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The Effectiveness of Theraplay as Treatment for
Older Children with Attachment Difficulties

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
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St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Current research suggests that infants and young children can make great gains in the area of attachment with a consistent and nurturing caregiver; the established view has been that after the age of three forming a secure attachment is incredibly difficult. The purpose of this systematic literature review was to answer the question: What is the effectiveness of Theraplay as a form of treatment when working with children over the age of three who have difficulty in forming a secure attachment to a caregiver? This review was set up using peer-reviewed articles, books, and dissertations. The databases PsycINFO, Academic Search Premier, and SOCIndex were systematically searched using the terms; “theraplay” AND “attachment” or “stress response” or “attunement” or “neuroplasticity” or “treatment” or “reactive attachment disorder” or “trauma” or “children” or “effectiveness”. Out of these searches, 11 articles, books, and dissertations satisfied criteria for inclusion and were used in the final review. Four themes emerged through the synthesis of the literature around the aspects of Theraplay that appear to make it an effective therapeutic intervention for children over three who have issues in the area of attachment; 1) increasing parents’ ability to understand child and child’s needs; 2) engaging in ways that build connection between child and parent; 3) Making the child feel nurtured and cared for; and 4) the commitment and skill of the Theraplay therapist. The research suggests that the many elements of Theraplay cohesively support the strengthening of parent-child relationships. Moving forward, more experimental design studies are needed to ground findings in more concrete and generalizable outcomes. Exploring the effectiveness of Theraplay with children who have co-occurring disorders is also an important area for further study.

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Background

Children who are placed in the foster care system, some of whom are subsequently adopted, are likely to have experienced trauma and, therefore, are more likely to develop problematic attachment patterns (Troutman, 2011). While the exact prevalence of attachment issues among children is unclear due to its frequent resemblance to other pathologies, many children have trouble adjusting to new home environments and developing trusting relationships with new caregivers (Sherperis, Renfro-Michel, & Doggett, 2003). While a robust amount of research suggests that infants and young children can make great gains in the area of attachment with a consistent and nurturing caregiver, the established view has been that after the age of three forming a secure attachment is difficult.

According to Weir and Brodzinsky (2013), adoptive families more frequently seek mental health counseling than the general population and consistently report that access to these services provided by someone who understands adoption is their greatest post-adoption support need (Atkinson & Gonet, 2007). In many cases, problems facing adopted children predate their adoptive placements (such as abuse, neglect, life in institutions, multiple foster care placements); in other cases, children may have difficulty adjusting to their new life and everything that comes with such a transition (Weir & Broszinsky, 2013).

In September of 2013, 76% of the 402,378 children in the United States foster care system were between the ages of 3 and 18, with an average age of entry of 7.5 years old, the average age of exit of 9.1 years old, and the average length of stay 21.8 months (U.S. Department of Health and Human Services, 2013). Of the 402,378 children in the

foster care system, 53% had a case plan goal of reunification with parents or principal caregivers. The remaining 47% had other case plan goals: living with other relatives (3%), adoption (24%), long-term foster care (5%), emancipation (5%), guardianship (4%), or no case plan goal established (7%) (U.S. Department of Health and Human Services, 2013). Of the 24% waiting to be adopted out of foster care, the average age was 7.7 years old with an average length of stay of 33.5 months. Only 14% of children waiting to be adopted spent less than one year in foster care (U.S. Department of Health and Human Services, 2013). Therefore, not only may their early home life be unpredictable, but their time in the foster care system awaiting permanency may be also.

It is clear that children who are adopted through the foster care system have had unreliable and unpredictable caregiving experiences. An overwhelming amount of research supports that consistent caregiving is foundational to healthy development and positive future outcomes for children (Harden, 2004).

Attachment

Attachment refers to the emotional bond between child and caregiver. A caregiver must consistently respond to cues and cries from their child, so the child has a secure base as a part of their internal working model. Attachment trauma broadly describes the difficulty forming trusting relationships and managing emotions. Attachment trauma develops when children are unable to consistently connect with or depend on a primary caregiver. This lack of connection can occur in the following ways: a baby cries and no one offers comfort; a baby is hungry or wet and are left unattended for hours; no one talks to or holds the baby; a young child who only gets attention through acting out or displaying extreme behaviors; a caregiver is unpredictable in their care; a young child or

baby is mistreated or abused; the young child is moved from one caregiver to another, and more (Help Guide, 2015). When children feel repeatedly abandoned, uncared for, isolated, and powerless, they learn that they cannot depend on others and that the world is a dangerous place in which they are alone (Help guide, 2015).

There are four patterns of attachment that have been identified in children: secure attachment, insecure avoidant attachment, insecure ambivalent attachment, and disorganized (Bretherton, 1992). Secure attachment is observable when a child shows some signs of distress when their caregiver leaves, but can self-soothe knowing that their caregiver will return. Children with secure attachment trust, and feel they can depend on, their caregiver. A child with a secure attachment is likely to have a caregiver that is attentive to their needs (Bretherton, 1992).

Children with an insecure avoidant attachment style do not orient themselves to their caregiver while exploring their environment. They show little emotion when their caregiver leaves or returns, either avoid or ignore their caregiver, and do not seek contact from their caregiver when in distress (Bretherton, 1992).

Insecure ambivalent attachment is a type of attachment style where a child commonly exhibits dependent behavior, but rejects their caregiver when they engage in interaction. This occurs when a child does not develop a sense of security from their caregiver and, therefore, has difficulty moving away from their caregiver to explore their environment. A child with insecure ambivalent attachment likely has inconsistent responses to their needs from their primary caregiver (Bretherton, 1992).

Disorganized attachment is seen as a lack of any attachment strategies (Solomon, 2011). Disorganized attachment behaviors often seem bizarre or inexplicable under the

circumstances. They include approach, avoidance, or angry behaviors that are succeeded or interrupted by opposing displays of behavior. Indications of disorientation, confusion, or fear of the parent sometimes accompany these events and indicate disorganization (Solomon, 2011).

Attunement

Attunement is a building block of healthy attachment. Attunement describes the degree to which an individual reacts to or is in touch with another's emotional needs and moods (Rees, 2007). Caregivers that are well attuned to their children respond to them by using appropriate language and behaviors based on the emotional state of the child. They are also easily able to recognize the emotions, thoughts, and feelings of their children and adapt their responses accordingly (Rees, 2007).

Attuned parenting communicates meaning to the inner world of body signals for children (hunger, full bladder, satiety, thought, and emotions). As they learn that others are able to recognize their needs, a foundation of trust, understanding, empathy relationships, verbal and nonverbal communication is built (Rees, 2007). Interruption to the cycle of attunement affects the quality of attachment as children may learn that their caregiver is unreliable or unpredictable. Parents who are sometimes attuned and sometimes antagonistic send the message to children that attention is important, but unreliable and frightening causing them to be ambivalent about seeking or sustaining it (Rees, 2007). This can lead to a child being hypervigilant to the moods of their caregiver and over-reading disapproval. They often then seem to push away those that they are closest to while also craving their attention (Rees, 2007).

Parents who are consistently unattuned do not teach their children the benefits of closeness. These children often become avoidant and inept in connecting with others as well as having difficulty understanding non-verbal cues and the subtleties of language. Abusive parenting can leave children disorganized, unable to be self-sufficient or successful in relationships, and without empathy (Rees, 2007).

Internal Working Model

Humans develop an internal working model from a very young age. An internal working model is a cognitive framework made up of mental representations for understanding the world, self, and others (Pietromonaco & Barrett, 2000). This includes our beliefs about whether people can be trusted, self-worth, and how to interact with others. A child's internal working model develops largely through the quality their primary attachments. With healthier attachments comes a more positive internal working model as children see the world as safe and themselves as worthy of love and care. The first, and arguably, therefore, most important, relationships we have are with our caregivers as they help us shape this internal working model. The initial development of attachment between child and a caring, stable adult is one of the greatest predictors of successful future relationships, academic achievement, and emotional regulation (Stinehart, Scott, & Barfield, 2012).

Neuroplasticity

Neuroplasticity refers to the ability of the brain to adapt and readjust throughout the course of life. Neuroplastic changes can happen on small scales; i.e. changes in individual neurons, or on a large scale, affecting the entire brain such as a remapping due to injury (Liou, 2010). Environmental stimuli, behaviors, emotions, and thoughts can also

cause neuropathic changes in the brain. While new neuropathways can be formed quickly in the brain, for this to happen, the neurons need to be stimulated through activity (Liou, 2010). This suggests that with the proper stimuli, the brains of children with attachment trauma can be retrained to develop healthier attachments with caregivers. This is promising when researching the progress in the area of attachment in older children.

Issues in Attachment

There are many biopsychosocial influences that enable or hinder the development of attachment. The early socialization of children is crucial in the development of healthy attachment throughout life. Corbin (2007) suggests that early trauma in childhood attachment results in a structural, neuro-chemical, and connectivity changes in the brain. Many studies have been conducted surrounding the development of children coming from Eastern European and Russian orphanages. This demographic is of particular interest, because institutional facilities in this part of the world are often over populated and understaffed, creating even fewer opportunities for child attachment. A longitudinal study conducted by Smyke, Dumintrescu and Zeanah (2002) found that children who experience limited opportunities to form selective attachments are far less likely to develop preferred attachments. This also results in an increase in insecure attachments compared to the established norm. Even after adoption and a formed attachment to a caregiver, children were found to have exhibited indiscriminate behaviors. Indiscriminate behavior refers to a form of attachment disturbance where a child lacks selectivity in the choice of attachment figures (American Psychiatric Association, 2000).

The age of adoption, as well as the length of time within an institution, appears to contribute to the development of attachment disorders. Chisholm (1998) found that

children who had spent at least eight months in a Romanian orphanage displayed disinhibited reactive attachment disorder (RAD) through significantly more indiscriminately friendly behavior as compared to children who were adopted before the age of four months, or who were living with their birth parents. The group of children that had spent at least eight months in a Romanian orphanage also scored lower on the Stanford-Binet Intelligence Scale and their adoptive parents reported significantly more parenting stress than the comparative groups (Chisholm, 1998).

A study conducted by Chisholm (1998) suggested that it may be difficult to develop a first attachment after the first year or two of life. He discussed three factors that may contribute to this problem. First, parents may be less responsive to older children's need for close contact. Second, many children did not exhibit the ability to build attachment behaviors at the time of their adoption. Lastly, it is probable that the older children had developed internal working models of distrust as a result of their neglect. This could create challenging or passive interaction styles between child and adoptive parent, in turn having a negative impact on the parents' responsiveness towards them.

If unaddressed, the consequences of attachment difficulties do not appear to dissipate with age. Sigal (2003) conducted a study which looked at the effects of long-term placement in orphanages in adults. He found that members of a randomly selected, middle-aged group of orphans, most of who were institutionalized at birth, were significantly more psychologically dysfunctional and had significantly more chronic illnesses. He also found that on average the orphan group had five years less education than the comparison group. Adult orphans were also more likely never to have been

married and lived in more isolation. They reported more psychological distress, suicidal ideation, and made more suicide attempts than the comparison group.

Reactive Attachment Disorder

Some children who have a severe or repetitive disruption in attachment may become diagnosed with Reactive Attachment Disorder (RAD). Reactive Attachment Disorder is characterized by a consistent pattern of inhibited, emotionally withdrawn behavior towards adult caregivers by either minimally seeking comfort when distressed or minimally responding to comfort when distressed. Additionally, children diagnosed with RAD often have minimal social or emotional responses to others, limited positive affect, and/or episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers (American Psychiatric Association, 2013).

Adoption and Issues of Attachment

Because most adopted children were first in foster care, the research on attachment patterns of children in foster care can inform adoption outcomes. Smyke and Zeanah (2012) found that children placed in a supportive foster care environment after being in institutional care were less likely to experience disturbances of attachment than those who had only been institutionalized. Additionally, 30 months after children were placed in supportive foster care, their scores were indistinguishable from children that had never been institutionalized. Early placement in foster care (before 24 months of age) was associated with fewer signs of inhibited type of RAD because they were less likely to experience an attachment disturbance.

While the inhibited type of reactive attachment responded quickly to placement in foster care, the improvement in the disinhibited type was less dramatic. For those who end up in an unsupportive foster care environment, many age out of the system and are ill-equipped to lead independent and thriving lives. Adults who have been a part of the foster care system are twice as likely to have mental illness and three times more likely to live in poverty than the average population in the US (Allen & Vacca, 2010; Mandell, 2006; Vacca, 2008). RAD appears to be a contributing factor to these statistics.

Many factors appear to contribute to the development of attachment. The timing of adoption, the presence of a first attachment, and the conditions within institutions all appear to play a role. As evidenced in this research, there appears to be a correlation between the age of adoption and attachment disorders; the older the child at adoption, the more likely that child will have an attachment disorder. An important question then, is at what age of adoption into a nurturing environment are the effects of unsupportive environments reversible? Attachment disorders also appear to remain life long issues, spilling over into other areas of mental health and adjustment. To alleviate this issue, the further examination of effective treatment options and longevity of their results is necessary.

Theraplay

Theraplay has emerged as a possibly successful model for treating children with attachment difficulties. Theraplay is operationalized as a form of child and family therapy that is aimed to enhance and build attachment, self-esteem, trust in others, and joyful engagement. The principles underlying Theraplay are that in healthy relationships there should be natural patterns of playful, healthy interaction between parent and child

(Gordon, 2014). The therapy model of theraplay has been used to treat children suffering from attachment disorders. The Theraplay Institute defines Theraplay as “a child and family therapy for building and enhancing attachment, self-esteem, trust in others, and joyful engagement. It is based on the natural patterns of playful, healthy interaction between parents and child and is personal, physical, and fun” (Theraplay Institute, 2015).

Theraplay has been used within the framework of early intervention, day care, special education, the American Head Start program, parenting skill programs, with hospitalized patients and in out patient clinics, and especially in family therapy (Wettig, Franke, & Fjordbak, 2006). While Theraplay is used as a rehabilitative intervention, it also helps with normative development as a child is growing, which is why it is used in routine day-to-day functions such as day care. Rather than using external controls, Theraplay promotes internal self-control and the desire to relate appropriately. It is also used as a way to teach social and communication skills to older children (The Theraplay Institute, 2015).

Theraplay is a directive and interactive short-term play therapy aimed to help children with behavioral disorders, attachment disorders, developmental disabilities, trauma, and who are resistant to change symptoms of their interactive behavior (Wettig, Franke, & Fjordbak, 2006). Play therapy can be directive or non-directive and involves a therapist participating in the child’s play and then interpreting his or her feelings or thoughts. Theraplay includes specific elements of play and is led by a therapist who is responsible for the course of the therapeutic play (Wettig, Franke, & Fjordbak, 2006).

In Theraplay the therapist guides the parents and child through playful games, developmentally challenging activities, and nurturing activities. The act of engaging each

other in this way helps communicate love, joy, and safety to the child while also helping to regulate their child's behavior. It helps the child feel cared for, secure, connected, and worthy, providing a model of caregiving that is necessary for rehabilitative attachment. Theraplay focuses on interactions between parents and children in regards to the four qualities thought to be essential in a secure attachment: structure, engagement, nurture, and challenge (Theraplay Institute, 2015).

Theraplay involves the playful interaction of child and therapist. The therapist communicates verbally and non-verbally, offers both rituals and surprising elements, seeks eye contact, and uses gesture and pantomime to engage emotionally the right hemisphere of the child's brain. These activities to the four dimensions for theraplay, focusing on which the specific dyad needs the most. Play is used by the therapist to initiate and maintain a relationship with the child, reacting with empathy and warmth based on the needs of the child (Wettig, Franke, & Fjordbak, 2006). Activities that are introduced are decided by the child's developmental level and affect. The therapist regulates the child's level of arousal by soothing, comforting, structuring, or through exciting or challenging games (Wettig, Franke, & Fjordbak, 2006).

It is hypothesized that changes in the neural networks of children can be changed through Theraplay. Schore (2003) explains that early childhood experiences that create negative interactive behavior may be mitigated by such therapeutic interventions. Imaging methods such as positron emission tomography (PET) or functional magnetic resonance imaging (fMRI) offer evidence to suggest where information is encoded in the child's brain as new knowledge is developed, positive and negative events are experienced, and as the child learns to regulate emotions (Schore, 1994; 2003).

Theraplay may attend to important emotional development; Seigel and Hartzell (2003) found that positive emotional interactions between child and caregiver could foster development of new neurons in the hippocampus and more synapses in the prefrontal and orbitofrontal cortex of the right hemisphere of the brain. These new positive experiences led to new positive behavior patterns. Learning in conjunction with positive emotional support, in this case fun and play, is more effective than learning without emotional support (Wettig, Franke, & Fjordbak, 2006). This gives additional credit to the idea that Theraplay may affect positive and lasting change to the interactive behaviors of children.

Research Question

Many studies have been conducted to examine the effects of trauma and neglect on attachment in children, as well as the effectiveness of specific treatment models, but less research has been done on the effectiveness of said models when used with older children. The purpose of this systematic literature review will be to examine the effectiveness of Theraplay as a form of treatment when working with children over the age of three who have difficulty in forming a secure attachment to a caregiver.

Methods

Research purpose. The purpose of this systematic literature review was to answer the question: what is the effectiveness of Theraplay as a form of treatment when working with children over the age of three who have difficulty in forming a secure attachment to a caregiver?

For the purpose of this study, attachment refers to the bond between child and caregiver. Attachment between child and caregiver can be classified as secure, insecure,

ambivalent, or disorganized. Issues in the area of attachment or attachment difficulties refer to the dysregulation of mood and behavior as a result of disruption of child to caregiver attachment. These terms are often used when discussing problems in attachment exhibited by children who have been adopted, neglected, or spent significant time in foster care. Theraplay is a relatively new term that refers to the use of short-term directive play therapy to build trusting relationships between child and caregiver. While children younger than three experience issues in the area of attachment, this study only included literature of children three or older at the time of treatment that have attachment difficulties.

This review looked at the use of Theraplay as an intentional therapeutic intervention used for the purpose of healing from past attachment trauma and facilitating new healthy attachments. This study considered elements of Theraplay, including child age and developmentally appropriate play, internal and external experiences of the child, and nurture provided by parents and therapist. All of these elements were included in the review under the umbrella of Theraplay interventions. However, the main focus of this review was on the effectiveness of Theraplay interventions with children over three with attachment difficulties.

Study types. To determine the effectiveness of Theraplay as a form of treatment of children over three with issues in the area of attachment, empirically based studies were considered including focus groups, clinical trials, quasi-experimental design studies, and other quantitative and qualitative methodological studies. Effectiveness studies, particularly quantitative studies, were useful in determining the impact that theraplay as

an intervention has on attachment among older children. Conceptual and theoretical studies were not included and only English language studies were used.

Levels of publication. This study included peer-reviewed literature, books, and dissertations. Twelve studies were conducted in other countries, two of which were included in this review. One study was written in Arabic and was not included. There was no limit to the date of publications for included studies.

Search terms, sensitivity and specificity. A systematic literature review is intended to be authoritative on the topic, drawing from all relevant research. To understand the scope of available literature around the research question, both a sensitivity and a specificity search were conducted. A sensitivity search retrieves a high number of studies related to the topic, which therefore include both relevant and less relevant studies in an effort to capture them all. A specificity search is more narrowly focused on all of the aspects of the topic and retrieves a smaller number of studies that is highly specific to the topic, but will also likely miss other relevant studies due to its smaller lens (Petticrew & Roberts, 2005). These two searches helped to establish the potential scope of the research project.

For the sensitivity search, the term used was “Theraplay” which returned 117 results on the database PsycINFO. The terms used for the specificity search included “Theraplay”, “effectiveness”, and “attachment”, yielding 10 results using the PsycINFO database. These searches informed the decision to include the term “Theraplay” in each search as well as a combination of one or more other search terms to insure that all relevant articles would be included.

Review protocol. Attachment is a concept that is a complex idea with many related and integral terms. The search terms that were used included: “theraplay”; “attachment”; “stress response”; “attunement”; “neuroplasticity”; “treatment”; “reactive attachment disorder”; “trauma”; “children”; and “effectiveness”. The databases that were used to retrieve the peer-reviewed articles for this literature review include PsycINFO, Academic Search Premier, and SOCIndex.

Inclusion criteria. In all three databases used (PsycINFO, SocIndex, and Academic Search Premier) searches were carried out with the following combination of search terms: “theraplay” AND “attachment” or “stress response” or “attunement” or “neuroplasticity” or “treatment” or “reactive attachment disorder” or “trauma” or “children” or “effectiveness”. The term “theraplay” was included in every search along with a combination of at least one or more of the aforementioned search terms. In psycINFO, 42 peer-reviewed articles and books satisfied the specified search criteria. A search using SocIndex produced 12 peer-reviewed articles and Academic Search Premier produced eight.

Exclusion criteria. Of the 62 total articles, books, and dissertations from these three databases 30 appeared to meet criteria based on the title and abstract. Of these 30 articles, only 11 met criteria within the full text to be included in this literature review. Articles that were excluded from the research review were: studies with participants younger than three or older than 18; studies that did not have outcomes; studies that were not in English; and studies with participants who presented with a co-occurring disorder. A list of included articles with content summary can be found in Appendix A.

Findings

The purpose of this study was to examine the effectiveness of Theraplay as treatment for children over the age of three who have issues in the area of attachment. As this is a newer area of study, it is important to note that researchers are at the front end of building a body of knowledge about the effectiveness of Theraplay in the area of attachment for this age group. Using the databases of PsycINFO, SocIndex, and Academic Search Premier, as well as working within the inclusion and exclusion criteria previously stated, 11 peer-reviewed articles, books, and dissertations met the inclusion criteria and were reviewed. Of the 11 peer-reviewed articles, books, and dissertations included in this study, one was a quantitative study, one was a treatment outcome clinical trial, one was a mix of a quantitative, treatment outcome and clinical trial, one was a mix of an interview, focus group, qualitative, and quantitative study, one was a quasi-experimental pre-test/post-test case study, and six were pure case studies.

The Marchak Interaction Method (MIM) was one of the primary attachment instruments used in the studies within this systematic review, used by seven of the studies (54%) (Bojanowski & Ammen, 2001; Booth & Lindaman, 2000; Booth & Winstead, 2015; Myrow, 2016; Myrow-Bundy & Booth; 2009; Robinson et. al, 2009; Weir, 2007). The MIM is a play-based observation used to evaluate parent-child relationship quality. Other attachment inventories such as Marschak Interaction Method Rating System (MIMRS) (Bojanowski & Ammen, 2011), Achenbach Child Behavior Checklists (CBCLs) (Bojanowski & Ammen, 2011; Mahan, 2001; Weir et al., 2013), Teacher Report Form (TRF) (Mahan, 2001), Attachment Story Completion Task (SCT) (Mahan, 2001), Randolph Attachment Disorder Questionnaire (RADQ) (Mahan, 2001),

Cermack's Developmental and Sensory Processing Questionnaire (CDSPQ) (Mahan, 2001), the McMaster Family Assessment Device (FAD) (Weir et al., 2013), Outcome Questionnaire (Weir et al., 2013), and self-report (Booth & Lindaman, 2000; Booth & Winstead, 2015; Hong, 2015; Mahan, 2001; Mason, 2007; Myrow, 2016; Myrow-Bundy & Booth, 2009; Robinson et al., 2009; Weir, 2007).

Of the 11 articles, books, and dissertations included in this study, all 11 (100%) indicated that Theraplay is an effective way to facilitate positive change in attachment between children over three and their caregivers. In each article, improvement in attachment was demonstrated in one or more of the following three different ways: statistical measure, the meeting of treatment goals, and/or self-report. Four studies (36%) found statistical evidence supporting Theraplay as an effective form of treatment in improving attachment (Bojanowski & Ammen, 2011; Mahan, 2001; Hong, 2011; Weir, 2013). Although not every measure in every study was found to be statistically significant, results show positive relationships among measures of attachment, indicating a positive impact of Theraplay.

Three studies (27%) examined relied predominantly on the completion of or progress towards treatment goals as a way to measure effectiveness (Booth & Winstead, 2015; Myrow, 2016; Myrow-Bundy, 2009). Four studies (36%) included in this research collected data based largely on self-report, observations, and qualitative feedback of caregivers (Booth & Lindaman, 2000; Mason, 2007; Robinson et al., 2009; Weir, 2007). Of the seven case studies (six pure and one a mix of quasi-experimental pre-test/post-test case study), all seven (100%) saw a strengthened bond between child and caregiver (Booth & Lindaman, 2000; Booth & Winstead, 2015; Myrow, 2006; Myrow-Bundy &

Booth, 2009; Robinson et al., 2009; Weir, 2007; Weir et al., 2013) In the same seven studies, all seven (100%) achieved or made gains towards their treatment goals. The majority of the articles found were case studies, highlighting that more definitive research is needed. These studies suggest that Theraplay is a promising form of treatment among children over the age of three who have difficulties in the area of attachment.

Thematic Analysis

Through systematic analysis of the literature, four interrelated themes emerged around the aspects of Theraplay that appear to make it an effective therapeutic intervention for children over three who have issues in the area of attachment. These themes include: 1) increasing parents' ability to understand child and child's needs; 2) engaging in ways that build connection between child and parent; 3) Making the child feel nurtured and cared for; and 4) the commitment and skill of the Theraplay therapist.

Increasing parents' ability to understand child and child's needs. Many of the studies indicated that progress within treatment is greatly influenced by parents' new understanding of their child's needs. Through Theraplay, parents gained a new understanding of their role as an attachment figure, to provide reliable interactions, and help their child build confidence and competence to explore the larger world (Booth & Lindaman, 2000; Booth & Winstead, 2015; Hong, 2011; Myrow-Bundy & Booth, 2009). These studies overtly emphasized the importance of commitment, patience, and openness of caregivers for this to take place.

Booth and Lindaman (2000) found that by teaching parents' appropriate developmental expectations and how to manage behavior problems with their children, parents were better able to adjust their expectations to meet their child's needs and give

more attuned responses. They also observed that through Theraplay activities parents were helped to understand the importance of providing firm, clear structure for their children while simultaneously providing an increase in nurturing and caretaking interactions to support the attachment process. Booth and Winstead (2015) also found that in order for parents to be able to make attuned responses they needed to be able to reflect on their own internal states in addition to their child's. They found that this capacity for reflection and insight is what makes it possible for parents to understand the link between behaviors and underlying mental states and respond sensitively to their child's signals.

Hong (2011) used focus group analysis to evaluate the effectiveness of Theraplay in helping facilitate attachment between parents and their fostered and adopted children. Based on feedback from 16 practitioners, the most frequent theme among effective Theraplay outcomes was the parent's increased insight to understand their children. Hong (2011) explains that Theraplay allowed parents to increase their own self-awareness and to interpret their children's behavior differently. She found that, through Theraplay, parents can gradually integrate a different approach to their children and learned a new sequence of interaction skills such as "repair and reunion". As part of a qualitative study Hong (2011) also found that practitioners believed that the greatest barrier to positive outcomes in Theraplay is a "difficult parent" who "does not believe in Theraplay concepts" or "is not ready to participate in Theraplay because of their own issues".

Over the course of treatment, the Theraplay therapists became less involved while the parents became more involved as parental feelings of competence and confidence

grew. Theraplay as a short term-treatment started the process of attachment and gave parents and children the tools to carry on after direct treatment in was completed (Booth & Lindaman, 2000; Booth & Winstead, 2015; Myrow-Bundy & Booth, 2009; Hong, 2011).

Engaging in ways that build connection between child and parent. While activities varied some from study to study, each engaged in some element of nurture, playful games, developmentally challenging activities, and nurturing activities. Some such activities included: rhythmical clapping games, adult and child feeding each other, blowing a feather to keep it in the air, or parent and child putting lotion on one another's hands (Booth & Lindaman, 2000; Booth & Winstead, 2015; Myrow, 2016; Myrow-Bundy & Booth, 2009; Weir, 2007). Of the seven child case studies presented in the research, all seven caregivers reported an increase in their feelings of connection to their children after participating in Theraplay (Booth & Lindaman, 2000; Booth & Winstead, 2015; Mahan, 2001; Myrow, 2016; Myrow-Bundy & Booth, 2009; Robinson et al., 2009; Weir et al., 2013; Weir, 2007).

The activities that occur in Theraplay treatment show promise in their ability to connect caregivers with their children. An example of this was illustrated though a treatment outcome clinical trial with five-year-old Eastern European twins conducted by Mahan (2001). Among other measures, Mahan used the Randolph Attachment Disorder Questionnaire (RADQ). The items of the RADQ consist of behaviors considered to be indicative of attachment problems. "John's" scores suggested a significant decrease in behaviors indicative of attachment problems with a pretreatment score of 31 and a posttreatment score of 14, a 52% decrease. The other twin, "Maria", had a RADQ

pretreatment core of 24 and a posttreatment score of 10, a 58% decrease in score. The participants' decrease in scores suggests a decrease in behaviors indicative of attachment problems post Theraplay treatment. Mahan (2001) also observed increased eye contact with caregivers post Theraplay as well as an increased ability to relinquish control in interpersonal situations.

Mason (2007) also found the activities that occur within theraplay to build connection between caregiver and child. Mason (2007) conducted a quantitative study involving 32 parents and 57 therapists. Within this study, therapists noted that throughout Theraplay treatment physical contact between parents and children increased and that affection increased not just from the child to the parent but the parent to the child as well. According to Mason (2007),

One gets the sense in talking with these therapists that therapy frees both the parents (who are angry and hurt because they feel rejected by the child and are fed up with his/her behaviors) and the child (who feels rejected by adults and is using anger as a cover for fear and sadness) to offer and receive affection to one another, to establish a mutual relationship (p. 101-102).

These studies illustrate how through the nurturing, engaging, and challenging activities that occur in Theraplay, healing can occur and connections between parents and their children are able to be built.

Making the child feel nurtured and cared for. The research indicates that although early experiences are not erased, the positive, healing interactions between child and parents that happen within Theraplay lead to a shift in the internal working model of a child from mistrust and anxious self-reliance to trust and acceptance of parental love

(Bojanowski & Ammen, 2011; Hong, 2015; Booth & Lindaman, 2000; Weir, 2007; Myrow-Bundy & Booth, 2009; Robinson et al., 2009).

Seven studies found that children's ability to accept nurturing care increased significantly post Theraplay (Booth & Lindaman, 2000; Booth & Winstead, 2015; Bundy-Myrow & Booth, 2009; Mahan, 2001; Myrow, 2016; Robinson et al, 2009; Weir, 2007). An empirical quantitative study conducted by Bojanowski and Ammen (2011) examined 11 dyads using the MIMRS and SBCL found a statistically significant increase in pre- and post-test scores after eight outpatient sessions to Theraplay. The dimensions that increased the most within this measure were the nurture and challenge dimension scores, indicating a positive change between the parent-child dyads over the course of treatment. The nurture dimension had the strongest strength of effect, with a very large effect size of -1.5. Ten of the 11 dyads showed significant improvement as demonstrated by a lower mean score of the total problems scale. The same dyads demonstrated a significant improvement in the quality of parent-child relationship as measured by the MIMRS.

Booth and Winstead (2015) illustrate how challenging it is for children with attachment difficulties to accept nurture and how Theraplay can help. In the case of "Jacob", he made many attempts to reject his parents and therapist as they tried to connect with him in sensitively timed and attuned ways. His resistance was met with patience and respect instead of criticism and rejection that he had come to expect from his birth mother. The combination of a controlled environment, a therapeutic atmosphere of repair and empathic responses allowed for a safe place for him to process the feelings that created his need to reject all his parents' and therapist's earlier attempts to connect.

Over time, his ability to trust his parents slowly improved both in and out of session, and he used fewer strategies to resist getting close.

In another study Weir (2007) observed “Aaron”, an eight-year-old participant in his case study, not only tolerating affection at the end phase of treatment, but wanting it. This was a dramatic change in behavior as “Aaron” was standoffish to his parents at the beginning of treatment. Weir (2007) found that “Aaron” was genuinely enjoying the time, attention, and playfulness he experienced with his parents.

Theraplay offered opportunities for these children to consistently and intentionally be loved and cared in a way that met their emotional and developmental needs while also allowing space for these children to gradually receive and experience these feelings. Over time this led participants to see themselves as worthy of such love and care, ultimately allowing them to have greater trust for their caregiver and strengthen their attachments.

Commitment and skill of the Theraplay therapist. The literature highlights the importance of competence of the Therapist conducting the Theraplay therapy (Booth & Lindaman, 2000; Hong, 2011; Myrow-Bundy & Booth, 2009; Robinson, et al., 2009). It is the duty of the Theraplay therapist to provide a safe, secure, and supportive base for the child as well as the parents. Empathic appreciation and understanding of their child’s needs begin as parents observe the Theraplay therapist with their child and see how much the therapist appreciates and values the child. By pointing out and enjoying the child’s unique and special qualities, the therapist helps parents see their child as more appealing and more loveable (Booth & Lindaman, 2000). After demonstrating the therapeutic behaviors, the therapist coaches parents in ways to provide for the emotional needs of

their children. Parents must be supported as they provide nurturing, engaging, structuring, and challenging experiences (Myrow-Bundy, 2009).

The importance of adequate training in and adherence to the Theraplay model is illustrated through a study conducted by Hong (2011). Using descriptive statistics, a correlation test, and a one-way ANOVA Hong (2011) found that there was a positive association between the levels of practitioners Theraplay training and the effectiveness of the use of Theraplay for helping foster and adopted children and their families. Weir, et al. (2013) found the therapist's attunement of families' emotional needs as well as understanding the roles of individuals within a family is a factor in the outcome of Theraplay. By doing so, the Theraplay therapist is better able to identify dimensions where the family may be weak in attachments.

A study conducted by Robinson et al. (2009) found that placing a primary emphasis on children's therapeutic relationships with specific committed adults and the children's individual developmental needs is likely to provide them with the best chance they will have for healthy growth and positive social adjustments. In this study, "Tom", a 14-year-old boy who lived in a residential treatment center, was surrounded by attuned "optimally responsive" adult care-taker led environment, which was found to be crucial to his success in treatment. Such programs require personnel who have the time and skill to establish relationships built on mutual trust and are able to become attuned to the needs of high-risk families (Robinson et al. 2009).

The knowledge and guidance of well-trained and committed Theraplay therapists provided parents with a model of how to interact with their children and to learn to adapt their parenting styles to better fit their needs as parents as well as the needs of their child.

Reliable, committed, well trained, and attuned therapists were able to give parents the support they needed to do this difficult work and gave tools they needed to adopt the Theraplay mindset to their parenting, allowing them to continue to benefit from aspects of Theraplay at home or once treatment was completed.

Discussion

This systematic review was developed to explore the body of literature available on the topic of the effectiveness of Theraplay as a method of improving attachment between children over the age of three and their caregivers. The goal of this research was to consider the whole relevant body of literature on the subject as opposed to a sampling. This review was set up using both inclusion and exclusion criteria, as well as both a sensitivity and specificity search as a means of finding pertinent research.

What emerged from this synthesis of the literature are the many elements of Theraplay that cohesively support the strengthening of parent-child relationships. This review can offer awareness to therapists and parents of the main ways in which Theraplay interventions can improve attachment. These components appear to ultimately alter the parents' internal experiences and how they relate to their children as caregivers, as well as the developing internal working model of children themselves. Furthermore, these findings suggest that Theraplay may be an effective therapeutic intervention with children over the age of three to facilitate attachment and outlines four overarching themes related to how its practices support attachment repair.

The first theme found in the literature focused on the importance of the parent's ability to understand their child and their needs. The initial existing internal working model of a child reflects the quality of early attachment experiences (Booth & Lindaman,

2000; Myrow, 2016; Booth & Winstead, 2015). This can be revisited and repaired in response to experiences that do not support their current working model, such as those experienced in Theraplay (Booth & Lindaman, 2000; Booth & Winstead, 2015). The increase of parental insight improved attachment through the continuous efforts of the parent to understand the child, ultimately shifting their views of the child (Booth & Lindaman, 2000). This adjustment in views of the parent led to a shift of the child's self-view and internal working model as well (Hong, 2011).

The second theme found in the literature explored the elements of Theraplay that were used to build connection between child and parent. In Theraplay therapists and parents provided excitement, surprise, and stimulation to maintain a maximal level of alertness and engagement, incorporating nurture, playful games, developmentally challenging activities, and nurturing activities. Engagement in such activities led to the enjoyment of parent and child that may not have been previously experienced. Parent-child play is a natural part of child attachment development. If a child misses out on this as an infant, experiencing it later in childhood can make up for its previous absence (Myrow, 2016; Myrow-Bundy, 2009). This theme ties into the third theme throughout the literature; making the child feel nurtured and cared for.

Many children with attachment difficulties have come to view themselves as unlovable and the world as a dangerous place. Whatever the age of the child, Theraplay dramatizes that the child is special and lovable, that the world of the child is now a place of responsiveness, lively experiences, and growth, and that the child can count on others. Rather than talk about these assurances, they were enacted in session (Booth & Lindaman, 2000).

The fourth theme found in the literature was the commitment and skill of the Theraplay therapist. While the first three themes focused on how parents engage in order to increase attachment, this theme focused on the therapist's expertise. In the beginning stages of Theraplay, the therapist acted as a model for caregivers, in doing so, the therapist took into consideration what the needs, strengths, and challenges were for each parent and child. Booth and Lindaman (2000) highlighted the importance of teaching parents appropriate developmental expectations and how to manage behavior problems with their children. It is apparent that within Theraplay connection building happens, largely, as a result of the practitioner's ability to consciously match the child's needs with appropriate activities and pacing. This may mean considering the child's capacity to accept healthy touch, awareness of voice modulation, or constant labeling of child's positive behavior (Hong, 2011). The holistic approach to client's internal system used in Theraplay requires therapists to be dedicated and attuned to both child and caregiver as they navigate through the therapeutic process (Hong, 2011).

This systematic review suggests that Theraplay can be an effective form of treatment in facilitating healing and positive change in the area of attachment with children over the age of three. This positive change occurs when a safe, loving, and nurturing environment is created through engaging and responsive play by which a child's existing beliefs about themselves and the world are repetitively and consistently contradicted. Theraplay encourages the feelings of self-worth, confidence, and being understood in children, which is a promising mindset from which to start the healing of previous negative attachment experiences.

While research suggests positive outcomes of Theraplay for older children and improved attachments, it is important to consider factors that are not discussed within the literature. Based on the research available on this topic, it is unclear whether Theraplay can be considered an effective form of treatment for families where parents are living in high-stress situations or are unable to attend or afford sessions regularly. For an overworked or overwhelmed parent it may not be feasible to expect them to go through therapy and translate what they have learned to their economic and time deprived parenting environments.

Entire family dynamics is another unexamined factor in the effectiveness of Theraplay treatment. Within this review only one study incorporated whole families (including siblings) into their treatment (Weir et al., 2013). Treatment outcomes could be influenced by family dynamics that go unexplored without such inclusion. It is also important to consider secondary caregivers that may impact the effectiveness of treatment, such as families that come from cultures that have a more collective or communal approach to parenting.

Limitations

While this review was designed to include all relevant research on the topic of the effectiveness of Theraplay as treatment for older children with attachment difficulties, there were still some limitations to this study. First, Theraplay as a therapeutic intervention, particularly for this specific age group, is still a relatively new area of study. Thus, one of the major limitations of this systematic review is the small sample of research available for this review. Another limitation is that the majority of the research used came from case studies, which are not typically considered to be generalizable.

This review was limited to articles and research that were peer-reviewed and written in English. This was done to ensure the rigor of the study, but may have left out less structured research on personal experience and less formal narratives. The focus on peer-reviewed and evidenced-based research also meant that gray literature, or literature that has not been formally published, was excluded from this study. As this research was focused on work with children over the age of three, articles that discussed treatment effectiveness with younger children were not included. Although participants within this research were, at least, three or older, participants' ages could range from three to 18. Participants in this study were anywhere from three to 14 years old. With such a large range of the ages and only one teenage participant, it is unknown whether and by how much this intervention may vary in effectiveness from childhood to adolescents.

This systematic review was also limited in its lack of discussion around whether or not Theraplay interventions would be an effective treatment for children who have co-occurring disorders or cognitive deficits in addition to attachment difficulties. It is likely that the effectiveness of Theraplay varies depending on parental involvement and parental attitudes. There was no real consistent measure of the energy, commitment, and availability of parents within these studies. Other treatments may also be needed either before, after, or during Theraplay treatment.

Further Research and Implications

One of the first things to emerge from this systematic literature review was how limited the research is around the effectiveness of Theraplay interventions for children three or older. Theraplay as an intervention is much more frequently used with younger children. This may be due to research suggesting that the development of healthy

attachments is crucial in the first two years of life and subsequently becomes more difficult. Future research would benefit from focusing on smaller age groups and study of those groups independently. Given the nature of Theraplay, it is possible that it is more effective for certain age groups, particularly younger children versus adolescents. Alternatively, it may be equally effective in work with adolescents with play that looks more mature or developmentally appropriate. Another implication for future research would be examining if Theraplay would be an effective form of treatment for children with co-occurring disorders or cognitive deficits.

The majority of research included in this study consisted of qualitative interview designs or case studies, the results of which are not considered reliably generalizable. It would be important to gather more quantitative data on this topic. The use of quantitative methods can help answer the *what* about Theraplay and for *whom* regarding the effectiveness of Theraplay more clearly and reliably.

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Appendix A: Included Articles and Findings Summary

Article	Sample	Design/Method	Findings
Bojanowski, J., & Ammen, S. (2011). Discriminating between pre- versus post-theraplay treatment marschak interaction methods using the marschak interaction method rating system.	Eleven Canadian parent-child dyads who received at least 8 outpatient theraplay sessions. Children participants ages 5-9.	Quantitative Study; Treatment Outcome/Clinical Trial	CBCLs completed by parents before and after treatment demonstrated significant improvement in child behaviors. Interrater reliability for MIMRS=.75. Results of dependent-samples t test revealed strong effect sizes (Cohen's d) on the total MIMRS score (-1.07) and the nurture and challenge dimensions (-1.50, -0.76). There was a statistically significant increase in MIMRS scores, as well as the nurture and challenge dimension scores, indicating positive change between the parent-child dyads over the course of treatment. The nurture dimension has the strongest strength of effect, with d of -1.5. 10 of the 11 dyads showed significant improvement on the SBCL as demonstrated by lower mean score on the total problems scales. The same dyads demonstrated significant improvement in the quality of the parent child relationship as measured by the MIMRS. Given the small sample size the study might underestimate the significance between pre and post treatment.
Booth, P. B., & Lindaman, S. (2000). Theraplay for enhancing attachment in adopted children.	One 3-year-old child and his mother	Case Study	MIM was used to observe interaction between the child participant and his mother. The participant's mother described feeling closer and more connected to her child, and that she had a better understanding of his feelings and actions post treatment. She also reported feeling heard, understood, and supported herself. There was a reduction in behavior problems of opposition, tantrums, anger, and withdrawal, and an increase in cooperation and acceptance of parental guidance.
Booth, P. B., & Winstead, M. L. (2015). Theraplay®: Repairing relationships, helping families heal.	Two children with attachment difficulties and their parents (3.5 and 9 years old).	Case Study	Through pre and post tests using the MIM, Theraplay was found to be effective in facilitating attachment. One of the children in this study improved in their ability to trust adults both in and out of session, and used fewer strategies to resist getting close to his parents. He laughed more and cried less, his tantrums decreased in frequency and duration. He became much more accepting of care and loving attention from his parents. Both children in the case studies achieved treatments goals. Both sets of parents reported feeling closer to their children post theraplay.
Bundy-Myrow, S., & Booth, P. B. (2009).	One 7-year-old child and one 8-	Case Study	For the 7-year-old participant, the following treatment goals were met: form a secure

Theraplay: Supporting attachment relationships.	year-old child		attachment between child and both parents, provide soothing, empathic, and regulating experiences that the child missed as an infant, change parents way of interacting with their child so they can continue therapeutic work at home, work on relationship issues that might get in the way of parents responding to their child's needs. For the 8-year-old participant, the following treatment goals were met: mother to be attuned to and meet her child's early nurturing needs, increase dads nurturing, playful, and predictable involvement with his child, develop dad's role as a secondary attachment figure to support his child's need for confident exploration.
Hong, R. (2015). Practitioners' evaluations of theraplay as an effective tool in serving foster and adopted children and their families.	87 Theraplay-trained professionals	Mixed Method; Interview; Focus Group; Qualitative Study; Quantitative Study.	The study found that the therapeutic factors increased parent-child healthy connections, increased self-regulation of the child, parents' increased understanding of their child, and gained skills in parenting. Finally, the findings from the focus groups illustrated that Theraplay helps children build a positive internal working model. The results of the statistical methods (descriptive statistics, correlations test, and one-way ANOVA) found that there is positive association between the levels of practitioners' Theraplay training and the effectiveness of the use of Theraplay for helping foster and adopted children and their families. There is also positive association between the practitioners' levels of competency and the effectiveness of the use of Theraplay for helping foster and adopted children and their families.
Mahan, M. G. (2001). Theraplay as an intervention with previously institutionalized twins having attachment difficulties.	Previously institutionalized twins from Eastern Europe. Adopted at age 3 years and 9 months, 5 years old at the age of treatment.	Treatment Outcome/Clinical Trial	One twin achieved calmer moments for longer periods of time allowing him to be available to experience more intimate interpersonal connection and to maintain a more consistent engagement with his parents. His score on the RADQ indicated a 52% decrease in behaviors' considered to be indicative of attachment difficulties. His problem behaviors as reported by his parents and his teacher decreased; however the decrease was not significant enough to move him to a less severe range. His total problem score decreased two points, but he is still in the clinical range. While some of the findings are incongruent, overall he showed an increase in his ability to experience calm attentive moments during which he enjoyed the physical and emotional intimacy of his reciprocal attachment relationships. This twin's pretest

			<p>problem behavior scores were 58 and 77 by his mother and father. His posttest problem behavior scores were 53 and 75 by his mother and father. Using the Child Behavior Checklist.</p> <p>The second participants pretest problem behavior scores were 65 and 67. Post-test were 49 and 66 by her parents. She was calmer and better able to experience more intimate interpersonal connections with her parents, to give up a significant amount of control, and appeared to be more trusting. Her score of the RADQ indicated a 58% decrease in behaviors considered to be indicative of attachment difficulties. Her overall score changed from insecure to secure, and the qualitative analysis shows more coherent, better organized stories with more attuned and empathic play. Her problem behaviors as reported by her parents on the CBCL decreased. Her mothers scores for total problems placed her in the clinical range initially, however at the end of posttreatment testing her mothers total problem score decreased 16 points, placing her in the nonclinical range. Her SCT clearly demonstrated an increase in attachment. Her overall score changed from insecure to secure, and the qualitative analysis showed a more coherent, better organized storied with more attuned and empathic play. Both parents reported feeling closer to both of their children post Theraplay treatment.</p>
Mason, C. M. (2007). Parent and therapist perceptions of therapy with a late-placed foster or adopted children.	32 parents and 57 non-matched therapists. Also, 6 parents and 6 non-matched therapists were interviewed. Child participants were 3-11 years old	Quantitative study	All indicators suggest both parents and therapists see significant changes between the beginning and the end of therapy. The study also found a reduction of problematic child behaviors. Therapists' beliefs about change correlated most strongly with how well they thought parents and children were doing at the end of therapy, but not at the beginning.
Myrow, D. L. (2016). Enjoying theraplay with school-age children.	8-year-old child and his father	Case Study	Treatment goals were met: The child and his father found more ways that they could share closeness and have fun; the child could accept his role as a child and take redirection from his father. His father reported feeling closer to his son post treatment.
Robison, M., Lindaman, S. L., Clemmons, M. P., Doyle-Buckwalter, K., & Ryan, M. (2009). "I	One 14-year-old child	Case Study	Treatment goals were met: he was able to give and receive physical affection and nurturing from caregiver, and he was ultimately able to attach to a secure parental

deserve a family”: The evolution of an adolescent’s behavior and beliefs about himself and others when treated with theraplay in residential care.			figure.
Weir, K. N. (2007). Using integrative play therapy with adoptive families to treat reactive attachment disorder: A case example.	One 8-year-old child and his parents	Case Study	Treatment goals were met: The mother was able to play games and interact with her child at home, he child was willing to receive attention and nurture from his parents, the child began to show verbal and physical affection, the child’s behavior at home dramatically improved as his tantrums, screaming, swearing, and lying had been either reduced or eliminated. Based on self-report by the clients as well as observations of the therapist, the child parent relationship was much better post theraplay treatment. Both parents reported feeling more connected with their child.
Weir, K. N., Lee, S., Canosa, P., Rodrigues, N., McWilliams, M., & Parker, L. (2013). Whole family theraplay: Integrating family systems theory and theraplay to treat adoptive families.	12 adoptive families, 23 parent participants and 30 child participants, average age 8.64 years old	Case Study; Pre-test/Post-test Quasi-Experimental Design	Three items showed statistically significant favorable improvement at the $p < .05$ level: the communication subscale, the OQ interpersonal relations subscale, and the overall total score the children on the Y-OQ. This may mean that WFT does show promising results and is worth further study. The results from the study indicate that adults/parents report that their interpersonal relations improved. The OQ scores were statistically significant at the $p < .04$. These initial findings indicate that WFT is a practice model that shows promising potential, and tentatively, might have some level of clinical efficacy in at least three key areas: improving family communication within adoptive family systems, enhancing adult parents’ interpersonal relational skills, and assisting children in adoptive families to have better overall clinical outcomes.