

One Therapist's Journey Integrating Child-Centered with
Sensory/Attachment-Based Approaches to Play Therapy with At-Risk Children
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I have been doing therapy with adults, teens, children, and families (and most recently infants and toddlers) for over 25-years. Early in my career I assessed a 13-year old boy for Juvenile Justice who had murdered his best friend's older sister for less than \$5.00 in her purse. My recommendation was to incarcerate him until he could be tried as an adult. Instead he was put into inpatient treatment and released about a year later. Within six months he repeated the crime. After this experience I no longer felt I could work within the Juvenile Justice system, as the prognosis for this boy and other teens I was seeing there were very poor.

So by the mid-eighties I began to seek training and new venues to work with younger at-risk children with the hope of preventing such violence. This led me to explore play-based methods of therapy (from ropes courses and new games to Child-Centered and Filial Play Therapies) and apply them in school as well as clinical settings. I still work as a 0-8 mental health consultant and trainer nationally and at a Head Start in SW Colorado locally where I also maintain a part-time private practice in infant, toddler, child, and family therapy. Since 1998 I have been integrating sensory/attachment-based (SAB) approaches into my work with individual children, families, and classroom groups. I have found these SAB therapies to be more effective than Child-Centered Play Therapy (CCPT) alone in the majority of the cases that involve two-to-eight year old children who experienced prior developmental derailments of self-regulation in the first two years of life. While I still have much to learn about SAB therapies, I believe they have many advantages over symbolic approaches as the primary mental health intervention model in clinical, Head Start, and other early childhood and early mental health settings. This is because many children with the most significant self-regulation problems have sensory processing AND attachment issues which traditional behavior management and symbolic/language-based approaches like CCPT do not efficiently address. SAB therapies represent a developmentally appropriate body of methods for treating both sensory dysfunction and impaired attachment by helping children develop self-regulation and build empathic behavior. This article describes my transition process integrating SAB therapies with CCPT as well as the rationale for it.

The term CCPT is used here to describe any school of play therapy (such as Child Centered, Experiential, Filial, Jungian, Adlerian, and Thematic) where the therapist "primarily" lets the child lead the symbolic play with miniatures and dramatic props. In these approaches toys are considered words and play with them language. The curative elements of CCPT are considered to be children's symbolic expression of issues through child-centered play with toys, the therapist giving language to the "correct" themes expressed in the play, the therapist letting children usually lead the way, and the maintenance, by the therapist, of a deep trust in children's ability to heal themselves. Filial Therapy (FT), one CCPT school, is an extension of this approach developed by the Guerneys where parents are trained to play in a child-centered fashion with their child. Many of the CCPT schools have a strong "Rogerian Client-Centered" slant but all seem to hold that direction or control of the play is considered counter therapeutic in most cases.

The term SAB is used here to describe any school of play therapy (such as Developmental Play Therapy, Theraplay, and relationship-based sensory integration therapy) where the therapist "primarily" uses sensory/relationship-based play, games, and/or adult-child activities reminiscent of the playful/nurturing interaction seen between infant/toddlers and their

parents. For the most part no symbolic toys are used. The curative elements of SAB therapies collectively are to help the children modulate/tolerate sensation related to contact, learn to self-soothe and self-regulate, feel safety and trust in their experience of joy with caregivers, and to ultimately establish healthy attachments with their caregivers. It is believed that the therapist must be fairly directive and structured in her interaction with children and parents, much like mothers with their infants, in order to achieve the therapeutic goals. This should not be confused with overly coercive “holding” therapies or attachment therapies intended for children older than eight. It is also important to note here that while therapy for sensory/regulatory dysfunction is not primarily an attachment therapy it non-the-less uses many methods with young children that are similar to Theraplay (TP) and can facilitate a healthier attachment with caregivers by addressing sensory modulation, self-regulation, and self-soothing issues.

I started the shift to seeing younger children individually and using play-based approaches to therapy in private practice 20-years ago and at a NW NM Head Start 15 years ago. In order to make headway in serving as many of the 25% of children at Head Start (HS) who needed interventions (and reduce the number of individual CCPT sessions) I developed a program during the early-to-mid nineties, I initially called Play And Language to Succeed (PALS) that adapted FT/CCPT for Pre-K-2 classroom/school use by teachers during centers or free play time. By 1996 I had developed a teacher training, published a PALS guidebook and video, and eventually a whole program that attempted to systematically implement FT into Head Start and Pre-K-2 classrooms.

During the mid-to-late nineties, my paradigm of why CCPT works had changed dramatically due to my exposure to research on brain development, attachment, emotional intelligence, trauma, limbic resonance, reflective function, and other exciting new work, especially that of Bruce Perry, Alan Sroufe, Stanley Greenspan, Rima Shore, and Daniel Goleman. This work, in concert with my own experience raised the question of why CCPT works: Is it because of the symbolic processing during symbolic play with toys and/or letting the child lead the way or some other entirely different reason? Many of the young children we worked with then in Pre-K-2 and clinical settings commonly had impaired attachments in my estimation (as high as 30% of children nationally according to some experts today). Therefore, I reasoned that CCPT worked, at least in part with “younger” children, because it was a medium for facilitating a more secure attachment with one caring adult during a prime window for the neurodevelopment of a “good enough” internal working model of attachment. By late nineties it was evident to me that establishing an attachment with a teacher was a primary healing component in PALS at HS and Pre-K-2 settings as well as in individual CCPT or FT. So I began to view CCPT and the PALS intervention model as “relationship-based” and to add other elements to CCPT and PALS such as movement and music and silly games to facilitate more positive relations between caretakers, teachers, and at-risk children. This appeared to improve outcomes and support my hypothesis. At that point I also changed the PALS name to “Positive Attachments & Learning to Succeed.”

I can still remember the CCPT session around 1999 when I realized that it was the joyful spark that ignited intense laughter between myself, and a 3-year old male client that became the conduit for building a secure attachment and a powerful curative element in his therapy process. Subsequent experimentation led to what I called then “sensory/relationship-based” strategies. For instance, I would engage a child and his teacher in an interaction like pitching a foam ball to the child who would hit it with a bat and each time he did we would yell “Yeah!” loudly and break into joyful laughter that reached deep into our bellies. Since that time I have trained with, been exposed to, and/or influenced by the Developmental Play Therapy work of Viola Brody, the “I Love You Rituals” work of Becky Bailey (in part derived from Theraplay), the Theraplay work

of Ann Jernberg, the relationship-based sensory integration work of Maria Anzalone and Georgia DeGangi, the Thematic Play Therapy work of Helen Benedict, the Infant-led Watch, Wait, and Wonder (WWW) attachment work of Mirek Lojkasek and the Muir's, and the brain development and attachment theories of Daniel Siegel.

By the late nineties I had also noticed that certain children did not respond well to CCPT even with a more relationship-based approach. I know now that these children were much more likely to have both sensory/regulatory and attachment issues that manifested before age two and/or were traumatized or neglected usually in the first 24-months of life when their sensory systems and internal working models of attachment were developing. In contrast, a typical 3-to-4 year old child who has reached relatively normal levels of development (capacities for self-regulation in all areas are viewed here as neurological in their basis) is much better suited to symbolically process "subsequent" trauma and/or neglect using a CCPT approach. Specifically, to make use of symbolic processing in non-directive CCPT, a child will need to have achieved some degree of Erikson's stages of basic trust, autonomy, and initiative and Piaget's stage of preoperational processing. Relatively normal brain stem and limbic system development would therefore have occurred in the first 24-30 months of life allowing the child to focus and function in a non-directed manner and lead the way in CCPT. Inter-hemispheric integration of the traumatic material is likely the neural mechanism for change and is probably why some practitioners have found the combination of EMDR with symbolic play therapy to be effective for these children.

If a child has been abused, traumatized, neglected, and/or has a poor temperament fit with his caregiver in the first 24-months, it is likely that an impairment in the development of basic trust, a "good enough" internal working model of attachment, and related brain/sensory development will not occur normally. It is important to note that what is meant here by building basic trust is the establishment of a neurological foundation for attunement, self-regulation, and self-soothing to mutually occur between the adult and the child (otherwise known in neuroscience as limbic resonance), a precursor to judging the trustworthiness of another, which develops later in childhood. It follows then that the development of autonomy and initiative would also likely have been disrupted. So if the development of autonomy and initiative is missed or disrupted, it is unlikely that CCPT alone will be adequate as it does not provide sufficient structure so the child can let her control down enough to reestablish basic trust, essential to attachment. In fact, I have seen some of these same children use CCPT to sustain control and avoid the development of attachments in their therapy sessions. It is also unlikely that structured or directive forms of symbolic play therapies (such as "Release" play therapy) would address the basic trust and attachment issues. Structured or directive symbolic play therapies also require the achievement of Piaget's cognitive stage of concrete operations, which is not usually established until age-8 or older making these approaches a poor choice for early intervention before age-8. At a neurodevelopmental level what is likely happening during SAB therapy is that neural connections and integration between the brain stem and limbic system are developing sequentially much in the same way it occurs in the first 6-24 months of life. This is assuming the child's brain is still plastic enough to develop appropriate neural connections sequentially. SAB methods such as TP and Developmental Play Therapy (DPT) are well suited to this therapeutic task as they focus on the development of basic trust and attunement where the adult remains in "loving" control directing the process much like a mother does with her 6-12-month old child. This is not to say that CCPT cannot achieve positive results with these children but when it does, in my experience, it is because the therapist has used the play as a "relationship-based" treatment medium where attachment is the curative element not symbolic

processing. However this can be very difficult to do with the more severe cases and can take much longer than with SAB therapies in my experience.

Carol Kranowitz, a well known expert on sensory integration sites numbers ranging from 12-30% of all young children have dysfunction of sensory integration (DSI), depending on how you define DSI, which in turn may contribute to or cause impaired attachments according to experts in the field of regulatory disorders. Regulatory disorders in infants have been shown in studies to be associated with a host of later problems especially social, emotional, and behavioral ones. So if these children have a regulatory or sensory processing problem in conjunction with an impaired attachment then they would need an approach to therapy that has a sensory component, addressing issues related to sensory modulation and learning to self-regulate and attune to their caregiver and, therefore, attach. At a neurodevelopmental level what is likely happening is that the sensory component of the SAB therapy is organizing the brain stem and building connections between the brain stem and lower regions of the limbic system so that sensory modulation, self-regulation, limbic resonance (attunement), and attachment can occur. Again, SAB approaches like sensory integration therapy (SIT), DPT, and TP are well suited to the task, and CCPT would not likely be the treatment of choice initially. However a child may require symbolic play therapy, following SAB therapy, to process stress which occurred after age two or address developmental delays in symbolic functions.

As mentioned earlier, CCPT maintains that a major curative element is letting the child lead the way where the adult remains non-directive, respecting the child's ability to heal himself, and gives language to the themes in the symbolic play. Some CCPT practitioners have criticized SAB approaches such as TP or DPT methods for being too intrusive or directive, and some SAB practitioners have criticized CCPT for being too non-directive; but here is where the paradigm of directive and non-directive therapy fails as a model to guide therapeutic interventions. It is not whether the therapists are too directive or not, as much as what level of "attunement" they bring to the interaction with the child and what level of neurodevelopment the child has achieved, especially in regards to the child's ability to act autonomously in her own best interest. In addition, the ability to accurately reflect upon what the child feels, needs, and believes is critical to the attunement process. So one can be quite directive, but not intrusive as long as you remain "exquisitely" attuned and have the reflective capacity to guess accurately what the child feels, needs, and believes. Approaches to therapy such as Greenspan's "Floor Time" and the WWW model of infant-led attachment therapy, while non-directive, focus almost exclusively on helping the caregiver develop attunement and reflective capacity versus on the child's play. I consider this to be a third camp of play therapy, which I refer to as a "Reflective" approach (RA) versus CCPT or SAB. It is usually best applied while children are still 8-to-30 months of age and the brain and internal working model of attachment are still evolving. Children between 3-to-8 years old who have displayed sensory/regulatory and attachment issues before age two tend to develop defense systems that interfere with building basic trust and therefore a "good enough" internal working model of attachment and related neural connections or nets. So SAB therapies like TP attempt to replicate relations typical of the first 2-years of life with a focus on relationship-based play like "peek-a-boo" versus play with toys. The adult provides a playful diet of sensory/relational activities instead, which challenges the child to learn to allow the adult's nurturing and develop the capacity to modulate sensory-relational input without becoming over stimulated or threatened. This makes SAB therapies ideal for 3-8 year olds whose attachment and sensory/regulatory development were derailed before age two and have defense systems against building basic trust, but still have the neural "plasticity" to change their brains. Beyond 8-10 years of age the prognosis for these children is poorer and may require different and/or more intensive forms of therapy in my opinion. This is because much of the brain has already

developed sequentially in response to sensory and psychosocial environmental stimuli and a major neural “pruning” process has usually been completed, reducing neural plasticity. This does not mean that these children cannot be helped, just that it is much more difficult and that the “quality” of change usually is lower.

Different stages of neurodevelopment require that caregivers provide differing levels of structure and control, which is also true in therapy. So accurately assessing the child’s neurodevelopmental level can indicate which intervention is needed. That is why today, I recommend that therapists and educators adopt a neurodevelopmental perspective that looks at self-regulation in a more holistic fashion rather than take a rigid stance about being directive or non-directive. This makes thorough developmental intakes and screening for delays at the sensory, attachment, social-emotional and behavioral levels critical. Then, interventions can be designed that begin at the level of neurodevelopment where the derailment originally occurred, and progress through the intervention process in a neurodevelopmental sequence from the sensory/regulatory/brain stem to attachment/limbic to symbolic/inter-hemispheric levels.

In summary, again while I still feel I have much to learn about SAB therapies, I believe they have many advantages over symbolic approaches as the primary intervention (for instance they appear to be briefer) in clinical or early childhood settings, with 3-to-8 year-olds who have experienced developmental derailments of self-regulation in the first two-years of life. This is because in my experience a large proportion of children with the most significant self-regulation/behavior problems have regulatory/sensory processing AND attachment issues which traditional behavior management and symbolic/language-based approaches like CCPT do not efficiently address. SAB therapies are developmentally appropriate for both sensory/regulatory dysfunction and impaired attachment, which helps children, learn self-regulation and empathic behavior that in turn leads to healthier socialization.

The author can be reached at pals@frontier.net or www.pals4schools.com. Barry is licensed as a professional counselor and school psychologist, the director of the Center for Early Intervention, and lives in Durango, CO where he practices therapy and trains professionals. The above material is part of a forthcoming book to be published by W. W. Norton entitled “The Brain at Play: Unifying Play Therapies and Early Intervention through Neuroscience” and may not be used without written permission from the author.