This chapter describes a nurturing intervention that is often included in Theraplay sessions. It is simple, cost effective, and brief, but powerful in its impact, and applicable to most children. It is called taking care of hurts, and is linked to the most important dimension of Theraplay: nurturance. One of the four basic dimensions of Theraplay (nurturance, structure, engagement and challenge), nurturance is a crucial component in the upbringing of all children, especially with those who have been neglected or abused.

A basic way to nurture a child is through warm, affectionate, appropriate touch. Research with animals and humans has shown that in order for babies to thrive, they need warm, physical contact. Appropriate touch helps to boost our immune system and releases endorphins, which give us a sense of well-being. Close bodily contact regulates a child’s bodily arousal system, and strengthens the bond between parent and baby. Body contact activates the release of opioids and oxytocin in the baby’s brain, which calms him or her. A great deal of scientific evidence indicates that the more touch a child receives, the calmer and less fearful he or she is likely to be in adulthood (Field, 2000; Sunderland, 2006).

This is consistent with Thayer (1998), who found an inverse correlation between the amount of touch and the amount of violence in a society. In North America, we live in a touch phobic society. Many people are afraid of any kind of touch, which is often associated with sexual intent. In many schools, there are policies against teachers touching children, to the point of not being able to offer a comforting pat on the back or hug to a child in obvious distress. Some schools prohibit any kind of touching amongst peers, even affectionate touching like a hug (Del Prete, 1997). This has contributed to creating an atmosphere where children do not experience nurturing touch in our schools. This outlook sometimes extends to families, where parents can be fearful of physical contact with their children, especially if they are older. This may be resulting in a “touch hungry” society where children may substitute aggressive touch for the affectionate touch they are missing. Some psychologists suggest that aggressive touch frequently seen in movies, video games, TV, sports, etc., may be giving the message that aggressive touch is more acceptable than affectionate touch. Some children may be hitting, shoving, and pinching in an effort to be physically close. This is related to Thayer’s (1998) finding, that US families showed the least touch compared to families in Russia and Greece. Another study, comparing the US with Puerto Rican and French families, confirmed these findings. Moreover, the US has one of domestic violence of the highest rates in the world (Thayer, 1998).

The lower, or reptilian brain, which needs stimulation through touch and rhythm, is first to mature. Furthermore, the tactile channel is the most highly developed sensory system in newborn infants (Gerhardt, 2004). Our earliest self-concept, then, is based on how we are physically handled, picked up, cuddled, caressed, rocked, or put down as an infant (Ford,
Caring for Hurts: A Theraplay Activity

(1993). How an infant is touched (or not touched) has a profound and long lasting effect on its emotional development (Sunderland, 2006)

The normal development of the middle brain (mammalian or emotional brain) and higher brain (cortex) is dependent on the organization of the lower brain (Perry & Szalavitz, 2007). If the lower brain does not develop adequately, the development of the higher brain centers is compromised. Accordingly, in neurosequential programming (Perry & Szalavitz, 2007), clients with a history of deprivation or trauma are treated first through interventions emphasizing touch and rhythm (e.g., massage, Theraplay, etc.) to help normalize their lower brains. As treatment progresses, therapies such as expressive arts, psychodrama, Eye Movement Desensitization and Reprocessing, etc., can be used to develop the emotional brain (limbic system), and later still, narrative or cognitive therapies for the growth of the higher brain (cortex).

The idea of going back and meeting the child at his or her emotional age, which is often below the chronological age, is consistent with the theory underlying Theraplay (Munns, 2000). Theraplay is guided by the belief that it is important to meet the child's emotional needs by replicating what a normal parent might do with a young child, in order to fill the gaps of his or her early life (Jernberg & Booth, 1999). Theraplay presupposes that the first attachment the child forms with his or her chief caregiver (usually the parent) forms the template for all later relationships. If the first attachment is not secure, the child will have difficulties forming subsequent relationships (Fonagy, 1994; Main, Kaplan, & Cassidy, 1989; Rutter, 1994).

Theraplay focuses on guiding the parent to be more attuned and responsive to the child's needs. Many children with relationship difficulties are emotionally and/or behaviorally dysregulated (Goldberg, 2000). It is important to help calm and soothe such children, so they eventually learn how to self-regulate. In Theraplay, this is first modeled by the therapist, while the parent observes from behind a one-way mirror or corner of the room. Then the parent interacts directly with the child guided by the therapist. The intervention “caring for hurts” is used to help soothe the child, to transmit a feeling that someone cares for him or her, and give the experience of positive touch that often has been lacking. The following case example illustrates this intervention.

**Case Example**

Four-year-old Billie was so “acting out” and aggressive that his mother had decided to “give him up,” and was contemplating putting him in a “home.” She stated that he was a “monster,” a replica of his father whom she had divorced. She could hardly name one positive aspect about him. On the other hand, she described his 9-year-old sister, in glowing terms. It was obvious that she was severely rejecting her son and had given up hope of changing his behavior. She would ignore him until he misbehaved so extremely that she was forced to pay attention to him. Her early history with her own mother was not happy or positive. Although no formal assessment of attachment patterns was conducted, it appeared that she had had an insecure attachment with her parent and was repeating this pattern with her own son (Zeanah, 1994).

**Procedure**

Usually, this activity is done fairly early in a Theraplay session, which typically starts with a welcome song or special handshake, followed by a quick inventory or checkup where the therapist notices the positive, physical features of the child (e.g., “You have shiny brown hair, rosy cheeks, and when you smile, did you know that you have a dimple in your cheek right there I see you’ve brought your strong shoulders and arms, and let’s see those hands. Uh oh, I see some scratches here [or “boo-boos” or “red marks”], and those need to be taken care of.”) Here the therapist takes lotion or powder, and gently rubs the lotion around the “hurt.” Attention is given to all of the hurts, while examining both hands. Sometimes feet are attended
to as well or any other hurt the child mentions. Children, including adolescents, very often start showing their hurts spontaneously.

However, some children, who are tactiley defensive, or have been physically or sexually abused, may initially resist this activity. If this happens, the therapist does not force the child, or try to coax the child. Instead, the therapist tries to be attuned to the child’s feelings and may reflect them: “You did not want me to touch you – that was uncomfortable for you. I will try to find another way that makes you less anxious.” The therapist then may lead the child in an activity involving less or no physical contact. However, although the therapist has been responsive to the child’s cues he/she does not lose sight of the child’s underlying need to be physically comforted. Therefore, later on in the session, the therapist may chose an activity such as “powder handprints,” where physical contact is again attempted. In this activity, the therapist rubs powder on the child’s hands, and presses them onto a piece of dark construction paper. Then the child’s handprints are compared to his/her actual hands pointing out the palm lines, different size of fingers, etc. If the parent is present, the child’s and parent’s handprints are compared. Most often, after experiencing the therapist’s touch in an activity such as “powder handprints,” the child accepts “caring for hurts” in the same or next session.

Billie was frequently controlling and sometimes resistive, but surprisingly, accepted the nurturing activity quite well. His mother, who observed at first from behind a one way mirror, was skeptical that the therapist was helping her child, making comments like, “I don’t see how playing is going to help my child.” However, after a few sessions her perceptions of her son started to change – she could see that there were positive aspects to his personality. In the fifth session, she entered into the therapy room and started to interact with her son. During the “taking care of hurts” the co-therapist first lotioned the “hurts” on the mother’s hands, saying, “Sometimes it’s good to experience the activity directly yourself, to better understand what your child might be feeling.” This was done for the mother to feel nurtured herself first, as she had had little nurturing from her own mother during her childhood. She was asked to lotion the hurts on her child’s hands. She did this very well, with a warm, loving approach. The child fully accepted his mother’s caring. During the parent counselling session following the Theraplay session, the therapist praised the mother: “You lotioned the hurts on your son’s hands so beautifully.” The mother replied “I could never have done it, if you hadn’t done it to me first,” highlighting the need to sometimes nurture parents first if they have had a deprived or abusive childhood, before asking them to nurture their child. Ordinarily however, parents are asked to care for their child without experiencing the activity directly.

Billie continued to respond well to the nurturing activities, becoming more cooperative with adult direction during the structuring, engaging, and challenging activities. His mother started to enjoy his company, was able to share laughter with him, and take pleasure in being with him. Gradually, more spontaneous affection was seen between them. The mother decided she would keep her son—there was no more talk about giving him up for adoption.

Conclusion

Nurturance is a basic underlying dimension of Theraplay with the goals of enhancing attachments, trust, and self-esteem. Theraplay can be applied to a wide range of ages (infants, preschoolers, latency-aged children, adolescents, and adults), with a wide variety of emotional, social and behavioral difficulties, especially attachment and/or relationship problems often found in adopted, foster, and step-children, and autistic children. Modifications often need to be made when working with traumatized, abused children or to those who are tactile defensive.

References


