

## CHAPTER 2

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# Play Therapy Approaches to Attachment Issues

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The need to explicate the role of play therapy and the creative arts therapies with attachment issues was vividly brought to my attention when I searched the index of the often consulted and acclaimed second edition of the *Handbook of Attachment* (Cassidy & Shaver, 2008). In this comprehensive volume of 1,020 pages, I found only four separate references to page numbers in the index for play, and none for play therapy, art therapy, creative arts therapy, or expressive arts therapy. I should note that the four selections of page numbers in the index referring to play were important ones, briefly detailing (1) the role of attachment security in social play repertoires; (2) the critical importance of attachment for the quality of play; (3) the dependence of “play-mothering” and later caregiving capacity on the experience of maternal care; and (4) the facts that exploratory behavior is playful and that play only develops in a secure context. In spite of this lack of attention until recently among attachment theorists and play therapy researchers, there is a long history of play therapy approaches dedicated to treating attachment problems.

### Early Roots of the Focus on Attachment in Play Therapy

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The crucial role of favorable early attachment was recognized and written about extensively by the early psychoanalysts. A consensus in psychoanalytic writing from the earliest days was that human infants need unconditional love in order to develop in a healthy way what one analyst called

“non-obligating solicitude” (Bonime, 1989). The psychoanalyst Erich Fromm (1947) expressed it eloquently:

Motherly love does not depend on conditions which the child has to fulfill in order to be loved; it is unconditional, based only upon the child’s request and the mother’s response. No wonder that motherly love has been a symbol of the highest form of love in art and religion. (pp. 99–100)

Freud (1909/1959) also weighed in on the incomparable role of early attachment figures:

For a small child his parents are the first and the only authority and the source of all belief. The child’s most intense and most momentous wish during these early years is to be like his parents (that is, the parent of his own sex) and to be big like his father and mother. (p. 237)

Lili Peller (1946) understood that this love needs to come from those with whom the infant is biologically bonded—a fact that has led to immeasurable heartbreak for children and parents in the foster care system. Peller wrote:

The child’s greatest need is for love from the persons to whom he is attached, and not merely from persons who chance to be near him. ‘Persons of his environment,’ his teacher or nurse or a kind-hearted aunt, may offer this love amply to the child—yet he profits but little. We can assume that many foster-children have been offered love and affection to no avail. (p. 415)

The psychoanalyst Edward Edinger (1972) beautifully described the gift enjoyed by recipients of unconditional love in infancy: “The sense of innate worth prior to and irrespective of deeds and accomplishments is the precious deposit that is left in the psyche by the experience of genuine parental love” (p. 167).

Early roots of play therapy’s focus on attachment and attachment trauma can also be found in the writings of Donald Winnicott (1971), as detailed by Tuber, Boesch, Gorlin, and Terry in Chapter 13 of this volume. Tuber (2008) has explained in an earlier publication that Winnicott (1971) identified a tolerable window of infant distress when the mother (primary caregiver) is absent; when this window is exceeded in duration, or the infant undergoes emotional duress, the experience for the infant is one of confusion and disorganization. Interestingly, nearly two decades later the term *disorganized attachment* was introduced by Main and Solomon (1990) to describe the effects of severe attachment trauma.

Winnicott became interested in attachment issues and the corollary experiences of separation and loss during World War II. Winnicott, along with John Bowlby, Anna Freud, and other prominent British and European analysts, worked hard to resettle children in the countryside so that they

could escape the incessant bombings in London. In a letter written in 1939 to the *British Medical Journal* and titled “Evacuation of Small Children,” Bowlby and Winnicott, along with the analyst Emanuel Miller, stated:

It is quite possible for a child of any age to feel sad or upset at having to leave home, but . . . such an experience in the case of a little child can mean far more than the actual experience of sadness. It can in fact amount to an emotional “black-out” and can easily lead to a severe disturbance of the development of the personality which may persist throughout life. (Bowlby, Miller, & Winnicott, 1939, pp. 1202–1203)

Thus, in the midst of the horror of World War II, these early analysts described what we now consider *attachment trauma* and what is sometimes called in children *developmental trauma*.

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### What Is Attachment Trauma?

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*Attachment trauma* is one of the terms intended to address the growing consensus that posttraumatic stress disorder (PTSD) does not adequately describe what happens to people when they suffer interpersonal trauma. This is especially true when the trauma ruptures relationships with primary attachment figures. PTSD—a diagnostic classification in the third, fourth, and now fifth editions of the American Psychiatric Association’s (1980, 1994, 2013), *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III, DSM-IV, and DSM-5 respectively)—describes a cluster of symptoms that tend to ameliorate in time (often in 3 months) and are responsive to evidence-based treatments, most notably cognitive-behavioral therapy. What the diagnosis of PTSD does not adequately detail is the often enduring relational impact when trauma intrudes into the interpersonal life of any person, but especially a child. If, for example, a child is abused by the very person(s) responsible for his or her well-being, safety, and nurture, the insidious effects on the capacity to trust, to risk closeness with another, and to envision a positive future are common enduring sequelae not addressed by the PTSD classification of symptoms; nor can they be addressed adequately in brief treatment models.

The inadequacy of the PTSD diagnostic criteria has long spurred a debate among some of the leading trauma researchers and clinicians. Judith Herman (1992) offered the term *complex trauma* to delineate trauma that involves repeated and chronic abuse, instead of a single traumatic event that can cause PTSD symptoms. Previously, Lenore Terr (1990) distinguished between *Type 1* and *Type 2* traumas. Type 1 represents single-event trauma, whereas Type 2 refers to repeated or chronic trauma and often multiple traumatic factors (such as growing up in poverty, exposure to abuse, and/or exposure to domestic or community violence). Herman

also decried the use of what she considered demeaning diagnostic labels that are used to characterize the complexity of symptoms resulting from repeated exposure to trauma, such as borderline personality disorder. More recently, Bessel van der Kolk (2005) has offered the term *developmental trauma* to describe complex trauma in childhood, because of its potentially devastating impact on the course of the unfolding developmental process.

Allan Schore (2012) has written eloquently about *relational trauma*. Schore emphasizes the impact of unfavorable early attachments (during the first 18 months of life) on the development of the right hemisphere of the brain. Schore has demonstrated that ruptures and lack of repair of the attunement process between the infant and the primary caregiver result in impaired development of the right hemisphere. One of the major effects is the inability to regulate emotions adequately, and another is impaired relational capacity.

There was a time some 20 years ago when the work of attachment researchers and the work of clinicians in therapy rooms ran on separate tracks, with little collaboration between the two groups. All of that changed when the writings of two master integrators from the University of California at Los Angeles (UCLA), Daniel Siegel and Allan Schore, became widely read. Siegel's (1999, 2012) *The Developing Mind* opened the eyes of many to the possibilities of making use of attachment theory and research findings in therapeutic work. His development of the interpersonal neurobiological approach not only combined attachment research with psychotherapy theory and research, but added the contributions of neuroscience to our understanding of how attachment and psychotherapy change the structure of the brain. As noted above, Schore (1994, 2003a, 2003b, 2012) is the other UCLA researcher and clinician who has been able to synthesize findings from psychoanalytic and attachment theory with neuroscience research to highlight the pivotal role of favorable early attachments in the proper development of the right hemisphere of the brain, which in turn critically influences the development of emotional regulation. Schore has also delineated the important implications of his work for psychotherapy, since emotional dysregulation is a key feature of most childhood and adult psychiatric disorders. This exciting work has not validated the concept of infantile determinism, because neuroscience research has demonstrated that new brain connections can be made throughout life, but it has affirmed the Freudian emphasis on early parent-child relationships and the critical periods for secure attachments coinciding with the incredible rate of brain development in the first 2 years of life.

Bruce Perry (Perry & Szalavitz, 2006), another key contributor to our understanding of the neurobiological underpinnings of emotional and relational development, has explained that if critical periods in the early attachment process are missed, a child is not doomed; however, when repair is attempted later in development, it will take much longer and require much repetition of favorable experiences with attachment figures. The good news

is that children possess impressive innate capacities for self-reparative and healing processes, combined with security in relationships with caregivers. The bad news is that if the healthy innate forces combined with favorable attachment experiences come later in the developmental sequence, it will take much more time to effect the positive changes.

Jon Allen (2013) is another seminal theorist and clinician; his work builds on the attachment research of British theorists, particularly Peter Fonagy (Fonagy & Target, 1997). Fonagy and his colleagues used the term *attachment trauma* to refer not only to trauma that takes place in the context of attachment relationships, but also to the damaging impact of such trauma on the capacity to develop secure attachment. Allen views *neglect* (defined as the lack of psychological attunement) as central to attachment trauma. Allen elaborates further that “trauma stems from being left *psychologically alone in unbearable emotional pain*” (p. xxii; emphasis in original).

In addition to the lack of consensus regarding the definition of attachment trauma and the controversies surrounding inclusion–exclusion of complex PTSD and developmental trauma disorder in DSM-5 (they were ultimately excluded), there is lack of agreement on variations of attachment disorders. Beginning with DSM-III, and followed by DSM-IV and DSM-IV-TR, reactive attachment disorder (RAD) was the only recognized attachment disorder included in this official diagnostic classification manual of the American Psychiatric Association. RAD is a rare form of attachment trauma suffered primarily by children who have been institutionalized in early life and/or severely abused. There were two recognized forms of this disorder: (1) the emotionally withdrawn/inhibited form, in which there is a failure to respond to comfort when offered and failure to seek comfort when distressed from a preferred attachment figure; and (2) the disinhibited/indiscriminately social type, in which the child is overly interested in interacting with and sometimes seeking affection from unfamiliar adults, without distinction. These more severe forms of attachment disorder are seen in some children in residential treatment centers, as well as in some (but certainly not all) cross-cultural adoptions of previously institutionalized children.

DSM-5 split the previously existing category of RAD into two separate diagnoses. Reactive attachment disorder is now defined as a lack of or incomplete formation of preferred attachments to familiar people, with a dampening of positive affect that resembles internalizing disorders (e.g., anxiety). Disinhibited social engagement disorder is the other diagnosis.

Play therapists may work with children with RAD in their private offices, clinics, or residential treatment center playrooms, but far more frequently play therapists see children with less severe problems of insecure attachment, and the goal is to increase attachment security. Even more advantageous are the prevention programs that can head off such relational problems by intervening early.

## **How Does Play Therapy Address Attachment Trauma?**

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Since the value of all psychotherapy rests on the foundation of the therapeutic relationship, play therapy, with its emphasis on the dyadic relationship, offers the possibility of greater attachment security for a child who has suffered interpersonal trauma. In addition, play therapy has a distinct advantage over other relationship therapies, in that one of the therapeutic powers of play is attachment formation (Schaefer, 1993; Schaefer & Drewes, 2014). Schaefer explains that secure attachment can be facilitated in children by replicating the positive parent–child relationship through sensory–motor play. Schaefer (1993) has observed, “Playful interactions involving touch and smiling are perhaps the most natural and enjoyable ways to form an attachment with a child in the playroom” (p. 11).

### ***Theraplay***

An early form of play therapy that preceded the seminal volumes on loss and attachment by Bowlby was a focused attachment process called Theraplay (Jernberg, 1979). In 1967, Ann Jernberg was appointed the director of the Head Start program in Chicago. She recruited Phyllis Booth as one of her assistants (see Booth, Lindaman, & Winstead, Chapter 9, this volume). Jernberg did not feel that referring the numerous children who needed intervention to existing crowded mental health clinics was an adequate solution; instead, she developed her own program. In order to meet the enormity of the need, she designed her program to make use of paraprofessionals working under the supervision of mental health professionals. Theraplay is a model of play therapy that is based on healthy parent–child interactions and draws partly on the work of Austin Des Lauriers (1962) and Viola Brody (1997). As a result of this pioneering work with Head Start, the Theraplay Institute was formed in 1971, and children from the community were referred for treatment. From this modest beginning in Chicago in the late 1960s, Theraplay is now practiced in over 36 countries around the world.

### ***Filial Therapy***

Filial Therapy (FT), developed by Bernard and Louise Guerney in the late 1950s, has considerable research support and has developed as a powerful family therapy and play therapy intervention (B. G. Guerney, 1964; L. F. Guerney, 2003; L. F. Guerney & Ryan, 2013; VanFleet, 2013). It has a specific focus on attachment and treating forms of insecure attachment, along with more severe cases of attachment trauma (see Topham, VanFleet, & Sniscak, Chapter 8, this volume). One of the compelling advantages of FT in the treatment of attachment trauma is the presence of the primary attachment figure(s) in the treatment. Attachment security is being built

between the child and one or more primary caregivers even as the trauma is being addressed.

### ***The Circle of Security***

In addition to the attachment formation power of play, play enhances the relationship of the child not only with the play therapist but with others who may participate in the play therapy, such as the primary caregiver(s) in FT, in developmental play therapy (Brody, 1997), and in prevention programs like the Circle of Security (see Stewart, Whelan, & Pendleton, Chapter 3, this volume). The Circle of Security program specifically teaches parents to recognize when children need encouragement to explore and to move away from the parent, and to provide support and a secure base to return to when the child needs a safety net. The playful interactions combined with the sensitive attunement of the parent's empathic responding to the child's needs greatly enhances the attachment bonds. Schaefer (1993) has written: "The role of play in facilitating a positive relationship is related to the nature of playful interactions that are fun filled and concerned with enjoyment rather than achievement" (p. 12). The most effective way to build an attachment or enhance a relationship with a child is to create safe, trusting, and gratifying experiences with an adult, and play is an effective and natural medium to facilitate the process.

### ***The Neurosequential Model of Therapeutics***

As noted earlier, one of the pioneers in the neurobiology of attachment is Bruce Perry (Perry, 2009; Perry & Szalavitz, 2006), who has articulated the Neurosequential Model of Therapeutics. This model involves many play components, including sensory-motor play to help soothe the brainstem (see Gaskill & Perry, Chapter 11, this volume). The Neurosequential Model of Therapeutics has brought new understanding to the work of the play therapist in addressing disruptions of early attachments. Perry explains that what we do in therapy sometimes doesn't matter as much as when we do it. Timing and sequence are essential in addressing attachment trauma, and Gaskill and Perry offer a map to guide us.

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## **Case Vignette: Play Therapy for Attachment Trauma**

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### ***Individual Play Therapy Sessions***

Jason, a 6-year-old boy constantly in trouble at school, entered the playroom and immediately headed for the plastic tubs of puppets. Puppets went flying in all directions until he found one that appealed to him. He finally settled on an alligator, with unusually sharp and long teeth; he then threw in the direction of the therapist a rather defenseless puppet, a

beaver. Before the therapist was able to get his hand fully into the beaver puppet, Jason, with a startling roar, pounced on the beaver and locked him in a vise-like grip with amazing strength for such a young child. What were striking about the alligator's aggression were the intensity and the affect behind it. At one point, the therapist had to set a limit, because the viciousness of the attacks caused physical pain. To prevent injury to child and therapist, Jason was told, "It is OK for the alligator to be angry and attack the beaver, but it is not OK for either of us to get hurt, so you need to be not quite so rough." It was the only time that a limit was needed: Jason, while still expressing considerable rage in the alligator's attacks on the beaver in the remainder of that session and in subsequent sessions, always stopped short of inflicting pain on the therapist or causing injury to himself. The individual play sessions that followed were active, largely focused on the theme of aggression and revenge, but there was a gradual, nonlinear reduction in the intensity of the affect expressed as well as symbolized through the action of the play. Also, accurately depicting the pain of Jason's life situation, the alligator always acted alone. There were no companions or friends.

The rage expressed by this first-grade boy in the form of a vengeful, attacking alligator puppet accurately symbolized his internal inferno, stemming from multiple factors—most obviously the sudden death of his father, who had died of a heart attack while running a marathon 6 months earlier. Of the four children, Jason, the second-born, had experienced the most conflictual relationship with his father and carried the heaviest burden following his sudden death. Jason's attachment with his father had been insecure/ambivalent, and there was no longer an opportunity to make it more secure. Jason's father had been harder on him than on his two sisters and his younger brother. The paternal grandmother observed that Jason's father had had similar impulse and externalizing problems when he was Jason's age. Jason's mother had tried to protect Jason and thought her husband was truly too hard on him, but she surmised that her husband mostly had good intentions and didn't want Jason to have the same hard struggles that he had experienced as a child.

Although the father's intentions were probably good, the effect on Jason was to make him feel that he could never please his father, in spite of desperately wanting his approval. Jason experienced his father's concern more sharply as massive rejection. In addition, Jason struggled with neurodevelopmental challenges. His impulsivity was a component of his attention-deficit/hyperactivity disorder (ADHD), which made it hard for him to function without alienating his siblings or his peers at school and in sports. Whether with his siblings or his peers, he always was determined to be first and was quite willing to push others out of line if they were ahead of him. He was far more than a "rough-and-tumble boy" on the playground, sometimes hitting peers broadside at full speed, and occasionally causing



injury (as well as alarm on the part of school officials and worried parents of other first graders). The play therapist attended frequent meetings with the mother and his teachers and school officials at his elementary school because of Jason's bullying, aggressive, and intimidating behavior. Behavioral plans were developed and implemented, with temporary improvements but no lasting change, because the underlying issues were complicated and would take time to work through adequately.

What Jason had experienced as a core part of his attachment trauma was a deep hurt shared by many children whose attachments are traumatically ruptured; it took the form of identification as a "child who does not fit." Jason "did not fit" in his family because of his dysregulated behavior associated with ADHD and his hostility stemming from his perception of rejection by his father. Jason "didn't fit" in school for the same reasons, plus his attempts to compensate for his lack of acceptance by becoming hyper-competitive. His extreme competitiveness further alienated his peers—not only in school, but when he played soccer or baseball. Jason always had to be captain, always win, and always be first, or else he would explode in anger. Any experience that symbolized "loss" in the slightest way triggered a huge emotional reaction, almost always taking the form of blind rage. James Garbarino (1999) has noted that the closest thing to a psychological malignancy is social rejection in childhood. When the rejection is perceived within a child's family as well as in his or her social world, the malignancy is particularly potent and often accompanied by the most profound forms of rage.

Jason shared another psychodynamic constellation with other children who suffer attachment trauma. Clinical experience indicates that anger/rage is experienced by children as an empowering emotion, whereas sorrow leaves them feeling vulnerable and exposed. Underneath Jason's burning rage was the far more delicate and vulnerable feeling of profound sorrow. The loss of his father was sudden and final, leaving him no opportunity to make amends or to resolve the struggle and conflict with his father. The wound was anything but clean, and healing would be complicated by the permanent absence of his father.

The individual play therapy sessions helped build trust in the therapist and enhanced the therapeutic relationship. Jason was able to displace safely, within the symbolism of the aggressive play (the alligator puppet's attacking the beaver and other defenseless animal puppets), the burning rage stemming from his unresolved loss and grief and from his social rejection. The play sessions allowed him to modulate his rage as he gave full expression to its intensity in a safe and controlled environment, and then, over a period of 10 subsequent sessions, exercised more conscious and safer control over different levels of intensity of affective expression. The individual play therapy, however, could not provide all of the ingredients needed for healing such a severe rupture in Jason's attachments. The play

therapist needed to shift approaches to enlist the resources of the family system.

### ***Focused Family Therapy Sessions***

Although the play therapist would not have credibility in convincing Jason that there could be another meaning to his father's harshness, his mother, paternal grandmother, and aunts were in a more favorable position to do so. Basically, what Jason needed was a phase of cognitive work focused on modifying his belief that his father had never accepted him or loved him. The play therapist knew that it was going to take more than one person and more than one session to make a dent in his strongly held belief that his father "hated him," which he repeatedly stated. The play therapist decided to call on one family resource at a time. In the first session, his mother was invited to join with the therapist in talking with Jason about her belief that although Jason's father had been strict and tough on him, he did so because he loved him and he didn't want his son to get into trouble repeatedly, the way he had done himself. The play therapist primarily played the role of "silent witness" (Gil, 2010), but did amplify the alternative way of understanding the father's intention. When the mother stated her view of what the father was trying to do, the play therapist said, "Oh, that's a new way of looking at how your father felt about you. He was hard on you because he loved you, and he didn't want you to go through the hard times he went through." Jason was attentive but seemed skeptical.

Next the play therapist called on the paternal grandmother, who, in spite of her own considerable grief resulting from the death of her only son, did a remarkable job of sharing with conviction her belief that Jason's father had loved him and wanted to teach him lessons that he himself had had to learn the hard way. What seemed to intrigue Jason the most were the many examples his grandmother gave him of how his father had gotten into trouble when he was Jason's age. Some of them, like the time his father poured glue on his first-grade teacher's wooden chair, made him laugh. He seemed relieved that he was not the only "black sheep" in the family, and he also gained a sense of solidarity with his father. His mother's argument that his father had only been trying to straighten him out and keep him out of trouble seemed to gain more credibility with every story of misbehavior that the grandmother told.

### ***Family Play Therapy***

The final stage of Jason's therapy took the form of family play therapy (Gil, 1994), with the goal of restoring connections with his mother and siblings. In one quite poignant session with the mother and all four of her children, the children decided that the eagle puppet had a broken wing.

This was a powerful metaphor. Until the sudden, traumatic death of the father this had been an “all-American” type of family. The family members were all quite active, into sports and outdoors activities, but now they were grounded and having trouble getting airborne again. In the beginning, Jason refused to participate with his siblings. He sat next to his mother, but turned away from the other children. Jason was literally enacting in the session the destructive identity that he had embraced of “the child who did not fit—did not belong.” His primary attachments had been disrupted not only by the unexpected death of his father, but by the alienation of his siblings and his peers. Jason enacted in the session the pattern that he doggedly enacted in his daily life, making sure that he was the “child who did not belong.” His unspoken credo was “I will reject you before you will even get the opportunity to reject me.” Yet beneath this maladaptive defensive pattern was the hunger that all humans share for acceptance and belonging.

The therapist recognized this as a critical moment in the family play therapy. Would everyone together—mother, siblings, and therapist—be able to convince Jason that he had an important place in the family, or would he choose to remain outside the circle of the family in his lonely, painful self-imposed exile? His mother expressed in a heartfelt way her wish for Jason to join the family and participate in the family play of the “eagle with a broken wing.” Each of his siblings also tried their best to convince Jason to join them, but he still was holding out. The therapist then said to Jason, “We need you, Jason. We will not be able to heal the eagle’s broken wing without you.” The therapist then handed him the doctor’s kit. Everyone in their room held their breath until Jason sprang to his feet and came over and began attending to the eagle, which was tenderly held by one of his sisters. This was a turning point. Jason finally was able to accept that he no longer had to be the “child who did not belong.” His family had been convincing, and he was invested from that point on in the family play drama of healing the eagle’s broken wing.

A particularly interesting feature of Jason’s empathic attending to the eagle as a doctor with his various instruments of healing was singing to the eagle. Only a few weeks later, in a meeting with his mother, did I learn the significance of the singing. His mother told me that an important breakthrough had occurred at home in the week before the pivotal session. The loving and empathic mom had always gathered the children at bedtime and sung to them a song they all loved. After the death of the father, Jason in his anger would not tolerate his mother’s singing. In the week prior to the “eagle’s wing” session, Jason had come to his mom and asked her if he could sing the song that she had formerly sung before bedtime to the children. Jason did sing it and remembered all the words. This was part of the reparative movement toward reunion with his family, his acceptance of his father’s death, and his willing to embrace the love of his family and perhaps for the first time enter into a heartfelt sense of belonging.

## Conclusion

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Play therapy has rich and enduring early roots in attachment theory, and some early work in attachment-focused play therapy even predates attachment theory. Not only did the early child psychoanalysts regard the parent–infant bond as a primary focus, but Theraplay—with its emphasis on enhancing attachment and bonding through playful interactions between primary caregivers and their babies—was launched in Chicago in the late 1960s, before the major writings of John Bowlby (who is most often identified as the pioneer of attachment theory) were published. Donald Winnicott, as an early analyst and pediatrician, used play therapy as a way of strengthening attachment, and collaborated later with Bowlby on projects during World War II to deal with the disrupted attachments of children evacuated from the bombings of London. More recently, the work of Allan Schore, Daniel Siegel, and Bruce Perry, grounded in the science of neurobiology, has greatly expanded our understanding of the neurobiology of early attachments; these researchers have shown how favorable consistent interactions are essential for infants to develop gradually the capacity for affect regulation, and how the timing of our interventions needs to be informed by new understandings of brain development. It is an exciting time to be a play therapist.

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