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THERAPLAY: CHILD THERAPY FOR ATTACHMENT FOSTERING

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Abstract

Many adults enter psychotherapy complaining of problems with self-esteem. As we come to understand better the origins of this sense of vulnerability it becomes increasingly clear that the quality of early parent-child relationships can range from esteem-enhancing to esteem-jeopardizing. This paper describes two techniques: one, the Marschak Interaction Method (MIM) for clinical assessment of the parent-child relationship and two, Theraplay, for therapeutic intervention into these relationships which are at risk for generating low self-esteem in the child. A sample case is presented and the kinds of cases for which Theraplay is appropriate or inappropriate are discussed.

Introduction

The popularity of such books as Elkind's *The Hurried Child* (Elkind, 1981) and Miller's *Prisoners of Childhood* (Miller, 1981) seems to coincide with what appears to be an increase in the number of patients who present themselves to psychotherapists complaining of low self-esteem (Kohut, 1977). What experience in the life of small children might make for such vulnerable self-esteem? Elkind and Miller describe the relationship of these children with their parents as follows:

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Miller states, "It usually does not occur to the parents that they might need and use the child to fulfill their own egoistic wishes" (Miller, 1981, p. vii), and Elkind entitles the sections of one of his chapters as follows: "the child as surrogate self," "the child as status symbol," "the child as therapist," "the child as conscience" (Elkind, 1981, pp. 23-45). Miller and Elkind are only two of many authors recently expressing concern about parental exploitation and empathic failure. And this concern, along with concern about other manifestations of disturbed parent-child functioning, are leading to a spate of literature on the specifics of parent-infant and parent-child interaction.

The Parent-Infant Relationship

In the past, efforts to explore and gather data about early life relationships have been handicapped both by the difficulty of gathering data which could subsequently be studied and by a lack of systematic ways of recording and evaluating data.

The available technology of videotape as well as a relatively new technique for evaluating parent-child relationships [Jernberg *et al.* (videotape), 1978; Jernberg *et al.* (videotape), 1979; Jernberg *et al.*, 1980, 1981, 1982, 1983; the Marschak Interaction Method, Marschak, 1960, 1980] now make this systematic study much more feasible.

It seems clear to many students of parent-child relationships that the child's capacity for attachment is strongly determinative of later mental health (Adams, 1982; Weiss, 1982). There is also emerging evidence that both infant temperament and parental behavior can serve to either enhance or inhibit the development of this capacity in the child (Ainsworth *et al.*, 1978; Brazelton, 1982, p. 4; Keller & Rothmund, 1982; Sameroff, 1975). Quite apart from the avoidance of early physical separation, parental eye contact and empathic and affective engagement are among these attachment-enhancing behaviors. In a myriad of different ways

mothers and fathers convey to their particular child his or her importance, uniqueness, brilliance, beauty, and strength. They convey, in short, that he or she is both wonderful and lovable (Stringer, 1971, pp. 51-52).

The baby, in turn, responds to his/her parents' accolades with an adoring gaze, a delighted smile, and imitative sounds and movements—hero worship which cannot help but flatter the hero/heroine. The resulting interactive pattern of mutual admiration, as manifested in baby's movements and mother's voice, furthermore, shows all the synchrony of a well-rehearsed dance (Condon, 1974).

The child in the process just described becomes happily attached with the result that the satisfactions experienced by parent and child together enhance not only the confidence of each, but also allow the child, in time, to begin the gradual move toward autonomy (Brazelton, 1982, p. 10). This chain of events is as it should be. The timing for each stage is critical. If, because of early object loss, or illness, or if, because of a series of foster homes ending in a late adoption, the child is "stuck" at an early stage and unable to move on (Altschul, 1968), the parent becomes frustrated at the child's lack of appropriate responsiveness and comes to resent the child. If, because of unmet childhood or marital needs of his/her own, the parent is unable to let the child move on, the child suffers emotional harm (Furman, 1982). If, for whatever genetic or other antecedent reason (Brazelton, 1982, p. 8) . . . or if, because of current stress, e.g., socioeconomic circumstances (Brazelton, 1982, p. 8; Sameroff, 1982) the parent is, even briefly, unable to engage the infant (cf. the still-face experiment of Tronick, etc., in Tronick *et al.*, 1978) or if the infant, in turn, is unable to respond to, or initiate overtures toward, the adult, the discounted party will smart from the rejection and will do what he or she needs to do thenceforth to protect him/herself.

The child may lapse into his own healthy or unhealthy coping behavior. Like Bowlby's grieving children (Bowlby, 1973). Harlow's huddling monkeys (Harlow, 1959), Spitz's marasmic infants (Spitz, 1945), the Robertsons' despairing *Young Children in Brief Separation* (Robertson & Robertson, 1969), and Fraiberg's autistic-like blind babies (Fraiberg, 1977) some may become depressed and "tune out," others may manifest the "aggressive display" underlying which there is, to quote Malmquist (Malmquist, 1971), "a denigrated self-concept." Parents attempting to relate to crying neonates who heed no comfort, who are physically unappealing babies, or ones who turn away, arch their backs, reject parental nurturing, or prefer the company of strangers, for example, will find their own ways to soothe, protect, and possibly even avenge themselves (DeLosier, 1982; Milowe & Lourie, 1964; Sameroff, 1975, p. 290). In either event, these children experience a dearth of empathy from the important adults in their worlds. That is, they experience a feeling of not being heard or valued. And not being heard or valued colors the kind of present or future behavior which is based in self-esteem (Bowlby, 1951; Broussard, 1976; Snyder & Fromkin, 1980, p. 208).

It is the opinion of steadily growing numbers of mental health professionals from fields as divergent/diverse as psychoanalytic self-psychology (Kohut, 1977), transactional analysis reparenting (Reese & Ryser, 1981), and pediatrics (Brazelton, 1982, p. 8) that if poor early parenting leads to faulty self-esteem, later remedial healthy parenting (whether by psychoanalyst, reparenting psychotherapist, or "educated" parent him/herself) is the means for "setting the record straight."

Theraplay

Theraplay is one method for doing this. Modeled on the often playful and frequently engaged behavior which characterizes the healthy parent with his/her infant, Theraplay provides Structure, Challenge, Intrusion, and Nurture (Jernberg, 1979, pp. 8, 46-47). That is, just as mothers and fathers may feed and hold, play peek-a-boo, exalt the baby's loveliness and charm, roughhouse and tumble, or vigorously challenge (Pederson, 1982), so the Theraplay therapist, in replicating this method, also may carry out these very same activities. The Theraplay therapist, like the parent of the infant, among many other parentlike behaviors, 1) takes charge (i.e., responds to what he or she knows the client/child "really" needs rather than appealing for approval and permission, asking "democratic" questions, apologizing for taking the initiative, or taking at face value what the child may claim to "want"), 2) communicates the child's uniquely wonderful qualities, 3) protects the child from hurts and tenderly cares for scratches, bumps, and bruises, and 4) makes eye contact whenever possible. All of these behaviors the Theraplay therapist carries out according to the individual child's underlying needs. For example, although Challenging and Structuring activities

such as chess and checkers may be overtly desired by the obsessive child, Theraplay therapists have found, as has Adams (1973, p. 220), that Intrusive activities (e.g., surprises) along with Nurturing ones (e.g., feeding applesauce, powdering and lotioning) are likely to be of greatest benefit. Although there are many children for whom Theraplay is not only appropriate but seems to be the therapy of choice, there are some (e.g. adolescents; Jernberg, 1979, pp. 339-385) for whom Theraplay must be modified, and others for whom Theraplay is generally not appropriate at all. Children who have suffered a recent trauma or loss are best helped by another kind of therapy (e.g., traditional doll play, puppets, discussion or drawings; Kuhli, 1983; Mann, 1983; Terr, 1983). Also, children diagnosed as sociopathic may enjoy their sessions in Theraplay yet generally derive small benefit. If they are truly sociopathic, family therapy or marital therapy for their parents will usually be of more help (Fisch & Segal, 1982; Minuchin & Fishman, 1981). For, in the family system, there sociopathy often serves a family function. For failure-to-attach children who are not true sociopaths but only behave in sociopathic ways because of an early attachment deficit, Theraplay, once again, can be appropriate, particularly in the case of late-adopted children, the new family bonding context being a prime example (T. Koller, personal communication, 1981). Theraplay is always done in a spirit of playful cheer and optimism. If at all possible, it is also done with a full understanding of, and a therapeutic program planned so as to deal with the parent-child relationship.

It is to provide this understanding of the parent-child relationship that the ideal course of Theraplay includes a traditional intake interview as well as the administration of the Marschak Interaction Method (MIM), videotaped if possible.

The Marschak Interaction Method

The MIM consists of a series of tasks which each parent separately is instructed to perform with his or her child. Tasks are designed to tap the following dimensions on the part of the parent: Promotes Attachment, Guides Purposive Behavior, Alerts to Environment, and Aids in Reducing Stress. On the part of the child the MIM taps: Shows Attachment, Shows Purposive Behavior, Shows Alertness to Environment, and Shows Ability to Cope with Stress. The MIM is geared to all age levels from infancy on up. When using it clinically the MIM observer not only records verbal and nonverbal interchanges, but also attempts to think through such questions as: 1) What would it be like living with this child all day? (cf. Brazelton, 1982, p. 14); 2) What would it be like living with this parent?; and 3) What characterizes their interchange? The latter includes such questions as, What is their degree of synchrony? of goodness of fit? Who leads and who follows? What is the sequence of response between them? What is the degree of empathy? of playfulness? of nurturing? What happens to either partner when the other is anxious or uncomfortable or absent?

Family Theraplay

In situations such as schools or day-care centers Theraplay treatment may have to be undertaken without the parents and with only minimal preliminary knowledge. In mental health centers and other treatment settings, on the other hand, Family Theraplay can readily and effectively be undertaken.

Family theraplay is conducted in two adjoining rooms and in two time segments. During the first half of the approximately 20-session Theraplay treatment course parents do not directly participate in their child's treatment; during the second half, they do. During the first ten or so sessions and even for a part of the later sessions, parents sit with an Interpreting Therapist as they observe their child's treatment—and perceive, perhaps for the first time, both his "wonderful" qualities and his distancing manuevers—through a one-way viewing glass. This barrier seems to provide a safe shield for parental fantasy, parental hopes, parental disappointments, vicarious interactions, vicarious identification, and the expression in consciousness of both positive and negative wishes as well as allowing for constructive planning. The glass shield, in other words, allows the same kind of parental fantasy activity post-birth as the placenta allows during pregnancy. The Interpreting Therapist, sitting with the parents, 1) discusses Theraplay strategies and the Theraplay rationale, 2) calls attention to their child's "keep-away" and other manuevers, 3) asks about problem areas and successful coping during the week gone by, 4) gives Theraplay hints and guidance regarding the week ahead, 5) allows the expression of acceptable and unacceptable wishes, fears, and fantasies, 6) explores resistances, and 7) attempts to redirect or refer for further help those marital issues which, particularly at that time, most affect the child.

With the onset of the second treatment phase, parents still spend the beginning 15 minutes of each 30-minute session in the observation room. The second 15 minutes, however, is spent with the child and his/her therapist in the Theraplay room. Here the parents are included as participants, are encouraged to respond to the child with upbeat optimism, are coached as co-therapists, and are directly or symbolically provided the Structuring, Challenging, Intruding and/or Nurturing which they themselves may need if they are to provide these same experiences to their child. Following a termination party at the final session, the family returns for quarterly "checkups" through the first year and annual "checkups" thereafter.

Family Theraplay need not include both parents and may include grandparents or stepparents (we have seen "blended" families sharing custody in which children have come for their sessions with both sets of parents in alternating sequence). Although the one-way mirror and the Interpreting Therapist are ideal, when not available, Family Theraplay can be conducted as follows: Parents observe their child and his/her therapist while sitting along a wall inside the Theraplay room. Prolonged postsession discussions, although they might appear to provide a useful format under these limitations, are in fact counterproductive (T. Koller, personal communication, 1983).

The Session

Whether the sessions are individual Theraplay or Family Theraplay, within the prescribed plan for the individual child (and leaving room for last-minute modification), each Theraplay session is carefully regulated. Exciting, boisterous activities, for example, are preplanned to alternate with calm soothing ones, calm ones being planned to close the session. The parameters of each session, furthermore, are clearly defined. Where a session takes place and for how long are carefully spelled out to every child. The rules are clear both as to who is in charge and as to what is and is not allowed.

The Treatment Course

So far we have described Theraplay from the point of view of what Theraplay therapists do. This section deals with what, from initial session to termination, they can expect the child to do. Six phases generally characterize the treatment course, dependent, of course, in tone and duration, upon the personality and psychopathology of the individual child: a) *introduction*, in which the child meets the therapist and learns the rules of the game; b) *exploration*, in which the child gets to know the therapist; c) *tentative acceptance*, in which the child puts on the appearance of "buying the package"; d) *negative reaction*, in which the child openly refuses any and all efforts at intimacy. This negativism may also show itself at home and/or in the classroom; and e) *growing and trusting*, in which the child begins to experience the genuine pleasure of the relationship.

Although children in Theraplay do not always follow this sequence of behaviors it is important for therapists to anticipate the possibility so that they can alert parents and teachers beforehand.

Withdrawn vs. Acting-Out Children

Withdrawn children and those who act out typically manifest different patterns of behavior as they move from Introduction to Termination. Aspiring Theraplay therapists are forearmed if they can anticipate this. For, whereas the withdrawn child begins with a low level of acting out, then moves temporarily to a high one—before leveling off at normal—the acter-outer begins with a high activity level, moves temporarily to a low (depressed) one, and only then levels out at normal. Unless the therapist has done the groundwork of preparing the family and the school beforehand, parents and schoolteachers may criticize the therapist who "turns" the timid wallflower into a demon. Aggressive tyrants, by the same token, who become woefully depressed will puzzle those around them if there is inadequate preparation for this possibility (Figure 1). Immature and pseudomature children, as their mental health improves, may show a similarly divergent pattern (Figure 2).

Theraplay, including Speech Theraplay (Bligh, 1977; Rubin, 1978; Searcy, 1983), can be usefully used as a diagnostic method (Jernberg, 1979). Some specific Theraplay activities may help in making the determination, for example, of low tolerance for intimacy, high need to maintain control, vestibular difficulty, or developmental delay.

Case Illustration

Evaluation

If not entirely hypothetical the following case is at least a composite of the several hundred cases typically referred to the Theraplay Institute:

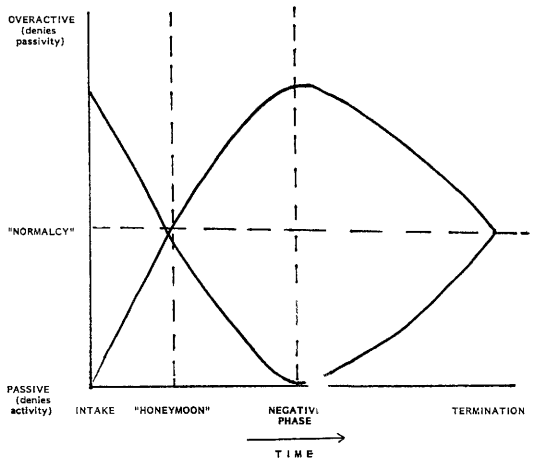

Figure 1. The effect of Theraplay on overactive vs. passive children.

Horace is a seven-year-old boy whose parents seek Theraplay because he is a poor sport on the playing field, a provocateur at school, accident-prone at home, stubborn with members of the family, and a terrified sleeper at night.

During the intake interview we learn that Horace was an "independent" infant, discontented when held or cuddled, calm when in his crib alone. He was an early reader and a self-sufficient eater and dresser. The MIM shows us how, a pattern having been established, this behavior is coming to be ever more pronounced. On the item ADULT TEACH CHILD SOMETHING HE DOESN'T KNOW, for example, his mother, rather than choosing to teach him to dance the boogaloo, or to count his freckles in the mirror, or to see the dimples when he smiles, asks, What do you want to learn about?" His answer, "atoms," leads her to ponder for him the world of nuclear disaster. "O.K., I'll teach you about what happened at Three Mile Island, Horace . . .," she begins. His father responds to the same task with a lecture and high-level discussion on the faltering economy. Even when instructed to FEED EACH OTHER M&Ms, his mother, looking uncomfortable, says, "You can feed yourself, can't you?" "Here," handing

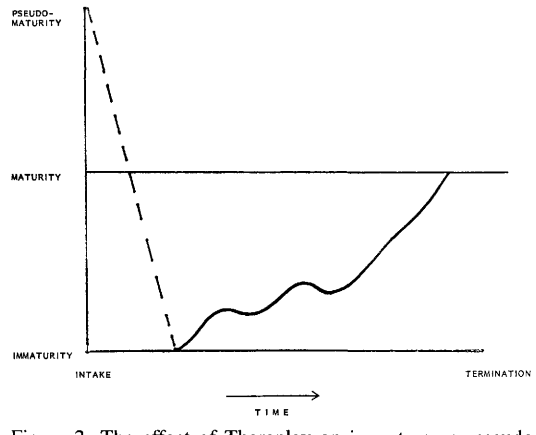

Figure 2. The effect of Theraplay on immature vs. pseudo-mature children.

him the package while she continues silently reading. (Horace, unhampered, proceeds to bombard the top of his mother's head with a shower of M&Ms, giggling anxiously as he does so.)[1]

His father, given the same assignment, selects only the brown and green candies, lines them up, and improvises a serious game of checkers. When Horace loses the first round he kicks his father's shin beneath the table. Father winces and pleads, "Don't hurt me Horace, huh?" but takes no steps to stop him. Throughout both sessions Horace leans back in his chair—so far back that the chair teeters precariously. Halfway through the MIM with father, Horace, swinging his legs with extra vigor, finally tips his chair backward and crashes to the ground. Father looks at him with contempt but says nothing.

With each additional task as the MIM progresses, the following formulations begin to emerge: a) With both his parents it is Horace, not the adult, who "runs the show." b) In the questions he asks and the comments he makes, with both his parents, Horace is more a pseudo-adult than a little boy of seven (cf. Elkind, 1981). c) Neither parent tolerates regression and neither is comfortable nurturing him. d) Neither parent sets limits or structures. e) Life for Horace is made serious and all-too-predictable. g) Horace is not recognized by his parents as a unique and wonderful individual. Rather, he seems valued for his intellect, his independence, his performance, and his capacity to deal with harsh reality. h) The world, for Horace, must be a frightening place where neither the limits he needs for protection nor consolation for his anxiety is available. i) His bodily hurts and physical needs are not attended to. Rather he is being brought up to be a "brave little man."

The goals of Horace's Theraplay are to a) enhance his self-esteem by treating him like the very small infant he is emotionally; this to be accomplished by engaging with him physically rather than intellectually; by emphasizing what a unique and wonderful person he is; by introducing him to the spontaneous and the joyful; b) build his trust in others; this to be done by protecting him from hurts; by taking good care of his bumps and scratches; by being predictably there at a consistent time and place; by demonstrating to him that it can be quite safe to let someone else "run the show"; by making sure that it is *his* underlying needs, and not the *adult's*, which are being met.

[1] In more extreme cases of this same inability to nurture, we find parents who say "feed *me*" yet fail to reciprocate in kind. It is these same parents who, on the task TELL CHILD ABOUT WHEN HE/SHE WAS A BABY, say something like, "When you were a baby . . . Let's see, I had my hair combed real pretty for my trip to the hospital," or, "Your Uncle Joe came to visit me when you were a baby."

It can be predicted that, following an initial pretense at conformity (as one way to "get them off my back"), Horace will resist with physical and verbal violence the therapist's slightest effort to nurture him, to take charge of him or to establish intimacy.

It can be predicted that his observing parents will find it all just as difficult. It is to be expected that their protestations will include "you're squelching his creativity." "you're subjecting him to infantile indignities," "you're spoiling him" (the last, particularly as they watch the therapist protect him from "accidents" or soothe and care for bumps and scratches, real or imaginary). And, as they watch his therapist ignore Horace's lecture on computers, dinosaurs or meteors and pick him up and cuddle him instead, they can be expected to say something like, "He (the therapist) should be paying attention to that. Horace was up half the night working on it with the Encyclopedia Britannica."

Treatment

Session 1

As his parents watch behind the mirror, Horace arrives in the Theraplay room secured in the arms of his jovially frolicking therapist. There is no formal introduction in the waiting room outside. Dr. Golden simply announces, "I'm Bernie and I've got these two great big arms just strong enough to carry you. See?" and to the tune of "Waltzing Matilda" he swoops Horace off the ground and dances with him down the corridor.

Therapist: Let's put you down . . . down nice and easy on these soft, down pillows here.
Horace: I don't . . .
Therapist: There we go. Now, let me have a good look at you. Ah! Freckles. Just as I thought! Freckles just the color of that nice brown hair . . .
Horace: Lemme go.
Therapist: and teeth! Oh, nice white teeth. Like pearls. Bet you chew your food real good. . . . And these arms . . . oh, they're long . . . like your legs. Let me see. Lie still. From your tips of your left hand to the tips of your right hand, oh, look, this long (marking on the mat with chalk). Now let's turn you around sideways. Oh! Horace! Will you look at that—You're the same length from head to foot as you are wide from hand to hand! Well, I'll be darned!
Horace: (Looks interested)
Therapist: Now, I want to see what's in these shoes . . .
Horace: My mother says, "No!"
Therapist: Oh boy! Toes!! How many? 1-2-3-4-5. Just the right number! That's dynamite!! Let's see you push me over with those toes.
Horace: (Pushes)
Therapist: Harder!
Horace: (Pushes harder)
Therapist: You're doing it Horace! You're pushing me over! Wow! Are you ever strong!! Bet you could even blow me over you're that strong. Sit right here (moves him). Now blow!
Horace: (Blows)
Therapist: Harder!
Horace: (Blows harder)
Therapist: (Therapist topples over slowly) Well shiver my timbers! Who ever would have thought? Now you got to pull me back up.
Horace: (Tentatively extends hand)
Therapist: That's it! Thanks. (Laying him down again)
Horace: (Resisting)
Therapist: Oh, my, you're wiggly. You got the best wiggles. Let me see . . . (looking him over) Oh, you got nice wiggly feet . . . and wiggly knees . . . and oh!, will you look at that!! . . . You even got wiggly back-of-the-knees!
Horace: (Peers at knees with interest)
Therapist: And when I tickle a little . . .
Horace: (Laughs)
Therapist: Ah! Guess what? I found a giggle spot. How about the other one?
Horace: (Laughs)
Therapist: Another giggle spot! Did you know, Horace, you got *two* giggle spots? I bet you never knew that! Oh . . . what do I see on this leg? A little scratch there? Oh, that can't be!
Horace: It's nothing.
Therapist: We don't want *that*. Here, some nice cool lotion. Hold on. Oh, there (covering small area of leg with lotion).
Horace: (Struggles)
Therapist: I bet *that* feels a whole lot better.
Horace: (Attempts to retract leg)
Therapist: No. We're not through yet with that leg. Now we got to put something nice and fresh onto it to protect it (placing Band-Aid).
Horace: (Studies it, grinning)

The session proceeds with more Intruding activities. . . . Toward the end, therapist places Horace across his lap, cradling his head with one arm.

Horace: (Struggles to free himself, wincing and groaning) No!
Therapist: Oh, you know my "no-no" song. O.K., let's sing it (rocking him to the tune of "Twinkle, Twinkle Little Star"). No–no–no–no–no–no–no. No–no–no–no–no–no–no. No–no–no–no–no–no–no–.[2] Oh! You're getting so wiggly again. I'll have to help you settle down. Come, come on, sit up (anchors Hoarce's leg with his own). Now I got a surprise. Close your eyes and be surprised.
Horace: (Opens eyes wide)
Therapist: Guess what I've got for us? Some hunks of nice chilled watermelon! (Pops one piece into Horace's mouth).

[2] With thanks to C. West.

Horace: (Looks surprised. Concentrates on chewing)
Therapist: We'll save the seeds, Horace. Here. Spit. I'll collect them in my hand.
Horace: (Spits reluctantly)
Therapist: Another piece . . . oh yum. Good melon! Another juicy bit (feeding him)! O.K. now. Look at all the seeds we got here. Now we're going to see how far we can spit them. Go ahead, *you* start.[3]
Horace: (Spits one seed, barely pushing it out of his mouth)
Therapist: Wow! You never told me you were a *champion* seed-spitter. Let's see, I bet *I* can't even match that ("attempts" to but falls short). Nope, just as I feared. . . . Here, teach me! You do another one.
Horace: (Spits this seed even farther)
Therapist: *Fantastic*! I've never *seen* anything like that. Just wait 'til I practice! Oh, that deserves a special victor's hug (hugs him) and a victor's lift-up-in-the-air. (Raises him up high.) O.K. now, it's time for shoes back on. (searches for them), and socks.
Horace: I can do it.
Therapist: No, socks and shoes I put on. You get to lie back and watch. You know, Horace? You know the way your toes curl? That's really something. Did you ever see musical toes before? Look when I sing, "da dum de dum" (lightly stroking sole of foot while singing), they curl right up in time to the music. . . . *Talented*! That's what you are, Horace. *Talented*!
Horace: (Smiles)
Therapist: O.K. now. First sock on (places it on Horace's hand).
Horace: (Looks surprised and begins to peel it off)
Therapist: What's the matter? That's where it goes, isn't it?
Horace: No, on my foot.
Therapist: Oh, I see. Oh your foot. Like this. Of course!! (Wrapping sock around Horace's ankle).
Horace: No, No. I mean . . .
Therapist: Oh, you must mean I should put it here like this (places sock correctly). Now let's find the other one (retrieving it) because I *know* how *that* one works. You don't even need to tell me about that one because I learned at school (heads for Horace's ear).
Horace: On my foot!
Therapist: Yes, I learned that at school. My teacher always taught me "socks, they go on feet" (placing second sock on foot which already has a sock).[4]
Horace: No . . . no. Not that way! (Laughing)
Therapist: (Similar hijinks accompany the putting on of shoes . . . at last Horace is dressed). Well, there you are. Let's stand you up. Ah. This tall. You fit right here on me. Perfect! Let's see next week how tall you are. (Holding hands, therapist ushers Horace out of the Theraplay room and knocks on the door of the observation room.) Hey Mom and Dad, I've got a boy here all ready to hold a hand of each of you. He's got nice hands, too. Nice and strong ones. See you next week, Horace.

In the observation room, the Interpreting Therapist has been pointing out to his parents Horace's insistence on running the show, on avoiding intimacy, and on being "grown up" and verbal. The Interpreting Therapist has been introducing to the parents the idea that, underlying Horace's show-off self-sufficiency, there is a very little child . . . a child who needs attention in a basic physical, close, and playful way. At the same time the therapist has been assuring them that they need not worry that Horace will be regressed forever. Rather, he is like a plant who needs much watering now so he can grow later. The Interpreting Therapist has also gently begun the process of urging them to do at home some nurturing and playfully intrusive activities with Horace and to omit question marks, "apologies," and legalistic discussions.

If "Horace" is typical of so many Theraplay referrals, what will be his course of recovery? As he experiences some of the infantile gratifications previously denied him, and as his parents begin to value him for who he is rather than for what he can do for them, Horace will begin to attach to his parents. He will manifest this attachment in the way he looks and smiles at them and in the way he initiates and is receptive to hugs and cuddling. Experiencing his new-found attachment to them, his parents themselves will feel a rise in self-esteem. Thus, the cycle of mutual admiration will be set into motion at last. As seen in Koller's work (Koller, 1981), it is in older-child adoptions that the attachment-promoting impact of Theraplay can most clearly be observed. For many of these children entrance into the adoptive family has been preceded by an initial early birth-parent rejection, leading to a multitude of subsequent foster placements. Suffering from a consequent failure-to-attach, these children are masters at avoiding intimacy at all cost. The pain experienced by Horace's parents is as nothing compared to the hurt well-meaning adoptive parents feel. These often-tormented people try everything they can to earn their youngster's love, only to be repeatedly rebuffed, run away or stolen from, or even watched in "frozen watchfulness"—an experience adoptive mothers usually describe as "creepy." In the course of the Theraplay belated-bonding program, attachment emerges as the parents are taught to playfully infantilize their child even though he or she may be chronologically of school age.

Horace and his parents will return every three months during the first year after Theraplay termination for a Theraplay checkup visit, conducted very much in the format of the initial session except that his parents will join in for the last 15

[3] With thanks to P. Booth.

[4] With thanks to E. Thomas.

minutes. He will return for annual visits thereafter.

Since the publication of the book *Theraplay* (Jernberg, 1979) and chapters in other books (Jernberg, 1976, 1981, 1982, 1982, 1982), this treatment modality has been expanded to include children preparing for surgery (Adamitis, 1983), children of step-parents, and infants. The Theraplay Institute's Parent-Infant Intervention Program (PIIP) is showing us what joy can be felt and how helpful it can be to a young parent (and thus to the infant) to learn, in a playful context, and at the outset, the myriad ways for evoking the optimum in their new baby's attachment behavior.

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