Theraplay® with Children in Foster Care: A Case Study

Marlo L.-R. Winstead, MSW, LCSW, RPT
Certified Theraplay Therapist

Theraplay can play a powerful role in the lives of foster children and their families. Trauma expert Bruce Perry observes, "These children prefer the certainty of misery to the misery of uncertainty," (2007). The attunement children receive from Theraplay is a certainty of a different kind—a potentially mind changing positive experience of empathy and care. The following case study illustrates how Theraplay provided stability in three different environments through the affective attunement of clinicians and caring adults during periods of great uncertainty in a foster child's life. This stability and attunement allowed for the gradual development and re-development of the child's internal working model reflected in healthier relationships with others.

Theraplay and Foster Children

What does a foster child need to sustain him through the uncertainties of removal and the path toward permanency? He needs caregivers who know, understand and have empathy for his past experiences and current behaviors. He needs adults in his life who make an extra effort to connect with him because his experiences of connection may be non-existent, negative or sadly lacking. He also needs a worker who facilitates the attachment process and sticks with him over time.

Foster parents and professionals frequently question whether it is inappropriate or harmful to facilitate an attachment between a child and foster parents who are not able to provide permanence. Ideally the adoptive parent(s) would be involved in therapy; however, one of the goals of Theraplay treatment with foster children is to transfer the attachment formed with the foster parent(s) to an adoptive parent or permanent caregiver. The endorsement of the adoptive parents by a consistent, predictable, accepting and attuned Theraplay therapist can help to establish a child's trust and familiarity with those parents.

One of the most important aspects of treatment when working with foster children is supporting their foster parents through education, consultation and encouragement. Many foster parents experience self-doubt when their parenting doesn't seem to be "working." Education about the child's history and how it has shaped his internal working model is vital. When foster parents learn to view their child's behavior through a lens of disrupted attachment relationships and traumatic experiences, and understand the difference between developmental age and chronological age, their empathy for the child increases and their understanding of that child deepens. Mental health professionals have the opportunity to come alongside foster parents and teach them that a child's behaviors are a way to get her needs met. When the parent is able to meet the need, the child's negative internal working model is challenged and an opening is created for emotional and behavioral change.

Another special consideration for clinicians working with foster children is the awareness that many of the children hold on to and find hope in the belief that they will return to their birth parents. This knowledge may increase the level of empathy a clinician or foster parent feels for a child and potentially provides relief for a child to know that the adults in his life are aware of this desire.

Therapists working with foster families must be prepared to accept the small steps toward progress that their clients will take. The duration of treatment for many foster children is considerably longer than treatment for biological children. It also may be more difficult for foster children to generalize the benefits of Theraplay to other environments. Incorporating Theraplay into several settings with adults who provide some form of care is an effective way to provide "felt safety" (Purvis, Cross & Sunshine, 2007) and generalize the modulation of arousal states with subsequent reduction of impulsivity, improved behavior and increased self-confidence and self-esteem.

Case Study

Background Information

Mark, 5, and his three siblings, Ruth, Matthew and Luke*, were removed from their home and placed in foster care due to physical abuse, emotional and environmental neglect and domestic violence. It is possible that Mark was sexually abused or that he witnessed his siblings being sexually abused. The children originally were placed with a relative but she was unable to care for them for more than a few months because of the intensity of their behaviors and needs. Then they were placed in two separate foster homes. As their parents' rights neared termination the state sought permanence for the children. Mark and Luke had been in a very nurturing and well-structured foster home for 17 months. Mark was thriving at school and at home; his speech and language skills improved and he was fully toilet trained during waking hours. Unfortunately, the foster parents had several biological children and were not planning to adopt, so Mark and Luke moved again. They were placed with John and Sarah who planned to adopt the boys. Mark had participated in talk therapy while living in his first foster home, but the foster parents did not feel that it was helpful. However, Mark's caseworker was familiar with my agency's therapeutic approach and she felt that Theraplay would be helpful for him. That is when Mark's Theraplay journey started. Mark, almost 7, presented with tantrums, physical and verbal aggression, enuresis, distractibility, hyperactivity, a tendency to gorge at meals, defiance, and an inability to accept nurture and care from his pre-adoptive parents.

Theraplay with Foster/Pre-Adoptive Parents

Theraplay was chosen as a way to have Mark and his new caregivers learn about and enjoy each other, support the foster parents and, hopefully, facilitate permanency.

Sarah's skepticism about Theraplay quickly diminished as she watched through a monitor while Mark allowed the therapist to care for him with lotion. During the first session she chuckled as he delighted in punching through newspaper and throwing it into the therapist's arm 'hoop'. She was pleasantly surprised by his playful demeanor and the

fun that the two were having. However, Mark's strong urge to avoid intimacy also was evident to Sarah as the therapist struggled to gain eye contact with Mark during Row, Row, Row Your Boat. When Sarah joined the session to find notes that were hidden on Mark, swing him in a blanket, feed him and sing the Twinkle song she commented on how much fun she was having with him and said, "We have lots of big blankets; we can do this at home too."

At the beginning of the second session, Mark collapsed to the ground and would not move when the therapist attempted to hold his ankles and have him enter the room as a wheelbarrow. Sarah felt she was not alone in her struggle to parent Mark as the therapist worked hard to gain his cooperation. She appreciated the therapist's playful persistence as she watched Mark's opposition weaken and he successfully walked on his hands.

Since moving in with John and Sarah, Mark had been adamant about Sarah staying out of the bathroom while he was bathing and had expressed a strong desire for John's presence during his bedtime routine. After six weeks of treatment Sarah was amazed by Mark's preference for her to bathe him and help him settle at night. Sarah and John also implemented daily nurture time with Mark and saw a correlation between his behavior and the amount of nurture time that he had.

The primary focus of treatment for Mark, Sarah and John was the development of a healthy parent-child attachment. We began treatment with a focus on Engagement and Nurture, knowing how distressed Mark was about the many losses and adjustments in his short life. The first change was that Mark began to accept nurture from his parents, first in the sessions, and then at home as well. When he began first grade, the length of time he spent away from Sarah and John increased. In school and at home Mark's tantrums and outbursts also increased. He had extreme difficulty modulating his energy and arousal states and was very impulsive and sometimes physically and verbally aggressive. In treatment he started to resist or simply refuse to participate in numerous therapeutic activities that were directed by the foster parents or me. In the midst of these difficulties, we were pleased to see that once Mark began to accept nurture from his parents, he continued to allow them to care for him even when he was dysregulated.

Over time my co-therapist and I modeled creative ways to deal with Mark's difficulty accepting adult guidance and helped the parents understand the underlying reasons. We continued with Nurture and added more Structure to sessions to increase his responsiveness to John's and Sarah's household routines and directives. Once the parents' ability to approach Mark according to his developmental age instead of his chronological age improved and their understanding of his internal working model deepened, the parent-child relationship started to strengthen. With the combination of the shift in parenting and the inclusion of more Structure in treatment, the foster parents and classroom teacher reported that Mark was less impulsive. He had fewer tantrums and recovered from them faster. Time outs and the need for physical containment lessened. Furthermore, the parents' level of empathy for Mark and Luke had dramatically increased.

Mark's incremental successes provided hope to Sarah and John, they felt that Theraplay helped to increase the intimacy in their relationship and provided tools for dealing with negative interactions at home. Sarah was encouraged by the positive results she witnessed as she became more playful and attuned with all of their kids. Sadly, one of their biological sons started to struggle. After trying to address their biological son's struggles and to meet the needs of the foster children they realized they were unable to do so and they made the difficult decision not to adopt Mark and Luke. Mark was devastated; Theraplay could not alter or fix his extreme disappointment, but it did help. Amidst the sadness and confusion we were able, during our final therapy sessions with Sarah and John to experience joy as we engaged in familiar activities that continue to be a part of Mark's life and treatment.

Theraplay was and continues to be the foundation of Mark's therapy sessions; however, I use several other therapeutic approaches to facilitate grief and loss work as well as trauma specific processing. During the first eight months treatment primarily consisted of Theraplay and Dyadic Developmental Psychotherapy (Hughes, 2006). However, when Mark's placement with John and Sarah disrupted, he was in several homes for very short periods of time and attended therapy by himself. Those sessions consisted of twenty to twenty-five minutes of Theraplay activities followed by sandtray, a puppet show, watching and processing a puppet show from a previous therapy session or a Directive Play Therapy intervention (O'Connor, 2004). In addition to mental health therapy he also participates in Healing Touch.

Theraplay and Sibling Visits

While in care, many foster children who are separated from their biological brothers and/or sisters continue to have contact with them. Sibling Theraplay was initiated as a part of the visits of the four siblings.

As Ruth, Matthew and Mark entered the room they exchanged hugs with one another and slid their shoes off to prepare for a Sibling Theraplay session. My co-therapist, Mr. Thomas, and I started with a Check-up and Caring for hurts. While I attended to Ruth, 14, Mr. Thomas focused his attention on Matthew. However, while Mark was anxiously waiting his turn he started to move into a caretaking role with his older brother and wanted to put lotion on him. With an accepting and playful attitude Mr. Thomas invited Mark to help him find hurts or special spots, and reminded him that the adults will care for the children. Mark was easily re-directed by the verbal message Mr. Thomas provided and he eagerly participated. Then we settled on our tummies on the floor facing each other in a circle. After giving a brief explanation of the next activity, "HA", I started by saying, "Ha, ha, ha," and directing Mark to copy me. Loud or soft, fast or slow, deep or high pitched "Ha, ha's" went around the circle and led to a great deal of spontaneous smiles, eye contact and giggling. Mark told me, "I like that you and Mr. Thomas come and play with me and my family now."

Mark had two hour bi-weekly visits with Ruth, Matthew and Luke since the time of their first placement in separate foster homes. The supervising adults reported that the visits

were chaotic. The children argued with one another about what to play or who should be in charge; these disagreements interrupted their playtime and in turn caused them to be isolated from one another. I thought that sibling Theraplay would provide structure, and help the kids learn to relate to one another in a positive and enjoyable way. Matthew's therapist, Thomas Donovan, agreed and we requested permission from Ruth and Luke's caseworkers. Initially the sessions were difficult because all four of the children had clinically significant behaviors and attachment difficulties. Matthew and Mark had experienced Theraplay in their individual therapy sessions, but it was Ruth's and Luke's first exposure. Luke, 3, participated in the first three sessions. Because of his great need for one-on-one attention, a referral was submitted requesting individual therapy for Luke.

The usual sibling visit took place immediately following sibling Theraplay. After the first Theraplay session, the visitation worker reported significant improvements in the children's ability and desire to interact with one another. The most noticeable improvements were in Ruth's relational exchanges with the other children and her attitude toward them. Ruth's individual therapist noted, "She said that you and Mr. Thomas are helping her to play and be silly with her brothers and that is making the visits fun." Ruth herself told us, "It's not as much fun (the visit) when we don't have therapy first." Moreover, Ruth's caseworker was pleased with the results of the intervention and stated that she wanted the sessions to continue. Thus, the local child welfare agency approved funding for sibling Theraplay in addition to her on-going individual therapy.

After several sessions Ruth and Matthew's foster mom, Rebecca, started participating. She was surprised by and subsequently empowered by the children's responsiveness. With her assistance in therapy sessions, we hope to include Luke in Sibling Theraplay again.

<u>Theraplay at School</u>

Mark and Luke moved to a new area and new school when their pre-adoptive placement disrupted. At Mark's new school it was clear to the teacher, social worker and principal after the second day that he would require additional services. He was not interested in relating to his peers. The majority of his contacts with authority figures resulted in a "game" of catch, seclusion in a time out room, or, sometimes, restraint. The frequency of time-outs and containment increased rapidly and de-escalating him lasted from one to three hours. Mark was moved into a classroom designated to provide support for children with Emotional Disturbances. I began to consult at the school.

Mark was smiling and waving as he sat at his desk on task. I was observing him in his classroom to see if using Theraplay at school was yielding any positive results after three weeks. He was behaving very well, but he typically did when I came to his classroom. It was time for lunch and two teachers and a paraprofessional escorted the students in the special education classroom to the cafeteria. I was getting ready to leave and one of the classroom teachers approached me. "I am amazed at how easily we are able to get him back on track with the little games and activities that you showed us. This morning he started to throw a fit over math and I just played peek-a-boo with him and he forgot why he was angry," Mrs. Green said.

When I first asked to observe Mark in his classroom the teachers were very receptive to my involvement. During my initial visit with the classroom staff I explained how grief, loss, and trauma had affected Mark. I suggested various strategies to prevent tantrums and interventions to help the staff guide Mark in the de-escalation process. The ideas were helpful, but his behavior continued to disrupt his learning as well as his classmate's learning. I was not in favor of restraint and I hoped that bringing Theraplay to his classroom with one or two of his teachers might be helpful. I shared my idea and explained the model and the goals of Theraplay. The teachers, the social worker and the principal were eager to give it a try and agreed to participate. Two of the four classroom teachers who spent quite a bit of time with him and who were usually involved in the de-escalation process volunteered to participate in the activities on a rotating basis.

My aim was to facilitate relationships with Mark's teachers, and to improve his affect and energy modulation and acceptance of structure. In order to meet this goal I decided that the activities would last for fifteen to twenty minutes and that they would be scheduled in the morning during a time when he typically struggled. The first week I went to the school and lead the "special playtimes" on Monday, Tuesday and Friday. For the sessions planned on Wednesday and Thursday, I selected the activities and provided the props that the teachers would use to lead the activities. The second week I went to the school and lead the activities on Tuesday and Friday, and on the third week I visited the school on Wednesday, but did not participate.

Mark was excited about having "special playtime" in his classroom and responded well to the activities when I was leading them. However, when I placed his teacher in a leadership position, he was controlling and would attempt to take over. I re-directed him several times by saying, "Mrs. Green can decide what the cue word will be," or "Putting three bean bags on your head is a great idea, but right now we're going to use two and Mrs. Green can decide if she wants to use three." Mark responded positively to the re-direction and Mrs. Green felt empowered by his positive response. Mark's feelings of safety were contingent upon his perception of his teachers as strong and capable.

Within four days of beginning these playtimes his teachers, the school social worker, and the principal observed a significant decline in the frequency of his outbursts as well as the number of times he had to be restrained. Also the amount of time needed for Mark to rejoin his classroom dwindled. Instead of taking hours, it only took minutes for him to rejoin his peers. Mrs. Green said that the "special playtimes" taught her how to use a playful attitude to keep Mark safe and contained. She also generalized the activities and skills in her relationships with other children in the classroom. As a result, the teachers continued to have "special playtime" with Mark.

<u>What is happening now?</u>
Mark will continue to receive individual treatment, Sibling Theraplay, school special playtimes and consultation to caregivers with this therapist until his permanent placement is consolidated. Unfortunately Mark has not had the opportunity to transfer the

attachments he has formed with his foster parents to an adoptive family. He is still in foster care anxiously waiting on his "forever family." He is dealing with the confusion of having another temporary foster mom and dad and holding on to the belief that he will return to his birth parents. We have processed this belief in treatment but until we find a stable placement for Mark it is not likely that he can integrate his history and resolve this longing to the extent possible. Mark continues to display better regulated behavior in the settings where Theraplay has been implemented. Due to his therapeutic program and the energy and commitment of his caregivers and teachers, Mark has pleasure, connection and achievement in his life.

Conclusion

This article has shown how Theraplay can be used in the lives of foster children. It was particularly helpful for Mark to experience the empathic affective attunement and the positive, enjoyable experiences that Theraplay facilitates. These experiences have taught him how to be an active participant in the dance of attachment. Bringing Theraplay to various settings served as an endorsement of the adults as well as the physical surroundings and Mark's feelings of safety increased. Many foster families benefit from participation in Theraplay treatment. We recommend continuation of treatment in the adoptive home to support the transition to permanence.

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*All names have been changed to protect confidentiality.