained provides valuable information that assists in providing appropriate interventions depending on the identified problem areas. It should be noted that the instrument was not created to make diagnostic inferences (Kelley, 1985).

Parenting Stress Index.

The PSI was chosen as a measurement tool to assess the degree of stress that may be occurring within the parent-child system. This tool is used to identify difficulties within the parent-child relationship that may place children at risk for emotional problems (Allison, 1998). Abidin (1995) cites literature that indicates that stresses in the family system can have an impact on the emotional and behavioural development of a child. Therefore, assessing areas of stress for the family is important, as it will assist in identifying appropriate clinical interventions for the family. According to Abidin (1995), the PSI was created to assess the components of parent and child characteristics, the family context, and stressful life events. These elements are all considered important as they may play a role in contributing to creating stress within the parent-child system (Abidin, 1995). According to Abidin (1995), the PSI is an appropriate measurement tool for parents of children between the ages of one month to 12 years.

The PSI is a 120-item self-report measure based on a 5-point likert scale. The PSI consists of the measurement of three domains of stress. These include: Child Domain subscales, Parent Domain subscales, and Life Stressors (Barnes & Oehler-Stinnett, 1998). The child domain consists of six subscales of 47 items, which include statements that are a combination of child characteristics and the parent's perceptions of these characteristics (Abidin, 1995). The subscales for the Child Domain are: Distractibility/Hyperactivity, Adaptability, Reinforces Parent, Demandingness, Mood, and Acceptability.

The parent domain consists of 54 items that have been divided into seven subscales. These subscales take into account parent characteristics and the contextual factors that may have an impact on their caregiving abilities (Abidin, 1995). The subscales for the parent domain are: Competence, Isolation, Attachment, Health, Role Restriction, Depression, and Spouse. The Life Stress scale consists of 19 items that aim at identifying stresses that may occur outside the parent-child relationship (Allison, 1998). The Life Stress scale is optional; however, high scores identify other stresses in the family's life that may need alternate interventions. According to Abidin (1995), scores that are within the normal range are between the 15th to 80th percentiles and scores that are at or above the 85th percentile are considered high.

Overall, the PSI is reported to have strong validity in that 95 percent of the items were linked to parental stress (Allison, 1998). In terms of reliability, the Total Stress score ranged from .96 following an interval of 1-3 months and .65 following a year interval (Allison, 1998). Allison (1998) identifies the lack of random samples in the studies to establish norms as a limitation of this measure and, therefore, the PSI is considered a good screening tool and not one for making diagnoses.

Consumer satisfaction/feedback questionnaire.

Appendix A contains the consumer satisfaction/feedback questionnaire that was provided to the clients following the termination of therapy. The purpose of this questionnaire was to gain an understanding of the clients' experiences at the

Elizabeth Hill Counselling Centre and to obtain feedback on the services they received and any suggestions for improvement of this service.

Evaluation of learning.

For this practicum individual learning occurred through a number of different avenues. Supervision with Linda Perry occurred on a weekly basis for each family and typically directly followed the session with each family. Supervision allowed for debriefing of the session and for guidance to be given regarding the direction of treatment. It was helpful to have supervision immediately following the session as the situation was fresh in everyone's memory. Regular viewing of videotapes occurred to view the interactions of the family and therapists as well as to ensure the accuracy of case notes. In the early stages of this practicum a reflection log was kept in order to keep track of ideas or uncertainties that arose during the initial stages of working with the family. Keeping a reflection log was primarily a vehicle for organizing my thoughts and feelings about the therapeutic process.

CASE STUDIES

This chapter will provide an analysis of the Theraplay intervention with three different families. In all of the case studies presented here, I was in the role of Theraplay therapist. These case studies were chosen due to the different family systems and the different challenges they presented to me as a therapist.

The format of the presented case studies will provide background information on the client system; the assessment and treatment goals; an analysis of the therapeutic intervention; and an analysis of the evaluation data.

Jack

Background information.

Jack is an eight-year-old boy who was referred for therapy by his mother, Sharon. At the time of the referral, Sharon was experiencing difficulties with Jack's behaviour and expressed concerns regarding the amount of anger and defiance he was showing at home. This anger had led to physical and verbal confrontations between the mother and son. Sharon described incidents where some confrontations had escalated to the point where Jack would hit her when he was angry. Sharon appeared to be very frustrated with Jack's behaviour, which was causing her to view him and his behaviour negatively. Sharon appeared to express genuine concern for Jack and was motivated to participate in the therapeutic process.

Sharon is a single parent of two children. She is employed full-time and described her life as fairly hectic, constantly feeling the pressures of juggling work and parenting her children. From Sharon's perspective, she receives little support from the children's father and reported that he plays an inconsistent role in the children's lives. She indicated that often the children were disappointed when their father did not keep the access arrangements. Sharon described her life as having very little time to spend time with her children. During the intake session, it became apparent that Sharon appeared to be struggling with understanding Jack's behaviour and where it may be coming from.

The Theraplay model appeared appropriate for this family, as the main issue described by Sharon was the behavioural difficulties she was having with Jack. The reported power struggles and the limited amount of time being spent between Sharon and Jack seemed to suggest that the Theraplay intervention would be appropriate for this family as it had the potential to assist in allowing the mother and son to engage in playful/interactive activities which could increase their positive interactions. Playful parent-child interactions and parent counselling appeared to be a good combination of therapeutic interventions for this mother and son. Sharon and Jack would have the opportunity to have positive interactions in a play setting and Sharon could have parent counselling to discuss concrete parenting strategies and to become more attuned to her child's needs. One of the primary aims of this treatment model is to assist the parent in viewing her/his child in a greater empathetic light (Jernberg & Booth, 1999). It was felt that this could be facilitated during the observation, participation, and parent

counselling aspects of the Theraplay model. However, it should be acknowledged that Sharon was experiencing a number of external stressors in her life (i.e. single parent, long working hours, little support) that would impact on her coping as a parent.

Assessment and treatment goals.

Sharon and Jack attended an initial assessment session where the Marshack Interaction Method (MIM) was used in order to observe the mother and son in play. This assessment tool assisted in formulating treatment goals to be worked on during the course of therapy. Sharon and Jack were given nine activities to complete together. These activities were geared to allow the mother and son to engage in the elements of the parent-child relationship: namely, structure, nurture, engagement and challenge. For example, some of the activities Sharon and Jack were requested to engage in were: "Adult draws a picture and encourages child to copy it" (structure/challenge); "Adult and child apply lotion to each other" (nurture); "Adult and child put hats on each other" (engagement).

This MIM showed that the interaction between Sharon and Jack was high in engagement as their play was very creative and imaginative. Sharon had little difficulty engaging Jack in play and the activities were long in the length of time. There did not appear to be any discomfort in their level of physical contact and both mother and child were attentive and responsive to each other. Sharon and Jack appeared to complete the activities at a comfortable pace. The observations

from the MIM did not clearly identify treatment goals but did highlight a number of strengths in the parent-child relationship.

The results of the pre-intervention scores on the Achenbach's Child Behavior Checklist (CBCL) and the Parenting Stress Index (PSI) are shown in Tables 1 and 2. The pre-intervention scores of the CBCL indicated that Sharon perceived Jack's behaviour to be in the "normal range" on all subscales measuring internalizing and externalizing behaviour with the exception of the Aggressive Behaviour subscale where the score fell within the clinical range and Somatic Complaints where the score fell in the borderline clinical range.

The results of the PSI indicated that Sharon was struggling with her perceptions of Jack in the areas of Adaptability, Reinforces Parent, Demandingness, Mood, and Acceptability. According to Abdin (1995), high scores on the PSI are considered to be above the 85th percentile. Each of these subscales had a percentile score of 90 or higher. High scores on these scales indicated Sharon felt that her parenting task was more difficult as Jack did not adjust well to changes in his environment (i.e., becomes emotionally upset easily when his routine is changed), that he places many demands on her, and that he shows signs of being unhappy and depressed. Furthermore, a higher score on the Mood scale may indicate difficulties in maternal attachment (Abidin, 1995). Sharon had scores in the "normal range" on the subscales measuring different aspects of stress in her role as parent with the exception of spouse where her score was in the 90-95th percentile range.

Table 1

Summary of the CBCL Percentile Scores for Jack as reported by Sharon

	Pre-Intervention	Post-Intervention
Withdrawn	84-93	84-93
Somatic Complaints	93-98*	84-93
Anxious/Depressed	84-93	84-93
Social Problems	84	50-69
Thought Problems	50	50
Attention Problems	69-84	50-69
Delinquent Behaviour	84-93	50-69
Aggressive Behaviour	98**	84-93
Internalizing Raw Score	16**	14**
Internalizing T-Score	69**	66**
Externalizing Raw Score	26**	19*
Externalizing T-Score	69**	63*
Total Score	52**	40*
Total T-Score	67**	60*

* indicates where the score fell within the borderline clinical range
** indicates where the score fell within the clinical range

Table 2

Summary of the PSI Percentile Scores for Sharon

Child Domain

	Pre-Intervention	Post-Intervention
Distractibility/Hyperactivity	75	55
Adaptability	99	99
Reinforces Parent	95-99+	85-90
Demandingness	95-99+	95-99+
Mood	95-99+	95-99+
Acceptability	90	40
Total for Child Domain	95-99+	90-95

Parent Domain

	Pre-Intervention	Post-Intervention
Competence	45	75
Isolation	5	50
Attachment	50	80
Health	50	50
Role Restriction	20	25
Depression	20	35
Spouse	90-95	90-95
Total for Parent Domain	35-40	65-70
Total Stress	80-85	85-90
Life Stress	75	80-85

Taking into account the results of the MIM, CBCL, and PSI, as well as the interview, it was formulated that the goals for Theraplay treatment would be to strengthen the parent-child relationship in the areas of structure and nurture. As Sharon described frequent power struggles between herself and Jack, strengthening the area of structure was seen as important so that Sharon would be viewed as the person "in charge" in the eyes of her children. Strengthening structure in the parent-child relationship would be done by the planned session and specific activities where Jack needed to listen to directions and cues from either the therapist or Sharon. The area of nurture was seen as an important goal as Sharon could explore new ways of responding to and soothing her child. As Sharon presented as being overwhelmed and frustrated with Jack's behaviour, strengthening the parent-child relationship in the area of nurture appeared to be appropriate.

Following the first Theraplay session, feedback was provided to Sharon in the parent counselling regarding our observations of the MIM and the results of the CBCL and PSI. Feedback was provided both verbally and through the use of the videotape, which was a helpful tool as it allowed Sharon to view the interactions she has with Jack from a different perspective. Prior to this feedback session, the MIM was reviewed and segments of the tape were chosen to assist in illustrating the observed strengths of Sharon and Jack. For example, Sharon and Jack were extremely creative in their play and this was highlighted for Sharon. Sharon had little difficulty engaging Jack in the activities and it was clear that Jack enjoyed the time he could spend with his mother. The feedback session was used to

highlight the strengths of the family and to identify possible areas to work on. The formulated treatment goals of strengthening the parent-child relationship in the areas of structure and nurture were discussed and agreed upon by Sharon.

Theraplay intervention.

At the start of treatment, eight weekly Theraplay sessions for approximately one hour in length were contracted with this mother and son, which they attended on a consistent basis. The Theraplay sessions were structured to allow Jack to engage in theraplay activities for the first half of the session while Sharon initially observed and then eventually participated in the play. The last half of the session was spent with Sharon individually in parent counselling.

Initially, Jack attended the Theraplay sessions with some apprehension and with little enthusiasm while engaged in play. He was somewhat cautious in his presentation and participated in some of the activities with tentative acceptance. This was seen particularly in the first two sessions where he participated in the planned activities but on occasion he was seen rolling his eyes and participating with little enthusiasm. However, as the sessions progressed it appeared that Jack became more comfortable with the Theraplay format, the activities of the sessions, and with myself as the Theraplay therapist. Over the eight weeks there was a change in Jack's presentation from initially being reserved to being very relaxed in his play. This was seen especially when his mother began to participate in the sessions.

Throughout the course of treatment, Jack was consistently cooperative in his play and could be easily redirected when he attempted to "take charge" of a particular activity. By the third session, Jack would often make suggestions of games to play or request that we play a different activity or attempt to change the rules of a particular activity. However, he could be easily redirected to stay with the scheduled activity list. The redirection would come in the form of validating Jack's ideas and stating we could play that next time. This allowed the adult to be in charge while at the same time emphasizing the importance of the idea. It was important to follow-through and incorporate Jack's idea into the following session.

From the onset of treatment Jack appeared to enjoy active activities that allowed a physical release (e.g., paper punch, paper toss, balloon tennis). These types of activities were incorporated into future sessions as Jack clearly enjoyed them and this allowed for an opportunity to build on his strengths.

In session three, Sharon was introduced into the Theraplay sessions and participated in the following five sessions. The introduction of the caregiver into the Theraplay session may produce some resistance for some children as their routine has been changed (Jernberg & Booth, 1999). This is an important element to be explained to the caregiver prior to her/his introduction into the Theraplay session as this resistance can catch the caregiver off guard. The introduction of Sharon into the session appeared to be a smooth transition for Jack. The play between Sharon and Jack continued to be engaging and it was evident that Jack enjoyed the time spent playing with his mother. The Theraplay activities for this

family continued to be a combination of the four Theraplay elements with a particular emphasis on structure and nurture as these had been the identified goals. As the Theraplay sessions progressed, Sharon was able to take charge of a number of the planned activities and Jack accepted her structure and direction fairly easily.

The parent counselling part of the sessions focused on providing education and support around parenting strategies for Sharon in managing Jack's behaviour and assisting her in being more attuned to Jack's needs. This became the primary focus as Jack's behaviour was the identified concern by Sharon. Resources such as *Raising Your Spirited Child* authored by Mary Sheedy Kurcinka (1998) were used in order to provide Sharon with information about understanding the different aspects of Jack's temperament. This information assisted in helping Sharon to be more attuned to Jack's needs and his behavioural cues. This resource also provided information/education to help Sharon to identify possible triggers for Jack in order to prevent tantrums and power struggles. Part of this intervention also focused on exploring Sharon's temperament and providing information on how her temperament impacted on her responses/reactions to Jack's behaviour.

Other behaviour modification approaches (e.g., charting and positive reinforcement) were also discussed with Sharon to assist in alleviating the power struggles that she was having with Jack concerning chores and homework routines. It appeared as though this information was helpful for Sharon and she made efforts to implement this at home. However, the course of improvement in

the presenting problem was uneven. For example, although some improvement occurred early, at one point Sharon called in between sessions when she was overwhelmed and hurt by Jack's behaviour.

The parent counselling that occurred during each session allowed Sharon to discuss her parenting stresses. Sharon expressed having life stresses that were impacting on her ability to spend time with her children. Sharon was a single parent who was employed and it was her perception that she did not receive positive support from her children's father.

As the Theraplay treatment progressed, it became evident that Sharon was gaining a better understanding of the needs of her children and the importance of spending quality time with them. Sharon reported that she was making efforts to spend one-on-one time with her children and made changes in her schedule to do so.

Theraplay appeared to be a good model of treatment for this family as it allowed for Sharon and Jack to engage in play and this was something they both clearly enjoyed doing. This was a family that due to hectic schedules did not spend a great deal of time together. One of the main principles of Theraplay is to assist the parent in viewing her/his child in a more positive light. Upon reflecting on the work that was done with this family, this appears to be the most important change that occurred. At session 4, there appeared to be a shift in Sharon's thinking from that of solely viewing Jack as the problem to realizing that there were other family/parenting issues. Prior to this Sharon placed a great deal of emphasis on Jack's behaviour and how this was impacting her and the family. It

appeared as though the parent counselling component of the session appeared to be a key element to the therapeutic process. Sharon was motivated to learn new strategies for interacting with her children.

Evaluation.

As previously mentioned, Sharon completed pre- and post-intervention standardized questionnaires (i.e., the CBCL and PSI). The post-test results of the CBCL indicated that Sharon's perception of Jack's behaviour had changed slightly as some of the subscale scores decreased. The subscales of Withdrawn, Anxious/Depressed and Thought Problems had the same scores at pre-intervention and post-intervention. The subscales of Somatic Complaints, Social Problems, Attention Problems, Aggressive Behaviour, and Delinquent Behaviour had a slight decrease in scores at post-intervention. All of the subscale scores at post-intervention were within the "normal range" including the Aggressive Behaviour subscale.

The Internalizing T-Score was 69 at pre-intervention and 66 at post-intervention. Both of these scores were in the clinical range. The Externalizing T-score was 69 at pre-intervention and 63 at post-intervention. The Externalizing T-score had decreased to the borderline clinical range when pre- and post-intervention scores were compared. Furthermore, the Total T-score at pre-intervention was 67 and this had slightly decreased to 60 at post-intervention. Therefore, in comparing the pre- and post-intervention results of the CBCL there appears to have been a slight change in Sharon's perception of Jack's behaviour.

The results of the PSI showed a slight but not a significant decrease in scores in the Child Domain from pre to post-intervention. The subscales of Adaptability, Demandingness and Mood had no change in percentile scores from pre to post-intervention. The Reinforces Parent subscale showed a slight decrease from 95-99th+ percentile range at pre-intervention to the 85-90th percentile range at post-intervention. The subscale of Distractibility/Hyperactivity showed a decrease from the 75th percentile at pre-intervention to 55th percentile at post-intervention. Furthermore, the subscale of Acceptability showed a decrease from the 90th percentile at pre-intervention to the 40th percentile at post-intervention. The Acceptability scale measures the parent's perception of their child's characteristics (i.e., physical, emotional, intellectual) and how this meets with their expectations for their child. This decrease may indicate that Sharon was more accepting of Jack's characteristics at post-intervention. The total score for the Child Domain of the PSI indicated a score in the range of 95-99+ percentile at pre-intervention to 90-95th percentile at post-intervention.

The results of the Parent Domain of the PSI were slightly different. Although the scores showed that Sharon was experiencing lower levels of stress in her perception of her parenting of Jack, the scores at post-intervention indicated an increase compared to the scores at pre-intervention. The subscales of Competence, Isolation, Attachment, Role Restriction, Depression and Spouse had all indicated an increase in percentile scores at post-intervention. The total for the Parent Domain indicated that Sharon's scores were in the 35-40th percentile at pre-intervention and in the 65-70th percentile at post-intervention. Although these

scores are both considered in the normal range, there was an increase in scores. The Total Stress (a combination of the Child Domain and Parent Domain) score showed that Sharon was in the 80-85th percentile at pre-intervention to 85-90th percentile at post-intervention. This indicates that Sharon's parenting stresses remained the same or slightly higher throughout treatment and that the intervention did not make an impact in this area.

Sharon completed a Consumer Satisfaction/Feedback Questionnaire at the conclusion of treatment. The responses from this questionnaire indicated that Sharon felt the treatment process was helpful for herself and Jack and that the Theraplay activities were the most helpful to her. However, she indicated that she would have preferred the therapeutic process to have included more of a discussion with Jack that centered around his feelings.

Conclusion.

It is difficult to know what part of the treatment was the most effective for this family. It appeared that the parent counselling was a key element since during it views were shared and knowledge and concrete parenting strategies were provided to Sharon. It was also a time to provide support and encouragement around the new strategies. It appeared that Sharon was receptive and motivated to implement new parenting strategies that were suggested to her. The Theraplay component was important as well as this allowed Sharon and Jack a time during each week when they could enjoy each other in play and learn new activities that could be incorporated into their daily routines. According to Sharon, she enjoyed

the Theraplay and felt the activities that took place were a valuable tool to use at home with her children. She indicated that it was the Theraplay activities that were the most helpful part to her.

This intervention appeared to be appropriate for this family. It was an intervention that actively engaged both Jack and Sharon throughout the treatment process. Jack was able to interact with his mother in a fun and playful way while Sharon was able to see her child from a more empathetic perspective. Although Sharon indicated she found the treatment received as helpful, she had hoped that more discussion could have occurred around Jack's feelings. This may indicate that Sharon had different expectations as to what the treatment process could provide Jack. At the end of treatment, it did not appear to be appropriate for Jack to receive individual play therapy based on the concerns Sharon was reporting. However, in hindsight the incorporation of family therapy techniques into the Theraplay session may have been helpful in order to include this treatment component. This may have allowed for the exploration into other issues that may have been impacting on this family.

In working with this family a "pure" form of the model was used. That is, there were no deviations or additions to the Theraplay model in the work completed with this family. This mother and son were one of the first clients seen for this practicum and they were good candidates for therapy as they appeared motivated and attended on a consistent basis. For an individual using this model for the first time it was beneficial for my learning to see the theoretical model unfold in practice with this family. This mother and son appeared to enjoy the

Theraplay activities and it was helpful for my learning to see the impact the activities had on them and how they both genuinely appeared to enjoy interacting with one another. This family demonstrated how the activities could be attachment building. Furthermore, one of the main goals of Theraplay is to assist parents in viewing their child in a greater empathetic light. This was seen in Sharon being more attuned to the needs of Jack.

Ben

Background information.

Ben is a seven-year-old boy who is a permanent ward of Winnipeg Child and Family Services. Ben had been in the care of the child welfare agency since he was three years old. Prior to being admitted into care, Ben's primary caregiver was his father. Ben's early years were described as very chaotic and neglectful. Ben was exposed to and witnessed a great deal of violence between his father and a number of his partners. Violence was a predominant theme in this child's life as he was exposed to it both at home and in the community. Ben had little contact with his mother because she left the family home when Ben was a young infant.

Ben's current foster parent, Maria, has been caring for him for the past two years. Prior to residing with Maria, Ben had a number of different placements within the child welfare system that broke down because of his increasing physically and verbally aggressive behaviour. Ben was described as engaging in behaviour such as hitting, yelling, and throwing objects when he was angry or frustrated. Ben was referred for counselling by his social worker due to concerns about physically aggressive and violent behaviour that appeared to be increasing both at home and at school.

At school, Ben had a full-time educational assistant to assist his integration into the classroom. Academically, Ben is described as a bright child who is functioning at an age appropriate level. However, behaviourally he struggles at school, which interferes with his success. Due to his behavioural challenges, Ben

was not left alone with other children, as his interactions with peers would often lead to physical aggression (e.g., hitting, biting, and scratching).

A number of different agency supports were involved with Ben and Maria, which supported the placement and the care provided to Ben. According to the professionals involved, Ben had been displaying behaviours that were consistent with a child who had difficulties in forming an attachment. At intake, Ben was described as having settled into the home of Maria and was demonstrating feeling more secure since he was now able to receive and give her affection, which had been very difficult for him to do in the past. Ben was described as being very reactive to physical touch especially from strangers because he would pull away and had been known to become physically aggressive if touched.

Maria described Ben as a very challenging child to parent. Although she reported seeing a number of changes in Ben over the past two years, she described him as a child who continues to require a great deal support, attention, and supervision. Ben was the only foster child in this home, which allowed Maria to meet these needs. However, Maria expressed at times feeling overwhelmed in parenting Ben. Maria is a single parent with married children. Maria had been caring for Ben for approximately two years and was upfront in stating her home was not a long term placement for this child. Maria had a number of external support systems to assist in her parenting.

Assessment and treatment goals.

In order to formulate treatment goals for Ben and Maria, a MIM assessment session was conducted the next week following the intake session. Ben and Maria were given nine activities to complete that were aimed at observing the elements of nurture, structure, engagement, and challenge in the parent-child relationship.

Throughout the activities, Ben demonstrated that he could be attentive, patient, and accept clear directions from Maria. Furthermore, he demonstrated that he had the capacity to be focused, accept structure, and comply. At times, he needed redirection to stay on task and Maria was able to provide him with this redirection. Ben responded well to one of the challenging tasks where he had to copy a picture Maria had drawn. From the drawing it became evident that Ben had a strength in creativity and enjoyed drawing and art.

The observations from the MIM showed that there appeared to be a lack of playfulness in the interactions between Ben and Maria. There was little to no spontaneous engagement in their play. There was a strong teaching element in a number of the interactions between the two and this often did not allow for any laughter or playful engagement. Ben also appeared to have some difficulty accepting nurture from Maria; however, during the MIM session he was able to accept some nurture following some prompting (e.g., Maria was able to lotion Ben's hands when he initially resisted and pulled his hands away).

The results of the pre-intervention CBCL indicated that Maria perceived Ben's behaviour to be in the clinical range on most subscales measuring internalizing and externalizing behaviours (see Table 3). These subscales were:

Table 3

Summary of the CBCL Percentile Scores for Ben as reported by Maria

	Pre-Intervention	Post-Intervention
Withdrawn	98*	69-84
Somatic Complaints	93-98*	93-98*
Anxious/Depressed	98+**	98+**
Social Problems	98+**	93-98*
Thought Problems	98+**	98+**
Attention Problems	98+**	98+**
Delinquent Behaviour	98+**	98+**
Aggressive Behaviour	98+**	93-98*
Internalizing Raw Score	36**	20**
Internalizing T-Score	83**	72**
Externalizing Raw Score	41**	26**
Externalizing T-Score	80**	69**
Total Raw Score	121**	70**
Total T-Score	82**	72**

* indicates where the score fell within the borderline clinical range
** indicates where the score fell within the clinical range

Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behaviours, and Aggressive Behaviours. The scores for the subscales of Withdrawn and Somatic Complaints fell within the borderline clinical range.

The results of the PSI (see Table 4) indicated that Maria was struggling in her perceptions of Ben as high scores were reported in all measured areas of the Child Domain: Distractibility/Hyperactivity, Adaptability, Reinforces Parent, Demandingness, Mood, and Acceptability. All of these scale scores fell in the 95-99th + percentile range. Similarly, in the Parent Domain Maria's scores were at the 90th percentile or above on all subscales for the exception of Isolation where she was at the 75th percentile. The Parent Domain subscales measures different aspects of stress in Maria's role as a parent.

Taking into consideration the results of the MIM, CBCL, and PSI, as well as the interview, the treatment goals for Ben and Maria were aimed at strengthening their relationship in the areas of engagement, nurture, and structure. Engagement was chosen as a goal in order to promote a playful and spontaneous element to their relationship. There appeared to be a strong teaching element to their interactions and, therefore, it was hypothesized that incorporating engaging and playful interactions would assist Maria and Ben in enjoying each other more while being together. The goal of strengthening structure in their relationship would assist Ben in viewing Maria as "in charge". Maria reported that Ben would often be defiant and had difficulty following the rules. The goal of strengthening nurture was important because it appeared that based on Ben's history his nurturing needs were not met in his earlier years. By incorporating

Table 4

Summary of the PSI Percentile Scores for Maria

Child Domain

	Pre-Intervention	**Post-Intervention**
Distractibility/Hyperactivity	95-99+	90
Adaptability	99+	99+
Reinforces Parent	99+	95
Demandingness	99+	95-99+
Mood	99+	60
Acceptability	99+	99+
Total for Child Domain	99+	99+

Parent Domain

	Pre-Intervention	**Post-Intervention**
Competence	90-95	35
Isolation	75	35
Attachment	90	85
Health	99+	20
Role Restriction	90	75
Depression	90-95	50
Spouse	99+	50
Total for Parent Domain	95-99+	35
Total Stress	99+	85
Life Stress	40	80

nurturing activities into each session it was hoped relationship between Maria and Ben would be strengthened.

Theraplay intervention.

Ben and Maria attended 12 Theraplay sessions on a weekly basis. The first four Theraplay sessions were spent alone with Ben while Maria and an interpreting therapist observed these sessions behind a one-way mirror. At session five, Maria was introduced into the Theraplay sessions and participated in the following eight sessions.

Ben attended each session with an initial presentation as a serious little boy. Prior to the session beginning, he would often attempt to control the situation by ordering people to play with him or by running to the playroom and insisting that we start right away. Ben appeared to have a strong need to have control of the environment. However, once the Theraplay session began he approached the play with enthusiasm and energy. From the initial stages of treatment, Ben attempted to "take charge" of the activities and this continued in varying degrees throughout the course of treatment. The goal of strengthening structure became an important goal in the treatment plan in order to reflect Ben's need to control the setting. With the therapist being in charge of the session the child is sent the message that he can be taken care of by adults (Jernberg & Booth, 1999). During the initial stages of treatment, Ben could be redirected fairly easily when he attempted to take charge of the activity. However, by session three this need for control became more persistent as it was more frequent and he constantly needed

redirection in order to remain on task. Ben began to show active resistance to some of the routine theraplay activities (e.g., hello song, check-up). During these activities he would refuse to sing or would hide under the blanket in order to avoid check-up. A great deal of encouragement and persistence was required in order to engage him in these activities. For example, when Ben was hiding under the blanket an attempt was made to make this into a game of hide and go seek or peek a boo in an effort to engage him and redirect him to the planned activity.

Maria was introduced into the Theraplay sessions during the fifth session. Although Ben continued to challenge some limits, it appeared as though Ben had made a connection to the Theraplay therapist and it seemed an appropriate time to begin introducing Maria into the sessions. Initially, Ben responded to this change in the routine with great defiance that required more redirection in order to keep him focused on the planned activities. This reaction is common for some children as their routine is being changed and a different dynamic is being created by introducing someone else into the play. Some of this defiance and resistance subsided as the therapy progressed, however, there were continually periods of defiance. Throughout the course of treatment there were periods of rejection by Ben in accepting nurturing activities, that is, lotioning and cradling from Maria. During the defiant periods, the focus of the Theraplay sessions continued to remain on the planned activities for the session. By staying to the agenda, Ben was being sent the message that the adult is in charge and is responsible for taking care of him. In some instances Ben was given two options to choose from. This was done in an effort to give Ben some control but the adult continued to be in

charge as she was providing the limits of the activities that could be completed at that time. The nurturing activities were a part of every session and by the conclusion of treatment there was a noticeable change in Ben's ability to accept physical touch and contact by others.

The parent counselling part of the Theraplay sessions was spent reinforcing the activities by encouraging homework activities and discussing the principles of theraplay as well as discussing any difficulties Maria was experiencing with Ben's behaviour during the week. Specific parenting strategies were discussed during this time in order to help alleviate some of the difficulties Maria was experiencing with Ben's behaviour. For example, the use of behaviour modification strategies such as charting, positive reinforcement, time outs, etc. were discussed in order to help manage some of the aggressive and defiant behaviours seen at home. Maria reported that she had attempted the parent strategies that were discussed at some point in time with varying degrees of success.

A regular family support worker who provided this family with a great deal of respite each week attended the Theraplay sessions. She observed the Theraplay session behind the one-way mirror and then joined and participated in the parent counselling component of the session. The incorporation of this support worker was important as she played a large caregiving role in Ben's life. It was felt that incorporating as many caregivers into the therapeutic process would allow for all adults to be consistent when interacting with Ben outside of the Theraplay session. Furthermore, hearing the support worker's concerns and impressions of

Ben at home were important to the parent counselling as it provided more insight into some of the difficulties the family was experiencing. By observing the Theraplay, she could also engage Ben in some of the Theraplay activities when caring for him.

On the whole, the parent counselling part of the therapeutic process did not appear to be very effective with this family. Maria had a great deal of difficulty making the transition from viewing the therapy as solely being for Ben to that of a parenting/interaction intervention. Maria had the involvement of many professionals in her life and had a number of external supports to assist in parenting Ben. The limited effectiveness of the parent counselling sessions could be due to a couple of factors. Maria may have already been receiving the parent counselling support from other professionals in her life and additional information may have been too overwhelming or unneeded.

Ben had a very traumatic early life that included a number of different caregivers and he exhibited great behavioural challenges. Due to this, the focus by professionals involved with this family was on Ben's special needs and how they could be best supported. It appeared as though Maria also held this view that Ben was the child who needed treatment. However, it should be noted that this was an understandable position for Maria to take as she was caring for a child who had behavioural challenges that were not due to the care she provided him but due to his early experiences. Complicating the picture further, Maria also did not consider herself a long term placement for this child, which may have been impacting what she could give of herself to her relationship with Ben who may

have been sensing this. In retrospect, I should have addressed this issue with Maria with more directness than I did.

Evaluation.

Maria completed the CBCL and the PSI at pre- and post-intervention. Tables 3 and 4 present the data received from these measures. The results of the pre- and post-intervention measures indicated a change in Maria's perception of Ben's behaviour. The results of the CBCL indicated that Maria perceived Ben's behaviour to have changed, as there was a decrease in all eight subscales measuring both internalizing and externalizing behaviour. However, it should be noted that although there was a decrease in scores for the subscales for Anxious/Depressed, Thought Problems, Attention Problems and Delinquent Behaviour, the scores continued to be in the clinical range at post-intervention. The post-intervention subscale scores for Social Problems and Aggressive Behaviour had decreased to the borderline clinical range. Overall, the Internalizing T-score decreased from 83 at pre-intervention to 72 at post-intervention. Similarly, the Externalizing T-score decreased from 80 at pre-intervention to 69 at post-intervention. However, it should be noted that the Internalizing and Externalizing T-scores were both in the clinical range at pre-intervention and post-intervention. The Total T-score was 82 at pre-intervention and 72 at post-intervention.

The post-intervention results of the PSI showed a slight decrease in scores from the pre-intervention results. Within the Child Domain all subscale scores

slightly decreased at post-intervention, however, all scores at post-intervention with the exception of Mood were at the 90th percentile or higher. There was a decrease in raw PSI scores in the Acceptability subscale as it decreased from 35 at pre-intervention to 22 at post-intervention. However, both of these scores convert to a 99th + percentile.

In the Parent Domain, which measured the overall stress Maria felt as a parent, a decrease on most subscales was seen. All subscales decreased and these percentiles were considered in the normal range with the exception of the Attachment subscale. This subscale was at the 85th percentile at post-intervention. According to Abdin (1995), high scores on the Attachment subscale may reflect the parent not feeling an emotional closeness to her/his child or the parent's real or perceived inability to understand her/his child's needs. A high score in this subscale is not surprising taking into consideration that Maria was a foster parent caring for Ben in the short term, which may have affected the amount of emotional connectedness she could give him.

Maria completed a consumer satisfaction questionnaire at the conclusion of treatment. Maria indicated that she found the treatment to be effective in helping Ben feel more comfortable with physical touch. Furthermore, she reported the cuddling and nurturing aspect of the sessions as helpful for both herself and Ben. It should be noted that Maria's comments in the questionnaire primarily focused on what the therapeutic process provided Ben and what she perceived as helpful to him. There was no mention of any benefits she herself may have gained from the therapy. Maria indicated that she would like to have continued services for

Ben to encourage his creative interests and develop his skills in this area. Information was provided regarding possible community resources for art or music therapy.

Conclusion.

The Theraplay activities appeared to be somewhat successful in engaging Ben in play and he clearly enjoyed the playful interactions. However, on the whole it is not too clear how effective this therapeutic model was for Maria and Ben. As the treatment progressed, Ben clearly demonstrated that he enjoyed coming and engaging in the play activities and Maria appeared to enjoy this support. However, the parent counselling was not an effective intervention and Maria did not appear to make the shift in thinking to viewing the problem as relational. Maria had a great number of supports in her life to assist in caring for the needs of Ben and since the focus amongst professionals was on Ben's behavioural challenges it may have been difficult for her to look past these issues.

The work that was done with Ben was valuable to my learning experience. Ben showed that he could develop a relationship with an adult but had periods of regression and progression throughout the treatment process. The work with this family showed me that the therapeutic process is not a linear progression but that periods of regression occur and should be expected. As an individual being introduced to the therapeutic process this can be a difficult concept to grasp as there can be the expectation that progress will be seen with each session. It was important for my learning to reflect on this family at the conclusion of treatment

in order to see the patterns of progression and regression throughout treatment. Especially, with this family where there were a number of periods of regression it highlighted the importance of continually assessing what Ben needed from treatment throughout the process in order to assist in appropriate interventions. Ben was a six-year-old boy who had an early traumatic life experience marked with family violence and chaos. He was a child who appeared to have an insecure attachment due to his early life experiences.

Dave

Background information.

Dave is an eight-year-old boy who was referred by his mother Jane to the Elizabeth Hill Counselling Centre to receive therapy. Dave is the only child of Jane and Steve. Jane was concerned about Dave's angry and aggressive behaviour that had begun following her separation from Dave's father, Steve, three years ago. Steve did not play a big role in Dave's life during the separation and saw him sporadically. Over the past two years, Jane had noticed a deterioration in Dave's behaviour. Dave was described as being increasingly aggressive and defiant at school. He was seen as a child who was constantly active and had difficulty focusing on one task. Furthermore, he was described as a child who did not have many friends at school but did have a few in the neighbourhood.

Jane reported that she did not see much of this behaviour at home and acknowledged that this was due to the fact that there was not much for Dave to be unhappy with at home as she had a "loose structure". Approximately a year ago a psychological assessment had been conducted on Dave where a diagnosis of Attention Deficit/Hyperactive Disorder (ADHD) was given. Jane reported that Dave had recently begun taking Ritalin and she had noticed some positive impacts, which she attributed to the medication. Both parents attended the intake interview and at that time they reported having recently reconciled and that Steve

was currently residing with Jane and Dave. Jane and Steve indicated that they were willing to participate in the treatment process.

Jane and Steve were both employed outside of the home. Jane had full-time permanent employment and Steve had occasional work. Both parents, especially Jane, were able to identify supports in their life.

Assessment and treatment goals.

During the first session, a Marshack Interaction Method (MIM) was completed with this family. The MIM was structured so that the observer saw that each parent separately completed five activities/tasks with Dave. Then the family as a whole engaged in three activities.

It was observed that Dave behaved differently with each parent. Dave was very active with his mother and would often challenge his mother's authority. He required a great deal of redirection from his mother in order to keep focused on the activity. However, he responded positively to the nurturing she gave him during the activities. For example, one of the activities asked Jane to tell Dave what he was like as a baby. Dave was very attentive while listening to his mother and asked questions throughout the discussion. There was also good eye contact between the mother and son with Dave giggling while listening to his mother talk about him.

Dave was a calmer child when he was alone with his father and appeared to be more accepting of his father's authority. Dave did not require much redirection from Steve during this session and Dave allowed Steve to direct the activities.

One possible explanation for this difference in demeanor is that Steve had recently begun to play a bigger role in this family's life and, therefore, Dave may have been demonstrating a more anxious attachment with his father. He may have been more compliant with his father as he feared that Steve may leave the family again.

Both parents were observed to have different strengths in their interactions with Dave. Jane was able to engage Dave in a playful way during the MIM. Steve demonstrated that he was able to structure and put limits on Dave's play but there appeared to be a lack of playfulness and nurturing. Throughout the session, Dave presented as an active child who for the most part was constantly moving. During what appeared to be anxious moments, Dave would run around the room in circles. This was seen when each parent left Dave alone in the room for one minute.

Both parents completed pre-intervention questionnaires. The results of the CBCL and PSI were also used as assessment tools in formulating initial treatment goals (see Tables 5-8). The results of the CBCL indicated that the parents perceived Dave's behaviour slightly differently. The scores of the CBCL Jane completed indicated that she perceived Dave's behaviour to be within the "Normal Range" on most subscales measuring Internalizing and Externalizing behaviour with the exception of Somatic Complaints, Anxious/Depressed and Attention Problems which fell within the borderline clinical range. The Internalizing and Total scores fell within the clinical range. The results of the

Table 5

Summary of the CBCL Percentile Scores for Dave as reported by Jane

	Pre-Intervention	**Post-Intervention**
Withdrawn	84-93	93-98*
Somatic Complaints	98*	84-93
Anxious/Depressed	93-98*	84-93
Social Problems	93-98	93-98
Thought Problems	69-84	69-84
Attention Problems	93-98*	93-98*
Delinquent Behaviour	50	50
Aggressive Behaviour	69-84	69-84
Internalizing Score	19**	16**
Internalizing T-Score	71**	69**
Externalizing Score	13	11
Externalizing T-Score	55	53
Total Score	49**	43*
Total T-Score	66**	62*

* indicates where the score fell within the borderline clinical range
** indicates where the score fell within the clinical range

Table 6

Summary of the CBCL Percentile Scores for Dave as reported by Steve

	Pre-Intervention	**Post-Intervention**
Withdrawn	98+**	98+**
Somatic Complaints	98*	84-93
Anxious/Depressed	98+**	93-98*
Social Problems	93-98*	84
Thought Problems	98*	93-98*
Attention Problems	98+**	93-98*
Delinquent Behaviour	69-84	69-84
Aggressive Behaviour	93-98	69-84
Internalizing Score	25**	20**
Internalizing T-Score	75**	72**
Externalizing Score	22**	15
Externalizing T-Score	66**	58
Total Score	70**	53**
Total T-Score	72**	67**

* indicates where the score fell within the borderline clinical range
** indicates where the score fell within the clinical range

Table 7

Summary of the PSI Percentile Scores for Jane

Child Domain

	Pre-Intervention	**Post-Intervention**
Distractibility/Hyperactivity	85-90	90-95
Adaptability	90-95	80
Reinforces Parent	80	85-90
Demandingness	75	55
Mood	95	95-99+
Acceptability	60	70
Total for Child Domain	85-90	85-90

Parent Domain

	Pre-Intervention	**Post-Intervention**
Competence	75	85
Isolation	85	80
Attachment	35	75
Health	65	65
Role Restriction	30	55
Depression	70	75
Spouse	55	65
Total for Parent Domain	60-65	75
Total Stress	75-80	85-90
Life Stress	95-99+	80-85

Table 8

Summary of the PSI Percentile Scores for Steve

Child Domain

	Pre-Intervention	**Post-Intervention**
Distractibility/Hyperactivity	60	65
Adaptability	40	80
Reinforces Parent	65	85-90
Demandingness	85-90	85
Mood	85	90
Acceptability	90	90
Total for Child Domain	70-75	85-90

Parent Domain

	Pre-Intervention	**Post-Intervention**
Competence	90	30
Isolation	25	75
Attachment	75	65
Health	70	65
Role Restriction	25	20
Depression	80	80-85
Spouse	85	55
Total for Parent Domain	70-75	50
Total Stress	75-80	70-75
Life Stress	95-99+	90-95

CBCL were not too surprising, as Jane had reported that the school struggled with Dave's behaviour to a much greater extent than she did at home. Steve perceived Dave's behaviour to be within the "Clinical Range" on the following subscales: Withdrawn, Anxious/Depressed and Attention Problems and within the "Borderline Clinical Range" on the subscales measuring Somatic Complaints, Social Problems and Thought Problems. The combined Externalizing, Internalizing, and Total scores all fell within the clinical range.

The slight difference in scores between the two parents may be due to the relationship they have with Dave. Jane had been playing a larger and more consistent role in Dave's life whereas Steve had recently come back into the family's life and was beginning to re-establish his relationship with the family. Jane has seen Dave's behaviour over a larger period of time and in different situations, which will have an impact on her perceptions of him.

The results of the PSI for both parents indicated that they were not experiencing overly high levels of stress in parenting Dave or with parenting stresses. In the Child Domain, Jane's results of the PSI indicated that her perceptions of Dave were in the high percentile range for the Distractibility/Hyperactivity, Adaptability and Mood subscales. These three subscales were all in the 85th percentile or higher. The subscales that scored high in Steve's responses were in the subscales of Demandingness, Mood and Acceptability which all were higher than the 85th percentile. In the Parent Domain, Jane's scores in this set of subscales were all within the normal range for the exception of Isolation, which was at the 85th percentile. Steve had high scores

on the subscales of Competence at the 90th percentile and Spouse at the 85th percentile. The higher scores in these two subscales in all likelihood reflect the new role Steve was playing in parenting Dave and the changes in his life following his reuniting with Jane. It should be noted that both parents had high Life Stress scores, which was a reflection of their recent reconciliation as they indicated on the questionnaire.

Taking into consideration the observations of the MIM session and the parents' scores on the CBCL and PSI, the treatment goals for Theraplay were seen as strengthening the parent-child relationship in the areas of structure for Jane and Dave and engagement and nurture for Steve and Dave. It was clear from the MIM and Jane's reports that she struggled with providing limits for Dave and that Dave had difficulty accepting her authority. Therefore, the goal of strengthening structure appeared to be appropriate for Jane and Dave as this would assist Jane in being in charge. Strengthening the parent-child relationship in the areas of engagement and nurture were the goals for Steve and Dave as there appeared to be a lack of playfulness in their interactions. Furthermore, this goal would assist the father and son in strengthening their relationship as they had been apart for a period of time.

Feedback was provided during the parent counselling component of the first session. Segments of the videotape to highlight the family's strengths were reviewed with Jane and Steve and it appeared as though the couple enjoyed viewing the tape. Both were attentive in watching themselves and each other engaging in the activities and were receptive to our comments. Feedback was

also provided on the standardized measures the parents had completed. Jane indicated that she thought her scores on the CBCL subscales for Withdrawn and Social Problems would be higher than they were as she thought these were the areas Dave struggled with. Steve reported feeling the results of the CBCL were an accurate reflection of his perceptions of Dave's behaviour. A discussion occurred around the Theraplay model and how this intervention may help in strengthening their relationship. The parents were in agreement to the above mentioned goals.

Theraplay intervention.

Dave and his parents attended 11 Theraplay sessions in addition to the initial Marshack Interaction Method session. The first four sessions were structured so that the first half an hour was spent with Dave in the Theraplay session with both of his parents and the interpreting therapist observing behind a one-way mirror. Both parents were introduced into the Theraplay room at session five. The remaining half hour after each session was spent in parent counselling with the parents.

Dave attended the initial Theraplay sessions (sessions 1 to 3) with some apprehension and very little enthusiasm. During the first two sessions, Dave participated in all of the activities but did so with a great deal of reluctance. While attempting to engage Dave in the games he could be seen rolling his eyes, hesitating, and often looking at the observation mirror and making faces. At the beginning of these sessions, Dave appeared to be very preoccupied by needing to

know what was listed on the agenda and with the play materials brought to the session. By the third session, Dave began to actively resist the Theraplay activities, in particular the nurturing ones. During this session, Dave needed a great deal of redirection to keep on task; in particular he had difficulty during the transitions between activities. He had difficulty with this change and would show his anxiety by running in circles around the room. Dave actively resisted all substances that had a texture (i.e., lotion, shaving cream, slime) during the nurturing activities. Furthermore, Dave resisted tactile activities by pulling away. For example, he resisted activities such as *X-Marks the Spot* and *Criss Cross Applesauce,* which are rhyming activities that incorporate physical touch through actions drawn on the child's back. At this time, it was unclear if Dave was resisting the physical touch of the activity or the rhyming song as Dave had often indicated that these rhymes and songs were babyish and would mock the rhyme. However, Dave showed no resistance accepting the nurturing activity of feeding and actively sought this out.

Following this session, changes were made in the structure of the Theraplay session in order to meet the individual needs of Dave. It was clear from the first three sessions that modifications in the Theraplay format were needed in order to engage Dave in play and to increase his comfort level in the Theraplay room. At the beginning of the fourth session, Dave was allowed to read the activity list prior to the session beginning so there would be some predictability in the session. A Hello Handshake was substituted in place of the Hello Song. For the first three sessions, Dave would mock the song and substitute the word stupid for his name.

The handshake was substituted as this appeared to be more age appropriate for Dave and there was concern that the derogatory names would further impact on Dave's self-esteem.

Nurturing activities were incorporated into each session that did not involve lotion or other substances with a texture. In the following sessions, Dave presented as very accepting of physical touch and feeding, therefore, the nurturing activities focused on these elements rather than using substances that have a texture. It appears that these changes had an impact on Dave as he became more accepting of the Theraplay activities and the format of the session as seen in a change in session four. During this session, Dave presented himself as much calmer and appeared to be more focused. This change could be explained due to a couple of factors. The change in format may have fit with Dave's individual needs and/or Dave may have become more comfortable/accepting of the therapeutic format. Furthermore, Jane and Steve also indicated that they were uncomfortable with the previous session and reported that they had spoken to Dave about cooperating and participating in the activities.

By session five, Jane and Steve were introduced into the Theraplay sessions. Including the parents into the process was a relatively smooth transition for Dave as he clearly enjoyed the playful interactions he could have with his parents. Prior to Jane and Steve entering the room the interpreting therapist prepared them for the possibility of resistance by Dave explaining that some children react when parents enter for the first time as the routine has been changed. After the parents participated in the first activity in the Theraplay room Dave responded by telling

his parents they could leave now. However, he was content once it was explained to him that they would be staying to play with us.

With the parents participating in the sessions, each parent was assigned particular activities to complete with Dave. Specific activities were aimed at the treatment goals for each parent. Jane and Dave participated in highly structured activities so that Dave would have to listen to the direction and instructions Jane gave him. This gave Jane the opportunity to learn new ways of getting Dave to accept her authority. As the sessions progressed, it appeared that Dave became much more accepting of Jane's structure and Jane reported that she noticed this at home as well.

The activities that Steve and Dave participated focused on engaging and nurturing activities to assist in strengthening this area of their relationship. On the whole, Steve was able to interact with Dave in a nurturing and playful way and Steve's comfort level appeared to increase as the sessions progressed.

The parent-counselling component of the sessions focused on providing the parents with support while emphasizing the importance of incorporating the Theraplay activities into their home life. Jane and Steve used this time to discuss strategies in parenting Dave. They were open in discussing their individual and shared concerns regarding Dave's behaviour. Both parents were able to identify strengths in Dave and areas that needed to be worked on. The parent counselling section was effective for this couple as it allowed them to discuss and share their concerns with each other. Both were open and did not appear to be hesitant about sharing their differences of opinions.

Dave's behaviour at school was a primary concern identified by Jane and Steve (i.e., he was spending a good deal of time outside of class, refusing to participate in classroom activities, homework was an issue). The parents were able to arrange and implement effective strategies that increased Dave's participation in class. As Jane and Steve had recently reconciled it appeared as though they were trying to define what their individual parenting roles would be. For example, as the course of treatment progressed Steve began to take the role of ensuring homework was completed and liaising with the school around issues that arose. The parents appeared to have good communication with the school and were highly motivated to ensure Dave's educational needs were being met. Therefore, no direct school interventions by the therapists was seen as necessary to assist in this area as the parents appeared to have a good handle on the situation.

Another issue that was raised by both parents in a few parent counselling sessions were concerns related to Dave's self-esteem. Dave was described as a child who was very critical of himself and who was easily frustrated when he did not complete tasks to perfection. Positive reinforcement and encouraging activities that Dave was interested in were discussed with Jane and Steve. Emphasis was placed on finding an extracurricular activity that Dave could excel in and to build on his strengths.

Evaluation.

Jane and Steve each completed the CBCL and the PSI pre- and post-intervention standardized questionnaires of the CBCL and the PSI. The results of this data have been displayed in Tables 5 through 8. The scores reported in the post-intervention CBCL scores that Jane completed indicated very little change from those reported at pre-intervention. Most of the subscale scores were in the "normal range" or "borderline clinical range" and there was a slight decrease in the subscales of Somatic Complaints, Anxious/Depressed and Aggressive Behaviour. There were no significant changes in the overall T-scores when Jane's pre- and post-interventions scores were compared. The results indicated an Internalizing T-score of 71 at pre-intervention and 69 at post-intervention. The Externalizing T-score was 55 at pre-intervention and 53 at post-intervention and the Total T-score was 66 at pre-intervention and 62 at post-intervention.

Steve's results were consistent with Jane's as there was a slight decrease in most of the subscales with a notable decrease in the Aggressive Behaviour subscale. In particular, there was a decrease in scores for the overall externalizing score. That is, the pre-intervention reported a T-score of 66 for externalizing and this had decreased to a T-score of 58 at post-intervention. The Internalizing T-score was 75 at pre-intervention and 72 at post-intervention. Both of these scores remained in the clinical range. The Total T-score was 72 at pre-intervention and 67 at post-intervention.

The results of the post-intervention PSI scores for both Jane and Steve were similar to the pre-intervention scores. In the Child Domain, Jane's scores

indicated that her perceptions of Dave in the subscales of Distractibility/Hyperactivity, Reinforces Parent, and Mood continued to be high. Steve's scores in the Child Domain all slightly increased with Reinforces Parent, Demandingness, Mood, and Acceptability being at or above the 85th percentile. Jane's scores for the Parent Domain subscales were all within the normal range with the exception of Competence where she was at the 85th percentile. Similarly, Steve's results for the subscales in the Parent Domain were within the normal range as well. The Life Stress scores of both parents decreased and this is reflective of their views that their reconciliation was not a recent event. Jane's score appeared to have a larger decrease than Steve's.

Jane and Steve each completed a Consumer Satisfaction/Feedback Questionnaire at the conclusion of treatment. Their comments were positive and highlighted different aspects of the therapy they individually found helpful. Jane indicated that she found the family play activities helpful as well as the feedback given throughout treatment. Steve indicated that he felt discussing the day-to-day living and life events of the family were the most helpful part of treatment.

Conclusion.

This treatment model appeared to be effective for this family. In particular, this model seemed most appropriate for this family since there had recently been the re-introduction of Steve into the family. As treatment progressed, all appeared to have a greater level of comfort with the Theraplay format. The entire family appeared to enjoy spending time with each other and this model allowed for an

opportunity to engage in positive interactions in a safe environment. Near the conclusion of treatment the parents reported that Dave had been making his own list of Theraplay activities at home for the family to play.

The changes observed in Dave's behaviour were most likely due to a combination of a number of factors. According to Jane, the involvement of Steve into their life had a positive impact on Dave and herself. She indicated that Dave responded well to Steve especially around the structure and limits he provided. According to Jane, Dave was needing a male figure in his life and was responding positively to Steve being a part of their lives again. The Theraplay format did allow Dave to play and interact with his parents and Jane and Steve were able to see how much Dave enjoyed this time with them. This type of play appeared to be enjoyed by all family members.

This family had an impact on my learning on a number of different levels. Working with Dave was both challenging and rewarding. In the initial stages of treatment, working with Dave's resistance to therapy was frustrating and challenged me to look at different and creative ways of engaging him in Theraplay activities. The first three sessions of solely working with Dave at times were frustrating and discouraging because it felt as though it was impossible to engage him. However, this resistance made me become more aware of how each child responds differently to treatment and it made me more creative in my approach to understanding and meeting his needs. Following the conclusion of treatment, it was helpful for my learning to reflect on the different stages Dave

went through from resistance to acceptance. It also showed the importance of staying with the child during rough periods.

Out of all the families seen for this practicum, this was the only two parent family. I found that using the Theraplay model with a two parent family brings different challenges than that of a single parent family. In planning the sessions, there was a higher degree of coordination required as it was important to include both parents in the activities as well as to ensure that each parent was participating in activities that addressed their own goals. The parent counselling also had a different dynamic as now there were two people who brought their own perspectives and insights into their child. It was important that each parent felt as though they were being heard in the parent counselling which meant having a greater awareness to ensure they both had their time to share their views.

PRACTICE THEMES

The purpose of this chapter is to discuss the common practice themes that emerged through the work with the families in this practicum. This chapter has been divided into subsections and will discuss parent counselling, phases of treatment for children, single parents, systemic issues, and additional clinical interventions to the Theraplay model.

Parent Counselling

Parent counselling was a part of every session for all of the families seen in this practicum. The parent counselling followed the Theraplay component and typically lasted for a half an hour. Parent counselling is an important element to the model as it allows for support, education, and problem solving throughout the therapeutic process. According to Booth and Koller (1998), parent support is an important element to Theraplay treatment. Parents who are experiencing difficulties in their relationship with their children all need support, empathy, and understanding (Booth & Koller, 1998). According to Braun (1997), parent education programs have the potential to serve a number of different functions for the parent. Braun (1997) cites that there are a number of goals in working with parents such as increasing their confidence in their parenting abilities, promoting an empathetic view of their child, increasing their pleasure in their children, and improving social support networks among parents. These were some of the goals incorporated into the parent counselling.

Of the families seen in this practicum it appeared that the parent counselling was an important and integral element to the therapeutic process. In the initial stages of therapy, the parent counselling allowed for an explanation of the entire therapeutic process. It was common amongst all of the parents who were seen to go through an initial period of skepticism. Even though the process was explained during the intake session, once the therapy began there were varying degrees of uncertainty amongst the parents about the process and how this model of therapy would be helpful to their individual families. Initially, it was common for parents to feel as though what they were observing was just play and would not be helpful or therapeutic for their family. The parent counselling was important as it allowed for further explanation of the Theraplay process and the normalization of feelings associated with this uncertainty. For most of the parents seen in this practicum, it appeared as though by session three or four there was a shift in thinking as to how Theraplay would be helpful.

One of the main functions of the parent counselling was to discuss what was occurring during the session and the relevance of the different activities that were planned for the sessions. Furthermore, the caregivers were encouraged to practice the activities observed in the session with their children at home. According to Jernberg and Booth (1999), it is important that the caregiver reinforce at home what has been introduced in the session. This is essential as the parent has the most contact with the child and incorporating the playful and positive interactions during the week will assist in strengthening their relationship. Typically, a copy of the week's Theraplay activities was given to the caregiver and discussions

would occur as to which activities they felt comfortable using at home during the week.

Completion of homework activities varied to different degrees with each family seen for this practicum. It appears that this may have been due to a number of different reasons. For a couple of the families, their schedules were hectic and it was difficult to incorporate the time needed to devote to doing Theraplay activities at home. Furthermore, engaging in activities at home appeared to increase depending on the individual parent's perception of the therapeutic model. It seemed as though if the parent had an understanding of how this model of therapy was helpful for her/his family the amount of activities completed at home increased substantially. In order to increase the parents' understanding of the model, the main principles of Theraplay were discussed in parent counselling and were used as examples in assessing specific behaviours the parents were seeing in their children.

The parenting counselling also allowed for a time where support and education could be given to the parents concerning specific parenting issues they were having with their child. Booth and Koller (1998) emphasize that support given to the parents around their child's behaviour should follow the Theraplay principles. This includes clear structure at home (parent is in charge), consistency, follow-through, and an empathetic understanding of the child's needs (Booth & Koller, 1998). When discussing specific parenting strategies these concepts were emphasized and reinforced in the parent counselling sessions as being important elements that all children need.

Parent counselling was also used as a time for discussing issues/difficulties that may have come up over the past week. According to Einzieg (1999), there are a number of different theoretical approaches that are commonly used in parent education, which include behavioural and attachment theories. These two approaches were utilized during the parent-counselling component. A behavioural approach is based on social learning theory and tends to focus on the child's behaviour while working on encouraging appropriate behaviour and discouraging inappropriate behaviour (Nolan, 2002). This approach focuses on behaviour management strategies and problem solving skills. This was used with some of the families. Specifically, information and education was provided regarding the use of behavioural charts and positive reinforcement with a view to encouraging the behaviour the parents wanted to see. There was a greater focus on encouraging positive behaviour through positive reinforcement. Attachment theory was used as well in order to emphasize the importance of the parent-child relationship and the impact this will have on the well-being of children (Einzieg, 1999). However, it should be noted that the parent counselling was not limited to employing one specific approach as there was an acknowledgement that are many facets to the role of the parent that need to be considered in order to understand the parent-child relationship.

The parent counselling varied depending on the specific needs of the family. For example, discussing parenting strategies for specific behavioural difficulties was commonly a focus of parent counselling sessions for the families who had children externalizing their behaviour. With these families, information and

education was provided to the parents allowing them to best support their child. For example, in the case with Sharon and Jack, a number of parent counselling sessions were spent discussing Jack's temperamental traits and how this impacted on his reaction to his environment. Discussions also occurred around Sharon's temperamental traits and how this affected her reaction to Jack. Specific parenting strategies were discussed that would assist Sharon in best supporting Jack at home. Focusing on temperamental traits gave Sharon a different perspective for why she and her son were commonly engaging in power struggles. This approach appeared to be effective for Sharon as it gave her some insight as to where the behaviour may be coming from and how to best to respond.

The parent counselling also appeared to be effective for Jane and Steve as they were open to sharing and discussing their parenting concerns regarding Dave. As Jane and Steve had recently reconciled both had different perspectives and insights into parenting Dave. The parent counselling allowed both parents to share their ideas and it also allowed for each one to identify and define their roles in the shared parenting of Dave. As Jane was Dave's primary caregiver for three years, there needed to be some negotiation and compromise between Jane and Steve in order to redefine their roles.

Overall, in the six families seen in this practicum the parent counselling appeared to be more effective with some parents than with others. From my perspective, the parent counselling in the families of Maria and Ben and Bill and Scott was not as effective. This may be due to a number of different factors. Both of these parents viewed their child's behaviour as being due to individual

factors and saw the therapeutic intervention as the primary mode for bringing change. It appeared that these two caregivers had greater difficulty making a shift to viewing the intervention as targeting a relational process rather than the child. Furthermore, both of these parents were experiencing stresses in other areas of their life that may have been impacting on what they were able to give their children. In retrospect, the parent counselling may have been more effective if I had placed a greater focus on the individual needs of these parents. Especially, in the case of Bill it appeared as though this single parent had a number of unresolved issues that were putting up blocks for what he could give to his children. Bill may have benefited from individual therapy. Booth and Koller (1998) indicate that it is essential for parents to have their own needs met in order to effectively meet the needs of their children. Furthermore, Maria and Bill may have benefited more from a therapist who was more experienced than I in parent counselling.

From my experience, the parent-counselling component of the weekly sessions was a key element in the therapeutic process. It appeared as though once the parent had a clear understanding of the model and how it would be helpful for her/his family this greatly assisted in the effectiveness of the intervention. It should be noted that a limitation to the Theraplay model is the lack of attention the literature pays to this component when in some situations it may play a large role in the success of the intervention. A greater emphasis should be given in the literature to parent counselling in order to assist therapists in understanding the

importance of this component of the intervention as well as to assist in implementing it more effectively.

Phases of Treatment for Children

As discussed in the literature review, Jernberg and Booth (1999) identify various phases that children typically go through in response to Theraplay treatment. These phases are: the Introduction Phase, the Exploration Phase, the Tentative Acceptance Phase, the Negative Reaction Phase, the Growing and Trusting Phase, and the Termination Phase. The length of each phase depends on the individual child and is influenced by the age of the child and her/his individual life experiences (Jernberg & Booth, 1999). Of particular importance is the negative reaction phase that children experience during treatment.

The six children seen in this practicum went through each of these phases to varying degrees. The Introduction Phase occurs when the child is introduced into the play setting, the structure of the Theraplay sessions, and the specific play activities. This is the phase where the therapist sets the tone of being in charge. All of the children appeared to go through the Introduction Phase, Exploration Phase and Tentative Acceptance Phase during the first or second session. From my experience, it appeared that the younger children (ages six and seven) were initially more willing to accept the type of activities that were played and showed less hesitation when the activities were introduced. The older children (ages eight and nine) tended to show more hesitation in the beginning stages of therapy and displayed a greater degree of reluctance to participate in the playful activities. As

the Theraplay model focuses on interactive activities that are typically childhood games, this initial reluctance in the older children may have been due to the unexpected nature of the activities as well as the likelihood of not recently having played these games.

Jernberg and Booth (1999) acknowledge that although there is a high level of variability in how each child will respond to treatment it is helpful for the therapist to be aware of the phases especially the likelihood of the negative reaction phase. The negative reaction phase can have an impact on all participants in therapy, that is, the child, the parent and the therapists. Having an awareness and an understanding of this phase this will assist the work done with both the child and the parent. The parent can be prepared beforehand to this phase occurring, as this can often be an upsetting phase for the parent to observe. The therapist working with the child can also prepare for this reaction and plan for alternative interactions/interventions in order to engage this child. Typically, children will enter the negative reaction stage following the second or third session (Jernberg & Booth, 1999).

All children experienced a negative reaction phase to treatment with some reactions being stronger than others. The negative reactions ranged from reluctance to participate to active resistance. Reluctance was seen by some children hesitating, rolling their eyes during activities, or stating they did not want to complete an activity when the specific game was introduced. Often, with some enthusiasm and persistence to make the activity engaging these children would begin to participate. Some children would attempt to change the rules of the

activity, or add their own suggestions of games in order to change the agenda. In these situations, the child's ideas were validated and it was explained that her/his game could be played next time while staying with the schedule of activities for the day. In the situations where children showed resistance and refused to take part in an activity through the session, attempts were made to engage these children. However, this required some flexibility and, as seen with Dave, changes in the activities and types of interactions were needed in order to meet his needs and to increase his comfort level with the intervention.

Overall, it was helpful to have an understanding of these stages prior to the work done with the children. Although each child's reaction to the progression of treatment was different and varied, by having knowledge of the typical phases it assisted in the planning of sessions and in preparing my responses.

Single Parents

One commonality amongst the families seen in this practicum was that the majority of them were single parent families. Of the six families who were part of this practicum, five were single parents: four single mothers and one single father. The remaining family was a two-parent family.

All of the single parents had common issues and stresses they were dealing with in their day-to-day lives that were impacting on their level of parenting stress. According to Golombok (2000), lack of financial resources, work stresses, loss/absence of a parent, and a lack of social support all have an impact on the lives of single parents and their children. Jackson (2001) cites that single mothers

are often over extended in being able to meet their children's needs. That is, they often feel overwhelmed by having the full responsibility of providing supervision, individual quality time with each child, working outside of the home, and finding quality childcare. These challenges were a part of the lives of the families seen for this practicum and to some extent were explored within the context of therapy.

According to Clark (1993), single mother headed families are more likely to be living in poverty than families with two parents. Furthermore, it is this demographic that tends to stay in poverty for a longer period of time and this obviously has an impact on their long term financial position (Lero & Brockman, 1993). Low income levels are in part related to low education levels and limited opportunities for employment (Lero & Brockman, 1993). A strain on financial resources was apparent in varying degrees with most of the families seen for this practicum. For example, the essential necessity of food was an issue as often a couple of the families were struggling financially by the end of the month in order to meet the nutritional needs of the children. In some situations, food donations the Elizabeth Hill Counselling Centre had acquired were provided to these families and an effort to provide nutritional snacks was also incorporated into the sessions. Although these efforts would not have a long term impact on the needs for these families it may have been some assistance at that particular time. For another family the cost of transportation each week to go to and from appointments was a challenge. Poverty was a large issue for these families, which had a direct impact on the stresses they felt as parents.

Access to quality and reliable childcare is another issue for single parents. This was an issue for at least three of the families seen in this practicum. In order to come to sessions, this required the caregiver to find childcare and juggle schedules in order to keep appointments. There were a few occasions where other children in the home were brought to the sessions in the absence of childcare.

Stressors related to work outside the home were apparent for two of the single parent families. Both of these parents struggled with the amount of quality time they felt they could give their children. They worked long hours and indicated feeling pressure balancing their work and parent roles. Furthermore, these parents were experiencing stress as they were in the role of completing all of the day-to-day living tasks (e.g., primary care of the children, ensuring adequate child care, household responsibilities, outside employment responsibilities, etc.). These parents also appeared to be struggling with feelings of guilt associated with being pulled in multiple directions.

The absence of a parent also appeared to have an impact on at least three of the children seen in this practicum. The loss and grief over the absence of a parent was present for these children and surfaced during the course of treatment. Confusion, self-blame, and anger were common feelings for these children. The Theraplay model focuses on strengthening the relationship between the child and caregiver. A limitation of the model is that it does not effectively allow for children to express feelings of grief and loss for the parent who does not play a consistent role in their lives. In the context of this practicum, additional interventions were incorporated into the Theraplay format in an effort to address

some of these issues. The variations of the model will be discussed in greater detail later in this chapter.

Social support is an important element for all parents. For single parents having reliable support is essential for the total care given to children (Clark, 1993). As single parents do not have another adult living in the home to share caregiving responsibilities, it is important for them to have good level of perceived social support in order to provide respite and to assist in emergency situations. According to Nolan (2002), mothers who have another caregiver available to them who can care for their children in times of need are more able to respond to the needs of their children than mothers who do not have this support. The issue of social support was common for the single parent families seen in this practicum. Some parenting stresses appeared to be related to not having an adequate amount of respite. It was common for these single parents to be overwhelmed with their parenting tasks and this had an impact on the positive interactions with their children. This was addressed to some extent in the parent counselling sessions by assessing the amount of support available to these parents and then exploring other areas in their lives that may be helpful. However, in retrospect more attention could have been given to this issue with a greater focus at intervening at this level. The model itself does not lend too much support into the area of social support and, therefore, it may be overlooked.

Systemic Issues

When working with children it is important to work within the system that she/he is a part of. One social work perspective is the ecological systems theory, which holds that an individual needs to be viewed in the context of her/his life situation (Compton & Galaway, 1994); that is to say, the individual and other members and systems of their life situation are viewed as a whole made up of interactions between the parts (Compton & Galaway, 1994). Theraplay, as a treatment model, facilitates this process as it involves the child's primary caregiver(s) into the therapeutic process. This model focuses on working with the child and her/his primary system, namely, their caregivers. The child is not viewed alone but as a part of the family system. By approaching work with the entire family the onus of the difficulties within the relationship is not placed on the child but rather on the family system. Therefore, the child is not blamed for the difficulties within the family but the problem is viewed as an interactional issue. Incorporating other influential people in the child's life into the Theraplay process can be helpful as they can support the parent through the therapeutic process as well as offer insight into the family's functioning, strengths, and challenges.

Winnipeg Child and Family Services (WCFS) referred two of the families seen for this practicum to the Elizabeth Hill Counselling Centre. These children had experienced a number of different placements and caregivers over their short lives. The primary goal of Theraplay was to strengthen the relationship between the child and his caregiver. Both families had the involvement of a WCFS Family

Support Worker. The role of the family support workers ranged from providing respite for the caregivers to teaching and supporting parenting skills. Both Family Support Workers had a good deal of contact with the child and the caregiver and therefore, it was appropriate to involve these individuals in the Theraplay process. The Family Support Workers were willing to participate in the therapy and attended a majority of the sessions.

For all of the Theraplay sessions, the family support workers observed behind the one-way mirror for the Theraplay activities and then joined in the parent counselling with the parent and therapists. The involvement of these workers was seen as important for a couple of reasons. Primarily, they were a valuable resource as they could support the parent in between Theraplay sessions and encourage the activities at home. By observing and participating in the process the family support workers appeared to grasp the concept of the model quickly and were able to reinforce this at home. In particular, one of the family support workers had involvement with her family for a long period of time and, therefore, had a good relationship with the family and a good understanding of their strengths and limitations. The primary role of this family support worker was to teach and strengthen the parenting skills of the mother. This worker was an important part of the process as it appeared as though she would often work with the mother in between sessions and reinforce the Theraplay activities.

One of the family support workers provided a large number of hours per week of respite for the caregiver. Therefore, she was spending a good part of time individually with the child. By being a part of the sessions she could incorporate

some of the Theraplay activities during the time she spent with the child. Involving family support workers is another way of incorporating important systems of the child's life into the therapeutic process.

In making the decision to include others into the sessions it is important to assess their role with the family and whether it would be a benefit for the child and family by including them in the process. With the two families involved in this practicum, the inclusion of the family support workers was an important part of the process.

Additional Clinical Interventions to the Theraplay Model

The primary aim of the Theraplay model is to strengthen the parent-child relationship through attachment-based play. For the all of the families that were seen for this practicum, this therapeutic intervention was the primary model used. However, for three of the families, further therapeutic interventions were used in addition to the model in order to best meet the needs of the family. For these families, other issues emerged during the course of treatment that needed to be explored. Therefore, continual assessment throughout the therapeutic process is essential in order to plan the most appropriate interventions.

One parent-child system consisting of a 6-year-old boy, Josh and his single mother, Karen, began Theraplay treatment due to Karen's concerns of sadness and frequent physical aggression by Josh. As the Theraplay intervention progressed, Karen reported that Josh was expressing sadness and loss over his father who played an inconsistent role in his life and who currently was not

having any contact with Josh. Some specific interventions were used midway through the course of treatment to help Josh to talk about his father and the feelings of grief and loss he was experiencing.

Through the use of stories, writing letters, and sharing personal photographs of Josh's father, it became known that Josh was feeling a great deal of guilt over the lack of contact with his father. Josh was able to express the feeling that he was to blame for his father not maintaining contact with him and that he had done something wrong at his father's home the last time he visited him. According to Sunderland (2000), the use of stories in a therapeutic way has the opportunity to speak to a child on a level that every day language cannot achieve. A well chosen story aims to identify an emotional issue a child is struggling with in an empathetic way (Sunderland, 2000). The story, *Franklin's Bad Day*, was used initially in order to begin the process of exploring feelings of loss. This story was a parallel for Josh as a close friend of his had moved away as had a friend of Franklin, the character in the story. This story was used as a vehicle to assist Josh in labelling and identifying the feelings of sadness and loss. Furthermore, using personal photographs in the session allowed Karen to tell Josh about positive memories she had of his father and it was a useful tool to lead into Karen telling Josh about why she and his father were no longer together. By incorporating these additional interventions into the Theraplay session Josh was able to identify and work through some of his feelings of loss and guilt.

Furthermore, having Karen involved in this process was beneficial for Josh's grieving as well as for strengthening the parent-child relationship. It was

important for Josh to hear from his mother why his father is not involved in his life and to give him the message that his father's lack of involvement is not due to anything Josh did. These therapeutic interventions allowed for some additional work to be accomplished that might not have occurred if a pure Theraplay format was used. This is a good example of the benefits of having the caregiver involved in the therapeutic process. According to Jewett Jarratt (1994), when working with issues of loss it is most effective to have one caregiver involved in the therapeutic process. The involvement of the caregiver gives the child permission to grieve. Furthermore, the caregiver provides essential information to the process and can, with the help of the therapist, learn to read the cues of their child (Jewett Jarratt, 1994).

This theme of loss was seen in another parent-child system. Scott was a 9-year-old boy who for most of his life had been primarily cared for by his father, Bill. Scott had limited contact with his mother. Bill had referred his son for treatment due to concerns of aggressive and defiant behaviour at school (i.e., refusing to complete his work, conflict with peers) and concerns of regressive behaviour at home (i.e., thumb sucking and carrying a blanket). Bill reported during one session that it appeared as though Scott was struggling with his feelings towards his mother and was having difficulty understanding why she did not play a bigger role in his life. Further therapeutic interventions were used in the Theraplay sessions with this family to help explore Scott's feelings about his mother. The additional interventions were included midway through treatment and it was also at a time when there appeared to be a block in the progression of

treatment. The inclusion of additional interventions began by talking to both Scott and Bill about their individual memories of Scott's mother. This was a difficult task for both the father and son. It was especially difficult for Bill who did not have many positive memories or messages that he could give to Scott about his mother. Additional activities aimed at identifying and expressing feelings were used in the sessions in order to give Scott a broader vocabulary of feelings and an avenue to express feelings. Therapeutic board games (i.e., Hugs and Tickles) were also added to the sessions in an effort to role model, provide positive reinforcement, and build on social skills. Board games were effective with this family as both Scott and Bill appeared to enjoy them and developmentally this was age appropriate for Scott. According to Nickerson and O'Laughlin (1983), using games as a therapeutic tool allows the child and adult to engage in a structured activity that facilitates communication, expression, and spontaneity. Children tend to feel comfortable and at ease when engaging in play or games.

Bill and Scott participated in a total of 20 Theraplay sessions. The introduction of family interventions was in an effort to work on issues of loss. In retrospect, Theraplay was not an entirely successful intervention for this family. Although Scott clearly responded to all of the Theraplay activities (especially to the nurturing ones) and the playful format of the session, it did not appear that this intervention was effective. Throughout the course of treatment there were periods of deterioration in Scott's behaviour especially at school where he was engaging in physically aggressive and defiant behaviour.

The ineffectiveness of treatment may be due to a couple of factors. Throughout treatment, Bill had difficulty understanding his role in Scott's behaviour and appeared to have difficulty understanding Scott's needs. Bill appeared to have a number of blocks and seemed to be going through a difficult period in his own life. Furthermore, the little experience I had in a therapeutic role did not help this process.

Another parent-child system that was seen for this practicum was a 9-year-old boy, Mark and his mother Shannon. Mark was in the care of Winnipeg Child and Family Services and had not been cared for by his mother for a few years. Theraplay appeared to be an appropriate intervention for this family since it would assist in strengthening the relationship between the mother and son. However, midway through the Theraplay treatment, additional interventions were included to work on feelings and loss for the mother and son. The family had attempted a trial reunification period that occurred during the course of treatment that was not successful. Therefore, it appeared appropriate to address this in the theraplay session so that Mark could hear from his mother why the reunification did not work out. Therapeutic board games and feelings activities were also used with this family in order to assist with the expression of feelings.

The incorporation of additional therapeutic interventions were important themes as it allowed for family work to be completed that might not have been addressed if a pure Theraplay model was used. Theraplay as a model does not focus on talk, explanations, or expression of feelings. However, in certain circumstances it appeared necessary to address issues in sessions that surfaced

during the course of treatment. Through the use of additional interventions it was discovered that they could be incorporated into the Theraplay format in order to meet the specific needs of an individual client system.

The family interventions discussed in this session were very helpful in facilitating the progression of treatment. It was helpful to use these interventions and to see how they facilitated a different interaction between the parent and child than the Theraplay activities. These interventions often evoked a more intense interaction between the clients than the playful nature of the Theraplay activities. For example, the sharing of personal photographs between Sharon and Josh was a turning point in the course of treatment for this family as this was when Josh verbalized his feelings of guilt and showed his feelings of sadness. This intervention also allowed Sharon to send reassuring messages that he was not to blame for the lack of contact by his father. As an individual new to the role of therapist it was helpful to explore different therapeutic interventions and to see their impact on clients.

CONCLUSION

Theraplay as a therapeutic intervention is a useful and valuable treatment model to employ when working with children and their caregivers. The inclusion of the caregiver in the therapeutic process is an important and key element to this model. As an individual being introduced to the clinical process, this model of therapy allowed me to gain a greater understanding of the importance of the relationship between the caregiver and child. Furthermore, theraplay gave me a better understanding of the importance of including the caregiver in the treatment process. This model takes the position that the intervention is family based rather than focused solely on the child.

Theraplay is a treatment model that fits well with the principles of social work. This model allows for a greater ecological perspective, as it is a relational therapeutic model that views children and caregivers as a system. It is a model that aims to strengthen the parent-child relationship, which in turn will assist in alleviating behaviours that may emerge due to relationship issues. However, it should be noted that the Theraplay literature does not place a great deal of emphasis on the other systems that may be impacting on the family's life.

I recommend this intervention for children and families. Theraplay is an engaging and fun intervention for families that focuses on strengthening the parent-child relationship through play itself. It appears as though one of the most appealing aspects of Theraplay to families is the play. In the context of therapy, play tends to be a non-threatening, non-intrusive mode of engaging families in a

therapeutic environment. Play can serve as a vehicle to allow family members to feel more comfortable in the context of therapy as this can often be an intimidating process. However, it must be noted that Theraplay is only one intervention in the broad spectrum of therapies and interventions for children and their families and to simply focus on this one intervention of therapy ignores many useful and valid other types of interventions for children and families.

The Theraplay model itself does present with some limitations. It is most effective with children and caregivers where there are relationship issues. In particular, this model would be well suited for newly adoptive families, and for children in foster care and their foster parents to assist in strengthening the relationship between child and caregiver. The Theraplay literature indicates that this model would be helpful for children who experience a wide range of behavioural problems that have resulted due to difficulties in their primary relationship with their caregiver (Jernberg & Booth, 1999). However, a number of the behavioural problems identified could be a result of other experiences or situations for the child and her/his family. Therefore, the assessment process is extremely important in determining what intervention would be the most appropriate for the family.

The Theraplay model would not be appropriate for children who have experienced recent trauma or abuse. A limitation of the pure form of the Theraplay model is that it does not effectively treat the processing of feelings or emotions as can be accomplished in play or talk therapy. In the context of this practicum, this was seen as a major limitation of the model as in a few situations

additional family therapy interventions were necessary to include into the sessions in order to continue moving forward in the therapeutic process. The incorporation of further interventions required careful planning and continual assessment of the family's needs throughout the treatment process.

Another limitation of the model is the lack of attention the literature pays to parent counselling. This is a large part of the intervention as it is generally half of the session and there is a remarkable scarcity of information provided to assist clinicians in this area. From the experience of this practicum it appeared as though the parent counselling played a large role in the success of the intervention. Therefore, further information on guiding therapists through this part of the therapy would be helpful.

I had the great opportunity to work at the Elizabeth Hill Counselling Centre at the same time as I was completing my practicum. This experience allowed me to do individual play therapy work with children within the child welfare system. I am very grateful for this experience, as I know it allowed me to gain a much broader experience in the different therapeutic approaches when working with children and families. Although Theraplay is a valuable and useful model to work with children and families, it should be acknowledged that there are many other valid clinical interventions that may be more appropriate depending on the needs of the client system.

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Appendix A

Consumer Satisfaction/Feedback Questionnaire

This questionnaire has been created to help me understand the experience you and your child have had at the Elizabeth Hill Counselling Centre (EHCC). Please answer the questions honestly; I am interested in both your positive and negative feedback.

1. Did the counselling you received at the Elizabeth Hill Counselling Centre meet your needs?

2. What was most helpful in the counselling?

3. What was least helpful in counselling?

4. Is there anything that you would like to see changed in the way service was provided to you at the Elizabeth Hill Counselling Centre?

5. Do you have any other comments or suggestions?

6. Would you recommend this service to other families?