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The Value Of Play in Infant and Child Psychotherapy in a Group Attachment-Based Intervention (GABI)

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ABSTRACT

There is growing interest in examining how attachment-based therapeutic interventions in early childhood can strengthen the bond between parent and child and prevent the transmission of intergenerational trauma. In recent decades, advances in attachment research have contributed to a greater understanding of how important the parent-child relationship is for a child's well-being and subsequent years in life. This thesis explores the value of play in children's therapy, specifically its use in dyadic play therapy as a therapeutic technique to strengthen the bond between parent and child. Two case studies from an attachment-based intervention are presented, and focus is given to the implicit nonverbal cues of communication expressed during the parent-child interaction in dyadic play. The value of play between the dyad is assessed from an attachment-based perspective and the correlation between the progression of play in relation to the quality of the parent-child attachment is explored. The therapeutic space of the case studies present play with two primary functions: play exposes the underlying relational dynamics of the parent-child relationship and it serves as the vehicle in which the parent and child can work together to create a shared meaning of their experience.

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Introduction: Being in Play

The origin of play is believed to be dated before the cosmos, to the 'big bang,' where the play between the 'organizing forces' and chance gave rise to the 'order of life' (Eigen & Winkler, 1981). Play is not a human creation, it is "a natural phenomenon that has guided the course of the world from its beginnings. It is evident in the shaping of matter, in the organization of matter into living structures, and in the social behavior of human beings" (Winkler & Eigen, 1981 p.3). From the perspective of play as a human behavior, it is believed to be therapeutic in and of itself (Landreth, 1991; Axline, 1947; Lieberman & Van Horn, 2008; Winnicott, 1971). It is a universal phenomenon that emerges during the early years of life and carries on throughout the lifespan (Brown, 2009; Winnicott, 1971, Sutton-Smith, 1997, 2008; Huizinga, 1950; Lyons-Ruth, 2006). Although common characteristics of play can be identified (Segal, 2004), play does not consist of a singular activity or affect, nor is it directed towards a definitive purpose, goal, or outcome (Bowan, 2002). Winnicott believes that play is a "basic form of living," an experience that has to do with one's sense of existence, self, and capacity for creative living (Winnicott, 1971, p.67). As such, play does not end in childhood as a stage or developmental phase that one grows out of as Jean Piaget believed.

In Huizinga's (1950) view, play is a constituent of humanity and human culture. It takes on the quality of one's interpersonal exchanges, environmental factors, and the cultural aspects in which it is situated. Huizinga defines play as an active pursuit of an individual, 'the typical western approach', that stands in contrast to Eigen's and Winkler's approach, as well as to the

anthropologist Richard Schechner (1988), who frames play as a phenomenon of the natural world, an occurrence beyond human behavior that is part of the continuum of existence (Sutton-Smith, 1997). The definition of play provided by Schechner in his book Performance Studies captures play's broad existence:

Play is a mood, an attitude, a force. It erupts or one falls into it. It may persist for a long time as specific games, rites, and artistic performances do - or it comes and goes suddenly- a wisecracker, an ironic glimpse of things, a bend or crack in behavior… [I] it's wrong to think of playing as the interruption of ordinary life. Consider instead playing as the underlying always there continuum of experience ... Ordinary life is netted out of playing but play continually squeezes through even the smallest holes of the work net... work and other activities constantly feed on the underlying ground of playing, using the play mood for refreshment, energy, unusual ways of turning things around, insights, breaks, opening and especially looseness.

(Schechner, pp. 16-18).

Sutton Smith describes Schechner's definition of play as one pertaining to a *broad play rhetoric* that "encompasses all the mind materials of dreams, daydreams, tropes, and active play forms' as play, 'everything is play that is clearly not of an immediate adaptive usefulness" (Sutton-Smith, 1997, p.58). On the other hand, the *narrow play rhetoric* defines nothing as play if not otherwise stated. Mental activity is not considered a form of play and children do many things that are not play, such as " exploring, practicing, exercising, learning, imitating, problem-solving, and all the art activities that are art…" (Sutton-Smith, 1997 p. 58). When considering the value of play for children, the *narrow play rhetoric*, unfortunately, informs how most view play. It is unfortunate because it establishes a hierarchical order where academic learning rises to the top as a fundamentally distinguished activity from play, as if learning and play were on the

opposite sides of a spectrum (Zigler, Singer, & Bishop-Joseph, 2004). There are serious implications with this outlook since play is not viewed as a major contributor to the child's intellectual, social-emotional, and physical growth. The No Child Left Behind Act of 2001 and Head Start programs, for example, have impacted early childhood centers since their emphasis on a narrow understanding of cognitive development and literacy has led to an increase of didactic instruction and a decrease of free-choice time. The focus on academic skill-building has led to testing pre-school children's pre-literacy and pre-math skills intending to access their readiness towards academic skills (Zigler et al, 2004). Many private and public elementary schools have either eliminated or reduced the amount of free time children have inside and outside of the classroom during recess. Parents who ascribe to the *narrow play rhetoric*, whether they are aware of not, view their children's play mostly as a pleasurable activity that does not contribute to or inform their education and overall development.

In line with the *narrow rhetoric of play*, attempts to define play often operate within binaries such as play vs. academic learning, play vs. work, play vs. seriousness, play vs. ordinary life, play vs. war, play vs. culture, play vs. reality, and contain contradictions. Part of plays complexity stems from its dualistic nature. Play swings like a pendulum: at one extremity, play can be performed with seriousness, as an act of the imagination, in solitude or isolation, and absent of joy or laughter. On the other, it can be a process of socialization that takes on the form of teasing between family members establishing closeness and intimacy (Sutton-Smith, 2008). As a subject of study, play has not been claimed by a specific field. It spans across academic disciplines capturing the imagination of many who wish to give it the right words and conceptual framework.

The study of play has generated a rich gamut of information that includes theories ranging from evolutionary biologists, who frame play as a primordial survival mechanism, to anthropologists and philosophers who explore its cultural significance, to psychologists and educators who account for its crucial role in development and well-being, to play scholars who attempt to delineate its boundaries. Part of the challenge to capture plays complexity is that any one perspective, or viewpoint, runs the risk of leaving out an equally important aspect of its dimension. Therefore, it is not uncommon for the literature on play to begin by describing the challenges to define it. The idea of organizing play into seven rhetoric's, as either "a form of progress, an exercise in power, a reliance on fate, a claim for identity, a form of frivolity, an issue of the imagination, or a manifestation of personal experience," was Sutton Smith's solution to addressing the assumptions scholars made of play within their fields and to address play's truly ambiguous nature (Sutton-Smith, 2008,p. 114). Being ambiguous means that play is potentially more than one thing at the same time, it has a dualistic nature (Sutton-Smith, 1997, 2008). Play's pendulum, therefore, does not swing to either side since it is present at both extremities simultaneously.

Winnicott (1971) viewed playing as an experience where he believes the individual makes use of their "whole personality", and this process incorporates the weaving together of that which is subjective and that which is actual, or shared reality:

> I make my idea of play concrete by claiming that playing has a place and a time. It is not inside by any use of the word and various uses in psychoanalytic discussion. Nor is it outside, that is to say, it is not a part of the repudiated world, the not-me, which the individual has decided to recognize (with whatever difficulty and even pain) as truly external, which is outside magical control. To control what is outside one has to do things,

not simply think or to do with, and doing things takes time, playing is doing (Winnicott, 1971, p. 55).

Lyons-Ruth (2006) points out in her article, "Play, Precariousness, and the Negotiation of Shared Meaning: A Developmental Research Perspective on Child Psychotherapy" , that Winnicott's view of play is individually oriented and she elaborates on what she names a "more fully dyadic view of play where shared reality itself is being created in the moment-to-moment encounters of the two play partners" (p.142). The relation between self and object has been richly conceptualized in psychoanalytic literature, but not on the dyad's co-construction of reality (Beebe & Lachmann, 2002).

There is an aspect of play that has gained more attention over the years and that is responsible for deepening our knowledge on human development. This aspect is given multiple names such as joint attention (Tomasello, 2014), joint intentionality (Seemann, et al., 2012), collaborative dialogue (Beebe & Lachmann, 2014), shared meaning (Lyons-Ruth, 2006), or knowing and being known (Beebe & Lachmann, 2014). Although these terms each present with a slight variation of what they mean, the unifying idea is that of two separate minds joining together to share their subjective experience by creating a unified viewpoint or perspective of the world.

This thesis explores the use of play as a therapeutic technique to help parents and their children establish a secure bond and attachment. The two cases presented exemplify the value of play in the therapeutic context when working with children and their parents. Focus is primarily given to the implicit forms of communication between the dyad since these are believed to be the underlying shared emotional experience. The two cases presented demonstrate the relational dilemmas and struggles that inform the therapeutic relationships in attachment-based dyadic play

therapy, illustrating how play in therapy constitutes a particular framework for encountering the parent-child relationship. Play is used as a tool to help support the dyad develop new ways of organizing their inner experience in conjunction with relating to each other.

Literature Review

Play in the therapeutic space: A Brief Historical Account

The literature reviewed for this section of the thesis explores the role of play in infants and young children's psychotherapy by tracing the historical development of play in child play therapy. A brief introduction of the rise of mental health treatment is included to contextualize the development of the value of play in child psychotherapy. Play transitions from being used as a tool to penetrate the child's unconscious fantasies to a therapeutic technique in favor of strengthening the attachment between child and caregiver.

Play made its way into the therapeutic space when children were seen as potential patients of psychoanalysis. The therapeutic space known as psychoanalytic treatment, the 'talking cure', first came about as a medical approach to treating psychopathologies that neurologists could not find a corresponding physiological explanation in the body (Zorzanello, 2011). The absence of an anatomical lesion led to an important shift where the psyche, the mind, became a medical object of study and treated as the origin of certain ailments (Zorzanello, 2011). Freud first published eighteen case studies entitled, *The Aetiology of Hysteria*, with the belief that he had found the source of what caused this "strange disease with incoherent and incomprehensible symptoms " (Herman, 1992, p.10). According to Freud's case presentation, the hysterics were not possessed by the devil as the Catholic church had deemed them, nor were their uterus

dysfunctional as the ancient Greeks believed (Herman, 1992). What these women had in common was according to Freud, premature sexual experiences (Herman, 1992).

Although these cases were not well received, and there is much debate over their unpopularity amongst physicians at the time, psychoanalysis was on its way to legitimize itself as a treatment of psychopathologies. The establishment of psychoanalysis as an effective medical treatment led to its dissemination amongst the doctors in Europe and Northern America. The famous case of "Little Hans" published by Sigmund Freud (1909) was one of the first accounts that made a connection between the child's difficulties and their emotional life (Landreth, 1991). It's popularity led many contemporaries of Freud to attempt to treat children psychoanalytically by using the same methods used with adults. But, they quickly realized that these methods were ineffective (Landreth, 1991). Before this case, it was common to think that children's disorders were deficiencies in their education and a lack of discipline.

The widely-read case of "Little Hans", titled, *The Analysis of a Phobia in a Five-year-old Boy*, "generated interest in the possibilities of using child observation to verify Freud's theories of infantile sexuality" (Drell, 1982, p.141). The case validates the Oedipus Complex as the origin of a child's psychopathology and the subsequent success of treating a phobia by bringing the 'unconscious tendencies to consciousness' (Klein, 1927). Although this is the first therapeutic case presentation of a child, there is no use of play therapeutically.

Play was not part of child therapy until the Austrian psychoanalyst, Hermine Hug-Hellmuth, considered to be the first child play therapist, incorporated play into the therapeutic space with the use of toys and an approach that valued the child's play (Landreth, 1991; Plastow, M. 2011). Devising play as an essential component in treatment and adding play materials to the clinical context allowed children to express themselves otherwise, and marks, according to Garry

L. Landreth, the first major development in the history of Play Therapy. Landreth (1991) traces four major developments in play therapy since its initial form in his book, *Play Therapy: The Art of the Relationship,* which this section of the thesis will cover in the subsequent paragraphs.

In Hug-Hellmuth's book, *The Study of the Mental Life of the Child* (1917) observations made of children's play expose her understanding of play's vital presence in the lives of children, "all the events of home-life find their place in the scheme of play, and even the tragedy of sickness and death loses its terror to the child at play… everything becomes a plaything for the child."(p. 40). The book is entirely devoted to detailed observations of infant and young children's interactions and play. Although Hug-Hellmuth was sensitive to children's play, she applied Freud's concepts of infantile sexuality as the driving motivations underlying the observed behaviors.

Although important modifications were made to treat children therapeutically, such as not expecting them to lay on the couch and the use of play and toys (Drell, 1982), the aim of treatment remained the same as that with adults (Klein, 1926 ; Plastow, 2011). Essentially, the goal was to resolve the Oedipus complex and bring forth to consciousness that which has been repressed. Klein used play to analyze and interpret for its symbolic content in the same fashion that speech and free association were used in adult psychoanalysis. Although she acknowledges the difference between the mental life of adults and children, she believes that, "analysis is not in itself a gentle method: it cannot spare the patient any suffering, and this applies equally to children…. by means of this technique we can reach the deepest repressed experiences and fixations, and this enables us fundamentally to influence the child's development." (Klein, 1926 p. 68)

The child for Anna Freud, was also viewed in light of the adult as incomplete lacking "a stable ego and solidified super-ego, both of which were precipitated by the successful resolution of the Oedipus complex" (Laubender, 2017 p.9) Although both Klein and A. Freud drew from the same psychoanalytic theories, A. Freud did not find it necessary to interpret the symbolic content of play as Klein did. It was not an essential aspect of analysis, and she did not view play as an activity that was necessarily imbued with symbolic meaning. Instead, play was a way to facilitate the bond between therapist and patient (Landreth, 1991).

The first generation of child therapists did not view the act of playing as therapeutic in of itself as later child therapists, such as Virginia Axline (1947) Landreth (1991), and Winnicott (1971). Child-Analysis, an offshoot or subspecialty of psychoanalysis, lacked a cohesive approach, and the attempt to treat the psychopathologies of children generated an interesting debate regarding the relationship between pedagogy and psychoanalysis (Drell, 1982, Laubender, 2017). Anna Freud viewed the analysis of children as the development of a healthy superego where the child experiences the right type of authority (Drell, 1982). Her clinical technique aimed at 'liberation', and the analysis for the child's freedom paradoxically came from "obedience, authority, and analytic leadership." (Drell, 1982). Landreth views the work of Hug-hellmuth, Klein, and A.Freud as "revolutionary in changing attitudes about children and their problems" (Landreth, pg. 29).

In the 1930s, David Levy developed a technique he called Release Therapy which Landreth marks as the second major development in play therapy. In Release Therapy, children who suffered from trauma were encouraged to reenact the traumatic event. During reenactment children were given complete control over the situation and took on an active position of 'doer' rather than being 'done to'. Play was used as a curative method to release the child's feelings.

While the child plays, the therapist does not interpret their play, but reflects back the verbal and nonverbal feelings being expressed by the child.

Around the same time, Relationship Play Therapy, developed by Jessie Taft and Frederick Allen, emerged as the third major development of play therapy. Relationship Play Therapy was heavily influenced by Otto Rank's person-centered approach, which shifted the clinical focus from the patient's history and unconscious processes to their relationship with the therapist. The emphasis placed on the patient-therapist relationship not only anchored the therapeutic process to the present moment, but it held the belief that this bond had curative powers. As Allen stated, " I am interested in creating a natural relation in which the patient can acquire a more adequate acceptance of himself, a clear conception of what he can do and feel in relation to the world in which he continues to live…I am not afraid to let the patient feel that I am interested in him as a person" (Allen, 1934, as cited in Landreth, 1991, p. 201).

The fourth major development is marked by Virginia Axline's work with children. Axline successfully applied many of Carl Rogers techniques of Non-directive therapy to Non-directive Play Therapy for children. She formulated eight guiding principles that have consolidated what is now Child-Centered Play Therapy. The underlying structure of Child-Centered Play Therapy (CCPT) draws from these four major developments traced by Landreth and offers a therapeutic method where children are given what they need to accomplish their most powerful inner drive of 'self-realization'(Axline) or 'self-actualization' (Landreth). This approach is grounded by the core belief that all children are born with an innate drive that directs their development towards growth and a positive sense of self. The setting and atmosphere created by the therapist in the playroom are carefully crafted to function as the optimal space where the child's inborn capacity for self-actualization can be adequately harnessed. When the expression of the child's inner

world is permitted and made possible, the child can experience who they are more fully and emphatically.

In Axline's *Play Therapy* book there are direct quotations of what children have said about play-therapy. These descriptions are in her view the best way to know what this process means for the child. Herby, an eight-year-old boy says the following in one of his friends in a group session:

> "I mean I wouldn't know how to do what she (Axline) does. She doesn't seem to do anything. Only all of a sudden, I'm free. Inside me, I'm free. (He flings his arms around.) I'm Herb and Frankenstein and Tofo and a devil. (He laughs and pounds his chest) I'm a dope and I'm so smart. I'm two, four, six, eight, ten people, and I fight and I kill! I'm good and I'm bad and still Herby. I tell you I'm wonderful. I can be anything I want to be." He seemed to recognize the power of self-direction within himself." (Axline, p. 19)

Axline describes this permission as a therapeutic process that helps the child have the "courage to go deeper and deeper into his innermost world and bring out into the open his real self" (Axline, p. 17). A successful therapeutic process releases the child from bearing the burden of being a 'problem child'. Whichever set of behaviors that brought the child to therapy in the first place no longer has such a firm grip over their personality.

The therapist, who is faced with such a task, has to perform a specific role in the playroom. In order to enable such a sense of freedom within the child, the therapist must at all times trust that the child will seek what they most need at the moment. Axline and Landreth stress the importance of a genuine acceptance of the child regardless of their actions in and out of the therapeutic setting. This acceptance aligns with what Landreth calls 'sensitive understanding' where "the attitude of the therapist is to sense as deeply as possible the experience of the child at

that moment and to accept as fully as is possible the emerging intuitive empathic response within the self as being sufficient for the moment." (Landreth, 1991, p. 71)

This attitude strategically rules out the therapist as the knowing subject and displaces the responsibility on the child to self-direct. The child is in the foreground of the relationship and does not feel any pressure to be different. Both Axline and Landreth believe that this attitude is not a technique, but a way of living. Unconditional acceptance and trust help the child gain self-confidence and self-efficacy. At every turn of events, the therapist tactfully ensures that the child will not form the same dependencies they have with others outside of the playroom, but rather experience through subtle and overt decision making in the playroom that they possess all the necessary capacities for 'self-actualization'.

For the therapist to create the optimal environment for the child to fully come into contact with the inner life that they have been deprived of, the therapist must not evaluate, interpret, or direct the child's actions. On the contrary, the therapist mirrors and reflects the child's actions and effects. This way the child experiences the therapist as an active participant who is engaged with them, rather than a passive observer in the room.

Child-Centered Play Therapy values a certain type of relationship between the therapist and child where a particular quality of intervention is desired from the therapist. How the therapist plans to intervene dictates what types of experiences are privileged for the child in the playroom. From what has been discussed about CCPT, it seems like this approach privileges a sense of freedom the most. The therapist will maneuver their being to ensure this privilege.

To conclude, Winnicott viewed the therapeutic process for adults and children as the attempt to "bring the patient from a state of not being able to play into a state of being able to play… psychotherapy has to do with two people playing together" (Winnicott, 1971, p.51). A

parallel is drawn by Winnicott between the play of children and the use of language by adults as play. Adults play with words, intonation, and cadence in the therapeutic space. Therapy, for Winnicott, is only possible with play.

Attachment Theory

Attachment Theory is considered to be one of the most influential theories in psychology in the past few decades that has led to a paradigm shift in our understanding of psychopathology (Elaheh et al, 2018). It is beyond the scope of this literature review to offer a comprehensive summary of the research findings on attachment theory. There is, for example, compelling data from longitudinal studies that establish the link between the formation of insecure attachment, particularly disorganized attachment, in infancy and childhood to later mental health problems (Woodhouse, 2018; Granqvista et al 2017). Its dissemination has led to significant changes within the health care system, child welfare, and the clinical setting (Granqvista et al 2017). Unlike other theories in the field of psychology, attachment theory can be empirically tested and there are several methods used to evaluate and assess the attachment style of the infant, child, and adult, such as the Strange Situation, the Adult Attachment Interview (AAI), and a range of computer programs designed to decode video documentation of caregiver and infant\child interaction are some methods. Attachment theory, most importantly, brought to light the universal need that infants and children have to feel safe and secure with primary caregivers, especially during moments of emotional distress.

As an evolutionary mechanism, the actions exhibited by infants that are identified as attachment behaviors are the ones that maintain physical proximity to their caregivers (Main, 2012). From the standpoint of infant survival, “death is far more likely to result from one hour’s separation from caregiving figures than from a much longer period without food” (Main, 2012 p.

1061). John Bowlby (1982), considered to be the founder of attachment theory, recognized proximity-seeking and proximity-maintaining behaviors directed towards specific figures as part of an *attachment behavioral system* that he believed to be genetically ingrained like the need for food and reproduction (Main, 2012; Bowlby,1982).

In 1950, the World Health Organization asked Bowlby to write a report on the mental health of homeless children. In the report, Bowlby formulated the following principle, "What is believed to be essential for mental health is that the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment "(Bowlby, 1982, p. xxvii). James Robertson, also a trained psychoanalyst, and Bowlby significantly advanced attachment theory together when they identified three phases children experience in response to the separation to their caregiver: protest, despair, and denial. These observations were discussed in journals and represented in films and caused a significant impact on the hospital care for children (Van der Horst & Van der Veer, 2009). Challenging behaviors in children, such as being defiant, angry, or inconsolably sad, were seen as signs of the lack of disciplinary action and moral education, rather than the experience of the loss of a loved one. In his later papers, Bowlby articulated this concept stating that he believed children experienced the loss of a *whole person* rather than of a "breast" such as Fairbairn, Klein, Spitz, and Winnicott envisioned (Van der Horst & Van deer, 2009; Bowlby 1982).

Bowlby, who was a trained psychoanalyst and supervised by Klein, dismissed terms such as *cathexis, libido, oral sadism, and infantile narcissism* (Van der Horst & Van deer, 2009). He found these terms to be problematic since they were not formulated from the direct observation of their subjects, but were the application of existing psychoanalytic concepts. In Bowlby's

seminal paper, “Grief and Mourning in Infancy and Early Childhood,” he describes some of Klein clinical cases and expresses indignation since she does not consider the possibility that the child may be experiencing the “lack of affection, changes in the mother’s figure, unwise discipline, or a combination of such experiences” (Bowlby, 1960, p.41). The inclusion of the infant and child’s social environment was the foundation of Bowlby’s main argument on infant’s and children’s mental health that distinguished his thinking from his contemporaries (Van Dijken et al., 1998). Including the environment as a contributing factor marked a major shift since it meant considering the impact that real-life events had on the mental health of infants and children, extending beyond the individual mental activity of their minds. He brought to light the emotional trauma experienced due to the hurtful and disrupted relationships infants and children may have with their parents or close relatives, which are the causes for “maladjustment and delinquency” (Van Dijken, et al. 1998). The view of parents as the major contributors to the child’s behavior was introduced and solidified by attachment theory.

Mary Ainsworth, one of the central figures in the history of attachment theory, maintained a similar stance to that of Bowlby. She was faithful to the value of direct observation and did not feel the need to apply a psychoanalytic framework to her observations (Waters, Petters, & Facompre, 2013). Ainsworth is primarily known for the elaboration of the separation-reunion paradigm she coined as the Strange Situation. The Strange Situation made it possible for her to observe the strategies amongst infants and children in response to the distress they experienced from the separation of their caregivers (Ainsworth, Blehar, Waters, & Wall, 1978). She categorized these strategies as either being securely or insecurely attached. Within the insecure category, infants and children responded by being avoidant and repressing their feelings, or resistant/ambivalent, where “infants seemed preoccupied with the mother throughout the

procedure, and yet too angry and/or distressed to take comfort in her return" (Main, 2008, p.1065). It was noted that when a child is securely attached this meant that they relied on their parents as sources of comfort and protection in moments of distress, and that they felt safe enough in their parents presence to explore their surroundings. It was observed that the parent functioned as a secure base for the child (Bowlby, 1982; Main, 2008; Ainsworth, 1978). It was evident that insecure attachments constricted the range of exploration the infant and child displayed of their surroundings. A later and crucially important category was added by Mary Main to the insecure attachment named disorganized attachment. This meant that there was a lack of a cohesive strategy when dealing with emotional distress and the infant and child expressed fear of their caregiver (Granqvista et al 2017).

The book, *Origins of Attachments: Infant Research and Adult Treatment*, presents research completed by Beatrice Beebe and Frank Lachman (2014), to locate the beginning of the formation of attachment ties between infant and mother. They document the "process of relatedness and rates of specific behavioral qualities" observed second-to-second during the dyads face-to-face communication (Beebe & Lachmann, 2014, p.40). By using film and the technique of microanalysis, Beebe and Lachman develop a coding system that is sensitive towards the following observable cues between the infant and mother:

- *attention* (looking, at and away from partner's face)
- *affect* (*facial affect*: degree of positive to negative facial expression; *vocal affect*: degree of positive and negative tones)
- *orientation* (mother's orientation from sitting upright to leaning forward to "looming" in; infants head orientation from vis-a-vis to arch away); and
- *touch* (mother touching infant, from affectionate to intrusive forms of touch; infant touching his/her skin, touching an object [such as chair or clothing], touching mother).

(p. 43)

The process of relatedness are believed to be represented by the infant as procedural memory, an internal working model, which refers to "the skills or action sequences that are encoded non-symbolically, become quasi-automatic with repeated practice and influence the organizational processes which guide behavior" (Beebe & Lachmann, 2014, p.24) The recurring of experiences shape the internal working model since the repeated experiences inform what the infant comes to expect (Beebe & Lachmann, 2014). In other words, internal working models are "essentially cognitive and affective representations of the self and others, and shape how individuals perceive and think about social interactions, influence how they respond emotionally, and help to organize how people regulate their emotion and behavior" (Woodhouse, 2008, p.1297). When disorganized attachment develops, contradictory behaviors from the mother have been identified, such as the mother's positive facial expression accompanied by rough touches on the infant's body, or the mother's display of positive facial expression in response to the infant's expression of distress, or insistent maternal looming when infant closes their eyes or looks away (Beebe & Lachmann, 2014). The mother's contradictory responses mostly occurred during moments of the infant's heightened states of distress where it is believed that the mother's unresolved fears about intimate relating, and/or fears of being re-traumatized by the infant's distress mobilized 'defensive behaviors' that derail the infant's ability to "know" and "be known by" the mother's mind, as well as the infant's ability to know their own mind (Beebe & Lachmann, 2014). The danger of disorganized attachment is that it "predicts contradictory and unintegrated mental process, particularly dissociative processes, in young adulthood" (Beebe & Lachmann, 2014, p.121).

The psychological world of the caregiver is as important of an area for assessment, prevention, and intervention when developing current strategies in infant and child mental health treatment as the infant's and child's emotional state (Weatherston, 2002.) Treating for the mental health of the infant and young child always involves a caregiver and therefore is dyadic work by nature. It is no longer possible to not address the impact that the negative emotions of a parent have towards the wellbeing of their child and on their relationship. It is also equally important to remember that at the same time that these negative emotions exist as "ghosts", the intergenerational transmission of trauma, there are protective factors known as "angels" (Fraiberg, 1975).

Knowing and Being Known

Infants, until recent decades, were not thought of as subjects who potentially suffer from psychopathology, and the question according to Ed Tronick and Marjorie Beeghly, “how do infants develop mental health problems?" most likely would not have made sense for classical theorists such as Watson (1928), Freud (1922), or James (1890) (Tronick & Beeghly, 2001 p.107). The image of the infant these classical theorists portray is far from the depiction of current infant research. Their infant, for example, could “not have a mental health problem because they lacked a mental life” (Tronick & Beeghly, 2001 p.107). Freud and Mahler envisioned the infant in a sleeping state removed from its environment, autistic and encapsulated by a boundless oceanic feeling. The newborn, in Freud’s words, is “a neat example of a psychical system shut off from the stimulus of the external world, and able to satisfy even its nutritional requirements autistically… is afforded by a bird’s egg with its food supply enclosed in its shell; for it, the care provided by its mother is limited to the provision of warmth (Freud, 1922, cited in Mahler, 1975, p. 41). The egg metaphor is representative of the *stimulus shield* (Mahler, 1975) and *the stimulus barrier* (Freud,1922) that both believed to protect the infant from the world’s overstimulating reality. This conception of the infant occupies a position where *knowing or being known* is not possible (Beebe & Lachmann, 2014, p.35). Until *hatching*, described by Mahler as “the process of emerging from the symbiotic state of oneness with the

mother, in the intrapsychic sense, ” does not occur, the infant is believed to not yet be fully equipped to relate to its surroundings (Mahler 1975, p. 290).

The current findings within the field of infant research could not be farther from these once held beliefs of theorists such as Fraiberg (1975), Lieberman & Van Horn (2008), Meltzoff (1988), Stern (1998), Trevarthen (2015), Tronick (2001), Lyons-Ruth (2016), and Beebe and Lachman (2014), who have contributed to innovative work that attempts to account for the infants' state of consciousnes. The selection of infant research literature reviewed by this section of the thesis focuses on theorists who hold a radically opposing view to the womb-like infants who are not fully awake.

Louis Sander (1962), considered the foremost pioneer to account for the emergence of a coordinated two-person system, mother-infant system, “saw the infant’s spontaneity and initiative in constructing his or her own direction of activity, as well as to the infant’s vulnerability to sacrificing that spontaneity when pressured to engage in a performance desired by the other” (Lyons-Ruth, 2008, p. 85) The infant Sander depicted in his writings brought to light processes of recognition between infant and mother that were reliant on mutual modifications and adaptations. Thus, Sander set the groundwork for further elaboration on a two-person systems theory where the presence of a powerful innate tendency in the mother and infant to establish a mutual, reciprocal relationship was accounted for (Sander, 1962). Beebe and Lachmann (2002) have made significant contributions toward deepening our understanding of how infants organize experience. They account for the infants capacity to form expectancies of different types that derive from distinctive temporal, spatial, affecticve, and other associated features of arousal. It is believed that towards the end of the first year, infants are capable of representing patterns into generalized prototypes (Beebe & Lachmann, 2002). These

expectancies emerge from the interaction patterns between the mother and infant which are co-constructed.

Sander points out that the parents' inferences on the infant's intentions, which is present during reciprocal coordination, facilitate and informs whether or not the infant will achieve a more acute and accurate perception of their inner experience, of who they are (Lyons-Ruth, 2000). The parents general perception of their infant, and how this perception plays out relationally, forms the basis to which the infant, toddler, or child, develops the ability to gain access to themselves and essentially *be known.* This offers an important view of infants and children developing and growing within the context of a relationship. Infants can no longer be comprehended as separate from their environment. As Sander states, "if we begin with life, we begin not with the living organism itself, we begin with a system", where being known by another gradually expands as the process of adaptation becomes increasingly complex (Sander, 2008, p. 217).

Viewing the development of the infant within a dyadic relationship caused a major shift in research that transitioned from examining the infant relating to *objects*, its non-social capacities, to the infant relating to *subjects* (Stern, 1985). As Stern remarks, infant researchers were not necessarily asking about the infant's social experience or sense of self, but paying attention to "physical landmarks: what can this baby do? When does it start sitting, grasping, hearing, walking, talking, etc, which "reveals little about what the "felt quality" of lived social experience is like? Moreover, they tell us little about higher organizational structures (Stern, 1985, p.17). The dialogical exchange of emotions, the infant's and child's investment in "learning how to mean", is an indispensable component when understanding the mechanisms involved in psychological anticipation and adaptive behavior (Trevarthen and Aitken, 2001).

The *intersubjectivity* of the infant has been conceptualized by Meltzoff, Stern, and Trevarthen. Meltzoff (1985) focuses on the perception and production of human action as mapped together, "you are like me", where all perceptual modalities speak the same language at birth. The other, the caregiver, is accessible to the self through cross-modal correspondences (Beebe., Sorter, Rustin, & Knoblauch, 2003). Trevarthen (1998) develops a "psychology of mutually sensitive minds" which is more dyadic than Meltzoff since it focuses on the communication between partners. Trevarthen (1998) infants intersubjectivity is innate and lays out a theory of how the mind recognizes other minds without cognitive or symbolic elaborations. The infant is born with the capacity for a "delicate and immediate with-the-other-awareness" (Beebe, Sorter, Rustin, & Knoblauch, 2003). Stern, unlike Trevarthen or Meltzoff, believes that infants' intersubjectivity is a "quantum leap" in development where the infant learns that the other has a mind. This happens between 9-12 months with the sharing of inner subjective experiences (Beebe et al, 2003).

The idea of infant intersubjectivity places the dyad of infant and caregiver as potential subjects to *be known and to know* (of their own experience and that of the other). The process of knowing and being known is a simultaneous phenomenon. The microanalysis of film and video has played an important role in capturing the nature of the simultaneity of relational and regulatory capacities of the caregiver and infant. The split-screen paired with the ability to view a second divided to eighths revealed an incredible sensitivity, or lack of, between infant and caregiver. Beebe and Lachamann (2014), analysis of the dyadic interaction has shown that contrary to thinking of the interaction between caregiver and infant as a sequence consisting of cause and effect (action and response) there exists learning that goes on where each partner attempts to anticipate what the other will do next, and acts accordingly. The example of boxing

fighters is provided to exemplify how one fighter continuously dodges, from one side to the other, even when a punch is not thrown with the intention of "already having dodge" the anticipated punch (Beebe and Lachmann, 2014).

But what exactly is being continuously exchanged between the mother and infant? In Stern's view, the mother and infant inhabit an ongoing stream of what he calls, *vitality affects*, which are to be differentiated from categorical affects, known as sadness, anger, joy, or despair. Vitality affects point to the ways of feelings rather than what is being felt. Some examples provided by Stern of vitality affects are explosiveness, calm, soothing, excited, and lethargic. Both types of affects are not separate or exclusive from each other, but for the infant's emerging self, vitality affects are what is perceived (Stern, 1985).

The importance of vitality affects is that they are the shifts and changes in pattern, "and are manifest in all behavior and can thus be an almost omnipresent subject of attunement. They concern how a behavior, any behavior, all behavior is performed, not what behavior is performed" (Stern, 1985, p.157) Stern provides an example: one is of the puppet that does not have much recourse to express categorical affects with a still face and so on, and relies on the expressiveness of vitality to bring it to life. In a similar spirit, the one-month-old infant does not yet know what the mother is feeling while she changes its diapers, but can perceive how the mother changes the diapers. The infant begins to categorize the mother acts according to their vitality affects-- how she reaches for the bottle, unfolds the diapers, stands up from a seated chair, the cadence of her speech and so on (Stern, 1985). Vitality affects, as indicated by their name, function as the bedrock of the relationship since they never cease to exist. They are like a continuous stream and an essential aspect of affect attunement, which is the most important

mode of sharing subjective experience (Stern, 1985; Beebe et al, 2003). Affect attunement is one of Sterns' most central contributions and can be defined as:

> the cross-modal matching of the intensity, timing, and "shape" (contours) of behavior, based on dynamic micromentary shifts over time, perceived as patterns of change that are similar in self and other. The infant perceives the mental state in the other on the basis of intensity, timing, and the shape of the partners behavior.
>
> (Beebe et al, 2003, p. 793).

In Stern's view, the processes of affect attunement are so powerful that the individual learns that some subjective states are shareable while others are not (Beebe & Lachmann, 2014). Lyons-Ruth (1999, 2008) defines the sharing of certain subjective states as intimacy, "and intimate relating entails the fundamental issue of how infants come to know and be known by other's minds (Beebe & Lachmann, 2014, p. 35). She argues that the ability for two partners to intimately relate is dependent on their capacity for collaborative dialogue which is defined as:

> the "close attention to the others initiatives, openness to the others state across the entire range of positive to negative emotions, attempts to comprehend the state or subjective realtor of the other, the attempt to respond in a way that acknowledges or elaborates on that state, ability to negotiate similarity and difference, and efforts to repair disruptions"
>
> (Beebe & Lachmann, 2014, p. 35).

To conclude, the ability of the infant and caregiver to engage in collaborative dialogue serves as the fundamental function of *knowing and being known*. When a persistent or continuous collapse in collaborative dialogue takes place the two subjects experience either, " I am being controlled by you, or you are controlling me" and the opportunity of being *known or knowing* is constricted (Beebe & Lachmann, 2014). The subjects enter a state of overlap, where

one overrides the consciousness of the other. If there is a repetition of disruptions and mismatches, without acts of reparation and repair between the dyad, the potential for the infant to develop attitudes towards the world that signal, “I am helpless and hopeless”, and become “apathetic, depressed, and withdrawn”, then there is the likelihood of the development of dysregulated patterns of self-regulatory behaviors, such as difficulty forming attachment with caregivers or difficulty establishing a sense of autonomy (Tronick & Beeghly, 2011, p. 107).

Group Attachment-Based Intervention (GABI)

A Brief History

Group Attachment-Based Intervention (GABI) is an attachment and trauma-informed therapeutic intervention developed in response to the needs of the most vulnerable families in child welfare, living in one of the poorest neighborhoods of the nation, to remain united (Murphy et al, 2015). Vulnerability here has been defined "in terms of attachment theory and contextually with regard to family's adverse childhood experiences (ACEs) (Murphy et al, 2015, p. 268). GABI first began as the therapeutic component of the Infant-Parent Court program initiated in 2009, that worked in conjunction with the Bronx County Family Court to preserve the family unit by strengthening and securing the attachment between young children, ages 0-3, and their primary caregivers, while also attending to the developmental needs of the children.

The families enrolled in the Infant-Parent Court project were involved in Child Welfare and the judicial system either because they suffered a child removal or were at risk of removal. GABIs therapeutic technique developed to achieve family reunification, family preservation, and as a preventative measure against the recurrence of maltreatment by addressing the families trauma and attachment; a secure attachment between the caregiver and child is more likely to be protective from the intergenerational transmission of trauma (Murphy et al, 2015). Helping families with a secure attachment and preventing a *disorganized attachment* from taking shape is one of GABIs primary goals (Murphy et al, 2015, Steele, 2018). A disorganized attachment is

characterized by the lack of a consistent strategy to seek comfort and nurturance when in distress (Steele, 2018) As such, GABI is an intervention grounded in psychodynamic, social-emotional developmental theories, and studies of trauma (Murphy et al, 2015).

Dr. Anne Murphy, the founder of GABI is a psychologist and Associate Professor of Clinical Pediatrics at the Albert Einstein College of Medicine, where she is the director of the Center for Babies, Toddlers and Families, and Clinical Director at the Rose F. Kennedy Children's Evaluation and Rehabilitation Center, the host site for the Infant-Parent Court Project. Around 2006, Dr. Murphy formed a partnership with Miriam Steele, Ph.D., and Howard Steele, Ph.D., two attachment researchers at The Center for Attachment Research at The New School for Social Research to further develop GABI (Steele, 2018). Over the years, the program has expanded to five locations in New York City's five boroughs. There is extensive evidence that supports the effectiveness of GABI, ranging from early studies, ongoing RCTs, to present efforts (Steele, 2018). GABIs primary funder ACS (Administration for Children's Services), a public agency that is supportive of families has, unfortunately, gained over the years the reputation of destroying them, and GABI stands as ACS's attempt to change their approach and relationship with the families that most need them. Impoverished families living in impoverished neighborhoods fear ACS more than they fear the cops (Joyce, 2019). So far, GABIs partnership with ACS has been a success and can hopefully serve as a therapeutic intervention model for other American states (Joyce, 2019).

Societal Context

The most pressing social justice issue that GABI faces is child removal and child fatality due to parental maltreatment. The vast majority of the parents who participate in the program have above average scores on the ACE assessment (Adversarial Childhood Experiences) which indicates that they have a history of child maltreatment. Most of these parents express the desire to be a different kind of parent than the ones they had (Murphy, et al. 2015). In the process of helping parents form secure bonds with their children, GABI's intervention simultaneously aims at preventing disorganized attachment from forming. The article, *Group Attachment-Based Intervention Trauma-Informed Care for Families With Adverse Childhood Experiences*, explains the risks that disorganized attachments has as the following: "disorganized attachment to the mother at 1 year has been linked to elevated levels of the stress hormone cortisol, to child behavior problems at 5 years of age, post-traumatic stress symptoms at 8 years of age, 14 externalizing symptoms at preschool and 9 years of age, and adolescent psychopathology" (p.269). This type of attachment, characterized by fear of the caregiver and the lack of a strategic response of the child to express their need for care and comfort, is most common amongst parents who themselves had very few positive experiences in childhood and who experience ongoing sources of stress (Murphy, et al. 2015).

GABI's therapeutic intervention developed with the socio-economic realities of the families it serves. The article, The Crime of Parenting While Poor, accurately describes GABI as the following: "It is guided by the fact that, while serious child abuse does occur, it's rare, and

many issues that fall under the broad umbrella of "neglect"- which alone accounts for 73 percent of all allegations of child maltreatment made to ACS- are simply the everyday struggles of low-income families"(p.36). After completing treatment, families most likely leave with a healthier attachment, but continue to struggle with poverty which is a major life stressor.

According to the Citizens' Committee for Children of New York 1.7 million children are living in New York and 500,000 live below the poverty line. Given the multiple studies that show the correlation between families who experience a lack of resources in their household and communities, and the increase of incidents of child abuse, neglect, and fatality, these 500,000 children below the poverty line are considered to be the most vulnerable. This means that 1 out of 3 children in the city of New York struggle to have their basic needs met. In 2017, ACS annual report stated that 44,445 children were enrolled in Child Welfare Preventive Services. Due to funding limitations, GABI only serves families enrolled in Child Welfare Preventative Services and is offered as an alternative to the usual parenting skill classes, such as STEP (Systematic Training for Effective Parenting), which is the requirement for parents to complete.

Treatment Process

GABI has a multifaceted therapeutic approach that consists of dyadic play therapy, parent-group therapy, and child only play therapy. GABI attempts to maintain the parent, the child, and their relationship at the center of its intervention. How this is done will be further discussed in the case presentations. For a family to join GABI, a minimum of 12 sessions is required. Many of the families referred to GABI are enrolled in multiple services and might have barriers to treatment. In order to overcome some of these barriers, GABI offers transportation. Once the family is considered eligible to join treatment the intake process begins. Usually, intake is completed around two hours and a half, and consists of a robust and comprehensive list of developmental screenings and psychological assessments. Below is the list:

- **ACE -** Adverse Childhood Experiences
- **GAD 7 -** Generalized Anxiety Disorder
- **PHQ9** - Patient Health Questionnaire (severity of depression)
- **PSI** - Parenting Stress Index (evaluates the magnitude of stress in the parent-child system)
- **CIB** - Coding Interactive Behavior (New School) 5 categories
- **ASQ** - Ages and Stages Questionnaire for children up to 5-year-old (Assessing development in five domains: Communication, Gross Motor, Fine Motor, Problem Solving and Personal Social)

- **ASQ: SE -** Ages and Stages Questionnaire screening for Social-Emotional Parent Satisfaction Survey

A GABI session is divided into two 60 minute long sessions. The first part takes place in the playroom with the parent, child, and therapist. The "client" is neither the parent nor the child, but their relationship. The parent and child then separate and move on to the second part of treatment. The parents leave the playroom and meet together with a therapist in a separate room for parent-group therapy, and the child remains in the playroom for a child-only play therapy. After the second hour, the parent and child reunite. Reunification is one of the most critical moments of the intervention since it is during this sensitive time that the attachment between the dyad is most clearly observed. For example, if the attachment between child and parent is secure then the child will comfortably reunite with their parent and express, if they will, their distress with the separation. But, if the attachment is insecure (avoidant, resistant) or disorganized, the child may pretend the parent is not in the room by turning away, by not displaying their emotional distress, or by not displaying any emotional warmth towards the parent. The parent may also not want to be close to their child, or soothe them if necessary.

GABI's therapeutic services are for the parent-child relationship, the parent, and the child. The main therapeutic components that promote securing the attachment between the parent and child have been operationalized in the following acronym **R.E.A.R.I.N.G.** The concepts described below are practiced by clinicians during the sessions with the parents and the children:

Reflective Functioning: the ability to call to mind one's thoughts and feelings as well as the others, and to know the distinction and connection of both.

- **Emotional Attunement:** the ability to recognize the child's emotions through actions: how the parent and child maintain nonverbal connection to each other's states of feelings.
- **Affect Regulation**: the process by which the parent and child can manage feelings to maintain a sense of emotional homeostasis.
- **Reticence:** the position one takes of containing their reactions to provide the other with the experience of their own feelings and states of mind, thereby enhancing self-efficacy.
- **Intergenerational patterns:** whereby there is the acknowledgment of the parent's own past experiences in terms of how they were parented and how that is affecting how they are now parenting
- **Nurturance:** providing the families with a warm inviting settings at all times and maintaining a non-judgmental stance at all times. It is the ability to cultivate empathy for the parent's personal challenges and difficulties in connecting with their child in the moment
- **Group Context**: providing valuable resources to the parents and facilitating peer relationships between children and parents and helping them combat isolation.

As part of nurturance, GABI provides a well-designed physical space that anticipates the parent and child's needs such as comfortable seating, waiting area, a playroom, parent group therapy room, diapers, wipes, food, money for transportation, etc… Anticipating the needs of the families and providing a nurturing judgment-free space is one way the program offers a healing experience that signals a different kind of narrative than the one these families are used to. It is common that the parents who participate in GABI to feel isolated, marginalized, and discriminated against. The nurturing environment counteracts these feelings that play into narratives that tell parents they are alone, unwanted, or "bad people/parents." No assessment

measures the effectiveness of the nurturing environment, but the attendance of the families can be a reliable indicator. The playrooms in all of the sites are the same for research purposes and consist of developmentally appropriate sets of toys that support healthy interactions and encourage engagement between parent and child. Other toys instigate more elaborate pretend play such as dollhouses and life-size baby dolls.

GABI also provides a flexible and consistent schedule for families that is sensitive to the unpredictable schedules and chaotic daily lives that is the reality of most parents attending the program (Murphy et al 2015). There are morning and afternoon sessions, three days in the week, that families are welcome to drop in. GABI has been structured in consideration of the major stressors most families are dealing with such as domestic violence, unemployment, housing instability, etc.. Making it to treatment is oftentimes the greatest challenge to maintain treatment. As mentioned, GABI covers the cost of transportation by offering car service one way and a subway card. Many of the families who participate in GABI Queens commute from other boroughs and are faced with tremendous difficulties when families with multiple children are involved.

Beyond providing therapeutic services and a physical space, GABI clinicians also develop relationships with the family's referral sources and other preventive agencies in the neighborhood. Queens has 18 preventative agencies that GABI does outreach to recruit families. Most of the families enrolled at GABI have a case planner, involvement with the legal system (judges and lawyers), and other service providers, such as teachers, speech therapists, etc.. GABI clinicians are sensitive to how these other relationships impact the lives of the parents and their children. For example, the clinician may decide to advocate for a parent in a legal battle or during an immigration crisis, as well as help with housing. This holistic approach that considers

these other factors as important players in one's life is part of providing a nurturing environment for the families.

Throughout treatment families are assessed and videotaped every 3 months, including when they finish treatment, and a follow-up 6-months after. Clinicians document parents and children playing for research purposes and to aid discussions with the parents about some of the things they see working and some of the things they would like to change in the play. The clinicians themselves are also videotaped in Dyadic sessions on a trimester basis for evaluation purposes of their therapeutic work.

There is an online system called EPIC that monitors the program's data. Therapists and supervisors from all the sites submit their daily notes to EPIC. The leading therapists at each site thoroughly evaluate the families, using two different scales that measure attachment and the child's development on a three-month basis and submit these evaluations to the research team that is both located at the Bronx and at the New School. The supervisors, both off-site and on-site, submit weekly notes to a supervisor at the Bronx office. The information and data generated by this intervention fluidly travels within the site and to the mother site in the Bronx because, as it was explained, GABI is a group-based intervention. This means that all the therapists on a site should know and have access to the same information on the family. The data is entered into EPIC which is later accessed by other parties interested in knowing the development and effectiveness of this program, such as the grant providers.

Given the expansion of the program from the Bronx to five other off-site locations, the support of grants to train people as GABI practitioners, and grants to research GABI's effectiveness, this program has the potential to be widely disseminated and accessible to greater numbers of families. The research conducted so far has rendered GABI very positive results

which may lead to more funding in the future. There is the belief amongst GABI practitioners that once more research is concluded on the positive effectiveness of GABI it is possible that policymakers incorporate this service not only for families who are part of the child welfare system, especially in foster care, but all families in the New York state area who would benefit from this intervention. Nurseries, day care, preschools and other locations that provide care for families and their young children could eventually incorporate GABI's training to help families develop secure attachment.

CASE I

Background information on the family collected during GABI intake

M is a 3-month-old female who currently resides with her biological mother, grandmother, and great-grandparents, as well as the mother's aunt and cousin. M is the youngest of six children and has a different father from her five older siblings who reside out of state with their father. K, M's mother, is a 34-year-old woman who is currently single and seeking employment. At home, she takes care of M for most of the time and receives help from her family members. K often visits her other children and reports having a positive relationship with their father. The family was referred to GABI due to the Administration of Children Services (A.C.S.) concern of K's positive toxicology when she gave birth to M. M tested negative. After K enrolled in substance abuse treatment and completed all of the requirements, her case with ACS was closed and she was transferred to Prevention Services. K reports having a history with A.C.S. and states that her major life stressors are her financial challenges and unemployment status.

K received prenatal care and described having a typical pregnancy with M that was not planned. When questioned about M's early development, K believes M is healthy and on schedule: M drinks formula milk every 2-3 hours, sleeps through the night and takes naps during the day. When K was asked about M's temperament she said, " M acts grown, is mature, and advanced." According to the Ages & Stages Questionnaire (ASQ) M met all developmental milestones in each domain: communication, problem-solving, fine and gross motor, and

personal-social, as well as the ASQ: SE-2 (Ages & Stages Questionnaire for Social-Emotional Development). K's assessment for depression, the (PHQ-9) Patient Health Questionnaire, indicated minimal to no symptoms of depression and the General Anxiety Disorder-7 (GAD-7), yielded a score of 0, indicating no symptoms of anxiety. Their Adversarial Childhood Experience (ACE) score was both a 1, which is below the average for most parents who attend GABI. As treatment progresses this score may change since it is not uncommon for parents during intake to withhold their childhood traumas only to share them later, once rapport is built with the therapist.

Dyadic Play Therapy Treatment 60 minute Sessions

12 sessions

M began treatment as a 3-month-old newborn with an active disposition. Her mother, K, was friendly and open to treatment. K presented as calm and gentle with an overall peaceful demeanor. Her smile was emphatic, and her speech accentuated by a soft intonation. During the first few sessions of dyadic play, the therapists observed that K was consistently affectionate towards M and that she accurately read M's non-verbal cues. K knew when to feed M, she carefully handled M by supporting her head, exhibiting awareness of a newborn's vulnerabilities, and successfully used soothing techniques such as cooing, a gentle rock, and looking out the window to help M regulate her distress. The dyads' play mainly consisted of K placing M on the mat and gathering stimulating toys for M to look, hold, and shake. M enjoyed being placed on the mat and actively inspected the objects her mother presented and reached out to touch and feel their texture. The therapists scaffolded their play by suggesting tummy time for M, encouraging more face to face interaction, and being supportive towards K's efforts to sustain play with M.

The therapist encouraged the mother to be more active and hands-on with M during play. This involved handing her toys, being more animated and vocal themselves, and suggesting that K move closer to M. K committed to play even on days when she shared not feeling her best.

It was clear that K had acquired substantial knowledge of M's temperament as a newborn and was emotionally attuned to M's fluctuating states. There were no immediate or explicit concerns expressed by the therapists in group supervision regarding the dyads' interaction during the play therapy sessions. When assessing K and M's attachment style there were also no overt concerns expressed with the dyad's separation and reunification. It was only in the second session that the dyad did not separate because of M's emotional distress. During the first session, M comfortably separated from her mother and was indiscriminate towards the therapist who held her- a common and expected behavior for a 3 month newborn. At reunification, M was vocal when she caught sight of her mother and her mother responded with affection. Two weeks later, during the second session, separation was not possible since M cried and became too dysregulated. K was asked to return to the playroom. But, in the following session the therapist who was holding M utilized similar soothing techniques as K to help M regulate her distress during separation, and M was able to self soothe and be soothed by the therapist. At reunification, K swooped M into her arms smiling, and expressions of joy ran across their face.

The dyads rhythm of separation and reunification remained consistent over the sessions: K was consistent with her approach towards separation by remaining affectively calm and using her words to reassure M that she will return. M was made aware of her mother's absence and with the therapist's help was able to maintain her engagement in the playroom. Their reunification was filled with mutual joy. During group supervision, the therapists expressed multiple times

what a delight it was to work with this dyad. The main goal set forth for the family was to be supportive of what the mother was *already doing.*

M was rapidly growing and changing, and the family attended GABI somewhat consistently. In the initial months they attended once every two weeks, which was then followed by a gap in treatment, and a return to consistent attendance towards the end. In each session it was observed that M was typically developing and learning how to move her body. She enjoyed being placed on the floor and challenged to twist and turn from her back to her tummy. M's expressions communicated that she took immense pleasure in reaching her arms and hands out to get a hold of things. Her tiny fingers wrapped around objects and K acknowledged M's strong grip. As teething began, M placed all the toys she found in her mouth with *mucho gusto* and rubbed them against her gums. Her mother described her as being "sassy" and "the center of attention." It was as if M was on stage, the center of attention, and K was in the audience, watching the show. It was noted by the therapists that as M gained mobility in the playroom, her mother K remained predominantly still, seated, even though she was engaged with M. K's body language was serene, at times unexcitable and understimulating for M.

As treatment progressed, K became increasingly comfortable to openly share what was on her mind in relation to M's behavior. There were instances where M's drive and curiosity towards things were received and interpreted by K as signs of M's greediness. For example, when M thrust her body to communicate attraction or aversion, when she did not let go of an object, or expressed frustration for not having something, K chuckled, "*See… she'll just get what she wants. She's so greedy, I'm telling you, she's selfish.*" At first, the therapists did not directly respond to K's remarks since these were uttered like side notes, not to be taken seriously. But, within a few sessions these phrases gained the status of routinely remarks, and the therapists

caught onto them. It seemed as if K were cautioning against her daughter, *"Watch-out! M will get what she wants and there is where nothing you can do about it."* The therapists then treated these moments as opportunities to help clarify and bring awareness to K's underlying beliefs about M by asking her the following questions, "Do you really think M is greedy, or is this her way of letting us know that she wants what the other children have? Or, that she doesn't want things taken away from her?" For most of the time, K responded by affirming that M was indeed greedy and explained that it was because of how other family members, especially M's grandmother, "spoiled her too much." K also believed that "M doesn't get along with other kids because she doesn't like them." The therapists pointed out to K that M seems interested in other children given how much she looks at them, and that there are no signs, so far, that confirm M's dislike of children.

During one of the play sessions, K was directly asked if she thinks of M as a baby who is dismissive of others? K's expectations of M's attitude towards others in the playroom were not developmentally appropriate. What would it look like for a 5-month-old infant to be considerate of others? But, given how K handled M and acted towards her daughter, her expectations were noted to be developmentally appropriate. K did not expect M to be walking or talking or doing anything that went beyond her abilities. K was capable of meeting her daughter where she was developmentally. The surfacing issue was to gain a better understanding as to why K expected M to have a different "attitude" towards others?

At this point, the dyad was about three months into treatment, and M was 6 months old. M rubbed her gums with toys, frequently displaying mild irritation by making guttural sounds, exhibiting distressed facial expressions, and excitement to practice standing, twisting, turning, and flips from her tummy to her back, and vice versa. The therapist asked K what M might be

communicating when she's on her tummy making guttural sounds and K replied that "M is a very active baby who needs to be moving from one thing to the next...she probably wants to be seated or standing." K attuned to M's disquiet states of excitation by picking her up and bobbing her up and down on her lap. M smiled and cooed with joy on her mother's lap. During these moments, the therapists reflected to K how well she knows her baby and can understand what she wants and needs. In the Parent group, K shared that she receives a lot of opinions at home on how to raise her child and that she knows her family loves her; however, she feels undermined by them. As M's mother, K expressed feeling dismissed by her family members.

Although K was confronted about whether or not she believed M to be selfish, there were no indications that the confrontations were effective. K addressed M in the same fashion. But, there were slight observable changes in K's approach to play with M. K was visibly more responsive to M's explorations by physically moving her body towards M to maintain an active engagement. These actions were very subtle, like a slight turn of the body towards M, sitting on the floor, or focusing more on the play rather than conversing with other parents or therapists. There was a general sense from K that M had her own agenda in the playroom and that K was left behind and not necessarily part of it. This was not explicitly stated by K, but rather an impression that slowly surfaced over time. The treatment addressed this implicitly by consistently encouraging K to take on an active role in M's play.

As M started crawling, she scanned the room from left to right and swiftly transitioned to different areas. K recognized that her baby girl was an active little one with lots of energy and curiosity that surpassed those of other infants in the playroom. K, on the other hand, had a tendency to be passive, which manifested itself through less movement and mobility, as noted earlier. She liked to spark conversations with the therapists working with her and oftentimes

observed M play and interaction from a distance. The therapists tactfully intervened in these moments by inviting K to join M either by handing her a toy or moving in themselves. K always accepted the invitation to join and took pleasure in noticing M's face light up with expressions of joy when she played with her. The therapists continuously reflected to K how much her baby girl liked it when she moved physically closer in play. It was heartwarming to see the dyad find each other's eyes and smile, accompanied by M's giggles. By this time in treatment M had become a very vocal baby.

K's almost imperceptible hesitation to join play was shared in individual supervision by one of the therapists. The therapist was wondering whether or not K's subdued attitude was a subtle sign of depression, or whether K somehow felt at a bit of a loss as a mother? As if she were not *fully* the mother. K was a storyteller and her stories were mostly about how other family members cared for her daughter. They were stories that involved the interaction between a caretaker and M. K was an observer and never part of the story. For example, she shared that M eats all the candy she wants because her aunt is permissive of it, and although K told this story in good humor, there was a sense of her not being in full agreement of the aunt's choices and M's behavior, yet, she did not have an input or voice in the story. K's stories were explanations of M's personality and behavior, and they did not involve her as the mother. In the playroom, this was subtly manifested in a variety of ways. When K brought up M's greediness it was presented as a permanent aspect of her personality, as if nothing could be done.

The supervisor and therapist slowly began to pick up on the possibility of the mother's feelings of defeatedness towards her motherhood. It seemed like she had very little influence over her daughter in comparison to the other caretakers in the house, and a similar behavioral parallel unfolded in the playroom. It was not clear at the time for the therapists that K was

attributing the attitude she experienced from her family members at the home to M in the playroom. Part of the delay in catching on to this was due to K's carefree intonation when communicating. She was good at conveying a sense of everything being "set and okay," even though she implied otherwise. There was a disconnect between the content, the overarching themes of the stories, and the spirit in which they were told by K, who was often smiling with the kindest squint in her eyes, and no signs of sadness, distress, or discomfort.

There was one session, in particular, that was a turning point in the case. K shared during dyadic play that her grandmother, M's great grandmother, had a hyper-vigilant eye. She described in great detail her grandmother's piercing glare from behind the window curtains in search of intruders on the street. She said her grandmother would call the cops if she simply saw someone walking down the street who she thought was not from the neighborhood. While K told this story, she imitated her grandmother's actions of opening the curtain, gesturing how she moved the blinds and stared out. She finished the story by reporting that M crawls to the window and does the same thing, embodying her grandmother's piercing and policing attitudes. K showed the therapist the look again and said, as a matter of factness, "she has it,".

The therapist reflected to K that she does not like seeing this particular influence of a family member on M. K nodded in agreement. More therapeutic work was necessary to offer an appropriate setting for K to emotionally unravel and allow a wider range of affective states to be experienced. In the playroom, K was focused on being available for M. Exploring K's interpersonal world was not the focus of the session. Further exploration, for example, would be appropriate in individual counseling. There simply was not enough time for the therapist to aid K's probing of the depths of her feelings when in this same session, M took her first steps, *ever*, by walking with K's support holding on tightly to her mother's hand.

By this time, K and M had completed 8 months of treatment. Over the course of these months, K was more active and hands-on in play. Towards the end, she didn't skip a beat to join her daughter. K also took more notice of M's changes and shared these observations with more enthusiasm with the therapist. She enjoyed that M was becoming increasingly vocal. K and M beatboxed together. This was one of the sole activities that was entirely their own. When K beatboxed with M, she brought M very close to her face to give her a warm snuggle. M burst with joy when her face was playfully pressed against her mother's. This level and intensity of closeness and shared joy was not witnessed in the beginning of treatment.

CASE II

Background information on the family collected during GABI intake

P is a 3-year-old male child that lives with both of his parents and his older sister. His mother, L, 32, is currently unemployed and shared that P barely sees his father since he works night shifts. L stated that attending required parenting services such as GABI is her biggest life stressor. The family was made known to ACS due to the older child's report of abuse by her mother in school. The nature of the abuse was not disclosed by the mother during intake or later in treatment.

The developmental screening, ASQ-3, indicated that P is typically developed in all domains (gross and fine motor, person-social, and problem solving), and needs further assessment in communication. His mother added that he receives speech therapy at school. The ASQ-SE (Ages & Stages Questionnaire for Social - Emotional Development) indicated P is typical development in all domains. L's PHQ-9 (Patient Health Questionnaire) indicated that she has mild depression symptoms, and her GAD-7 (General Anxiety Disorder-7) indicated that she has mild anxiety symptoms. The therapist provided L with referrals for individual counseling. The strengths of this family are the parent's desire to foster P's development and the desire to have a healthy relationship with him. The parent's ACE (Adversarial Childhood Experience) score was 3 and the child's 2.

Dyadic Play Therapy Treatment 60 minute Sessions

9 sessions

P presented as an active and quiet little boy who entered the playroom eager to set up the trains on the tracks. His mother, L, presented as a boisterous and noticeably anxious parent who expressed willingness to participate in play, an acute concern for her son's health (due to his recent hospitalization), and the expectation that he be a *good boy*. During the first two sessions, P's mother mostly participated in his play by interjecting with comments, questions, suggestions, praises, and disapprovals. L's questions inquired on the concrete aspects of the play and were mixed in with directives and other remarks, "Where are the trains going? Do you think they fit in there?... Trains don't fly over bridges, they pass under them... Oh, that's nice, the trains are being nice...Good boy." Within a few minutes in the playroom, L demonstrated curiosity, a sense of humor, and the desire to engage with P's play. L seldomly moved from her spot where she was seated, either on the couch or chair, and maintained laser focus on P's play.

At the start of play, it was observed that P was responsive to his mother's input and affective states. Her expressions of joy and excitement were met by him with smiles and he altered his actions accordingly to his mother's requests. He connected more trains when his mother suggested the train needed to be longer and showed warmth towards her when he received her compliments. L addressed the therapist by narrating what she noticed about P's actions: "Oh, he's going to play with the trains because he remembers them from intake," and "with the cars because his father really likes cars." The therapist [who was seated on the floor next to P positioned at an angle between child and parent forming a triangle], responded to her

with reassurances, “You know your little one very well….you knew what he would do next ”. L took delight with the therapist’s reassurances since she too wanted to be seen and behave as a *good mother*.

As play progressed, it was noted that L was in a state of constant concern with P and uttered *“no”* to an increasing amount of things he did, or didn’t do. She displayed being uncomfortable when he physically approached younger children in the playroom (L feared he might hurt them), it was unacceptable to her when he did not want to share his toys, or allow other children to join his play. She disliked P’s play when it took on a more energetic and athletic tone, or when it was imbued by silly and nonsensical actions. L’s worries set up a situation where there was very little P could do that was a *“yes”*. Her words quickly filled up the room and took hold of their interaction as if they were occupying all the available relational space, making sure not much else could make its way in. P’s arena to act good in his mother’s view was narrow, constricted, and confined. At the same time that the mother’s anxiety, which manifested as a verbal outpour, held play at a standstill, it also brought a wave of energy that charged the room with an emotional intensity where a session spent with this family felt like many sessions condescend in one, and the impression of the treatment moving at a faster pace was inevitable. After the first three sessions, a challenging pattern of relatedness emerged inhibiting play from flourishing and potentially elaborating between P and L. The sequence follows:

> L steps into the playroom in a good mood displaying willingness and excitement to play with her son. P enters the playroom eager to play as he moves around in the space deciding where to settle down and what toys to select. P remains sensitive to his mother's presence by maintaining eye contact with her. P sets up his play on the floor and his mother

joins him by either sitting on the couch or pulling up a chair next to him. She engages with him verbally and P responds to her input by answering her questions, following her directives, and taking notice of her compliments with smiles. Initially, he can reciprocate and there is a back and forth between them that resembles play. From the outside it looks like they are playing.

As P's play becomes more dynamic and takes on expansive qualities, whether he changes the narrative of the story, incorporates other toys, physically moves his body, or does something out of the ordinary, which might seem nonsensical such as stuffing a small cloth tunnel with all of the toys in the playroom, his mother struggles to shift along with him to continue the play. She attempts to redirect his efforts back, or towards, what she has in mind of how play should proceed. The connection between L and P stifles with inflexibility and begins to show strenuous signs. The potential of L and P's play to flow suffers significant interruptions. The therapists attempt to reframe P's play as appropriate and safe to help L view the situation from P's perspective. At first, L is receptive to the therapist's feedback, exhibiting some flexibility, but the weight of her concerns, or disappointments, end up halting the play nonetheless. P responds to his mother by escalating the "bad behavior." He enters a state of defiance that is accentuated by negative emotions, such as frustration and anger. He "acts out" and is "purposely misbehaving" doing exactly what his mother does not want him to do, and this becomes a predictable form of engagement between them. P is then placed in time out by L.

It was discussed in group supervision how treatment with L and P could proceed. Two main plans of actions were agreed upon. One consisted of asking L to take more of an observer position during play, " the back seat", and the other was for L to refrain as best she could from

saying "no" to P. These were suggestions to be proposed as experiments: how would P's play elaborate if his mother trusted that he knew what the "right things to do were", or that he had a reliable sense of safety? Would he continue to act out in the absence of her "no", or would he stop by himself if no attention was being paid?

L was open and willing to try these suggestions. The therapist working with her used a great deal of humor and nonverbal cues, like a nod of the head and a smile, as a response to when some of her "no's" inadvertently slipped out. Both her and the therapist shared laughs and it was obvious to her that the task was more challenging than expected. L's awareness of her hyper-vigilance gradually increased. The therapist followed up by sharing with L that they believe P in fact does not need to hear all these "no's" since he has internalized what is right and wrong, at least in the playroom. L agreed and recalled that when P is with his grandfather, the grandfather reports that, to her surprise, P's behavior is "really good". L was beginning to make a connection between how much she impacts P's behavior and that she is an active ingredient of the behaviors she condemns as "bad and wrong" than she was previously aware.

Although L tried the suggestions out, this did not prevent the dyad from spiraling into a direction where either P or his mother felt very upset. P's expressions of feelings of distress, such as anger and frustration, were intolerable to his mother and she tried to get rid of them as quickly as possible by correcting him, and the situation. L's difficulty to acknowledge, accept, and respond to P supportively in a moment of distress lead him to escalate his negative emotions. It was as if he were saying, "Mom, I know you don't like it when I'm like this, but I can't just wish what is going on away. I need your help! These feelings are really big for me." His strategies to assert the presence of these emotions were a cry for help and ranged from either an intense withdrawal into silence, weeping, or remaining stiff in anger. When P escalated, an "emotional

storm" was created with his mother. These were the times that L presented with a significant level of inflexibility.

L expressed feelings of ambivalence towards separation in the first and second sessions, but she was still willing to try. When the time came to separate and L walked out of the room, P became somber by directing his gaze to the floor and hunching his shoulders inwards, in a display of overall sadness. The therapist acknowledged that P misses his mommy and reassured him that she will return. P slowly shifted from standing near the door to sitting on the floor beside the trains and resumed to his play with the therapist. During reunion, the dyad warmly embraced and left the playroom comfortably. Later in treatment, it became known to the therapists that P and L rarely separate. If he was not in school, then P and L are always together. Separation and reunification presented the dyad with a few challenges that bore a connection to the occurrences during play therapy. For example, the sessions where P needed more therapeutic assistance to regulate his distress with separation where the sessions where during dyadic play conflict with his mother was more prevalent.

In the last session covered by this case presentation, the therapist checked in with L about continuing the *experiments* of the previous sessions. Both L and the therapist sat together and observed P from a close distance connect the trains on the tracks and begin his play. As they watched for a minute or two, L asked P if he was hungry and wanted some *fishy*. He did and she stood up to get a bag of fishes to feed him. L held one fishy at a time using the tip of her fingers. Her playful gesture drew P in and distracted him from other activities. Feeding P turned into a game where every time P came to eat a fishy L exclaimed, "Don't bite me, Don't bite me," and P didn't, to which she then said, "Mommy won!"

As the excitement between the two increased, the therapist witnessing the game asked L, "when does P win?" In the setup of this game, there was no way for P to win. If he bites, he loses since he knows his mother will be upset (they both know biting is not permitted), and if he doesn't bite, he still loses, since he was not able to catch her. The mother was not aware at the time that this game set P up to fail regardless of his actions, whether he behaved as a "good boy" or a "bad boy."

At some point L abruptly stopped the feeding frenzy, communicating to P without using words, "enough!" Her sudden halt was experienced as P as hurtful and possibly as some sort of gesture of disapproval or rejection. In a matter of a split second, P swung his arm in the air and his hand landed on the side of L's arm, right beneath her shoulder. It was a reflexive response to a sudden jolt. P hit his mom and she fumed with indignation. He was placed in time out and began sobbing uncontrollably. The therapist readily acknowledged the mother's anger by stating to P that Mommy does not like to be hit,, and right after asked her what she could do that could help P to calm down. L angrily replied to the therapist, "I'm not bending on this one." P's cry, which now were bellows, became louder. The playroom paused. The therapist, who was seated on the ground inched closer to P and L bent down to comfort him. They eventually embraced and ended their session early. L mentioned that P was not having a good day and the therapist led them to the door.

The therapists initially attempted to help the dyad regulate their distress by acknowledging and normalizing their emotional reality. This meant the therapists tried naming their emotions, to each other in the moment, and giving voice to their appearance. For example, when sharing was a point of contention the therapist observed out loud " L, I see that you didn't like it when P did not share, and you want him to share. You want him to be a good boy and a good boy is someone

who knows how to give to others," " P, I see that you want your mother to understand that you don't want to share, and it doesn't mean that you are not nice."

When P did not act as L expected, either as a "good or bad boy" it stirred an array of emotions in L. There was an instance, for example, when P shared his toys with the babies in the room and L remarked perplexed, "he never shares his toys like that at home with his sister." Her tone sounded almost as if he had done something wrong, which instigated a moment of pause for the therapist. The therapist offered an interpretation of P's action, "here [in the playroom] P can take care of the babies like you [mother] takes care of him at home". L smiled with delight. It was an attempt on the therapist's part to link L's actions at home to P's behavior in the playroom. Given L's perplexed reaction to P's "*goodness*", the therapists were sensitive to the possibility that P might feel like he is falling short of his mother's expectations of him.

Discussion

Play in the therapeutic space provides a unique framework of encounter for the parent and child. At GABI, the playroom provided a place for the families from the case studies to come together and be with each other in ways that were otherwise not possible in other contexts. During the dyadic play therapy sessions, the dyads confronted their relational patterns within a new context. This context of the playroom offered the mothers more time to observe themselves relating to their child and to observe the relationship. It was a time to reflect on how their actions impacted their child, including their own past experiences and childhood. The therapists reminded the mothers that this was a time dedicated to being with their child in play. The mothers were encouraged to be fully present and available to engage and the children were given the freedom to play.

During the first session, one of the mothers quickly realized that the playroom was a unique space where things were done a little differently than at her son's school and other social contexts. The therapeutic environment can be destabilizing for parents since there are no other contexts that abide by the same protocols and systems of values. As such, parents do not know what to expect, or what is expected of them and their child. There are common questions around what the therapist's expectations are, how the therapists are assessing the family and their interaction, and ultimately, how play can be helpful towards the parents' relationship with their child? It did not come as a surprise for the therapists that L's anxiety increased as the sessions progressed, along with the emotional intensity between the dyad and the therapist. The more

difficult and challenging aspects of L and P's relationship unraveled in play and the barriers to L and P establishing a connection in play went beyond what was observable. As mentioned earlier, L hit all the marks, so to speak, of what a parent should do when collaborating and being supportive of their child's play. She expressed a good sense of humor, displayed curiosity and interest, came up with questions and suggestions, and seemed to enjoy the process. But, beneath her participation in P's play lay a recipe which she followed. It was clear that L had a set of ideas of what was right or wrong in play, of how play should look, and what her role was. In her view, her son could only reciprocate her input either in accordance to her expectations, or by disrupting them. There was no middle ground where they could both meet.

The challenges of working with this dyad were apparent from the start and it was important for the therapists to keep in mind that the context of the playroom presented L and P, but especially L, with a multitude of unknowns that potentially contributed to her experiencing an even greater state of anxiety. Based on the initial conversations between L and the therapists, L knew that this hour of dyadic play therapy was to be solely dedicated to playing with P. Although P's play was familiar to L, being part of his play and playing with him was not. The therapists were also aware that in addition to L being expected to join P's play, she was also being watched while doing so by strangers who were, in her view, judging how "good or bad" of a mother she is, and consequently how "good or bad" her little one is. And, for a therapeutic process to work, L needed to succumb to the fact that these strangers would gain knowledge of her "wrongdoings" and "shortcomings" and potentially expose these in front of her child, and to her.

It was noticeable that being in the playroom with M helped K embody a more active role in M's development. K's confidence as a mother was highlighted and heightened over time. There

is the (safe) assumption by the therapists that if K was taking the initiative to be closer to M and participate then it might mean that K, at some significant level, felt more at ease and better as the mother and primary caretaker of her daughter. In retrospect, perhaps it would have been beneficial to ask if K thought of M as being dismissive of *her* in play. Shifting the focus of the question to K would invite K to possibly connect to difficult feelings she might be attributing to M, but was unaware. K's view of M's greediness or selfishness was not resolved and needed more therapeutic intervention. Since K's remarks did not increase, and possibly deceased, it was not treated as a concern requiring more attention.

Although it is tempting to state that M sought her mother more during play, it was not noted by the therapists. Moments of joy were indeed shared more frequently as treatment progressed, but that is also in line with M's developmental capacities of becoming more social. M's vocal flourishing provided a whole other arena for K to relate to her daughter. With beatboxing, K took the lead since it was a skill, something that K knew how to do well, had fun with, and felt proud of, that she could pass on to M, and that M was very receptive. What was of major importance, at the forefront of treatment, was the emotional connection between M and K. Their relationship towards the end of treatment resembled what we recognize as a secure attachment.

Even though there were many unresolved aspects of the dyads' relationships that the therapists were aware of, both dyads experienced a unified sense of meaning during their brief episodes of play. At the beginning of the session, it was observed that L and P had moments of laughter during P's play with the trains, and that K and M shared joy and excitement with M's developmental accomplishments such as when she began to walk. Although brief, these moments held significant importance since they offered an opportunity for closeness. Within the playroom

context, these mothers joined their child's experience by celebrating with them in humor and joy. If more therapeutic intervention were possible, the direction would be to widen the range of experiences the dyad has of feeling good in each other's presence. An intervention across a greater period would be necessary if the implicit and subtle presenting problems were to be more fully addressed.

The playroom offered the dyad an opportunity to begin to feel together wider emotional ranges than before, and in the process know and be known. In both cases, the presence of collaborative dialogue occurred within short periods of time and were not sustained for long. L and K's internal working models, which are understood to be one of the organizing mechanisms of how they respond to their child's needs and their expectations of their child's response to them, were impacted by their past traumas. L's overly anxious attachment to P, expressed by her hyper-vigilance in the playroom, at times hindered his exploration and presented with considerable inflexibility during moments of emotional distress between both. K's avoidant attachment to M predisposed her to assume that M was not interested in her and that she would rather be with someone else. K's level of energy remained at a significantly lower range in comparison to M's bustling development.

Dyadic play therapy offers the parent and the child the opportunity to play with one another, and although this might seem like an easy task, such a request can be daunting. Play requires that the parent and child develop a "joint capacity for spontaneous, un-self-conscious pleasure, and intimate communication" (Lieberman & Van Horn 2008, p. 81). In the case studies presented, this was possible at certain times when both parties were more at ease in each other's company, and what is of most importance is not whether the parent and child know how to play,

but the unfolding of their relationship. It is in play that the relationship unfolds in vivo, in the moment, as it takes shape.

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