In Tune with Play and Therapy

An Interview with Phyllis Booth

Phyllis Booth is a licensed marriage and family therapist, a licensed clinical professional counselor, a registered play therapist and supervisor, and Clinical Director Emeritus of the Theraplay Institute in Evanston, Illinois. Her professional career includes training in clinical psychology at what is now University of Chicago Medicine, teaching at the University of Chicago nursery school and serving as a consultant to Head Start in Chicago, working as a clinical associate at London's Tavistock Institute, studying with British psychiatrist John Bowlby and pediatrician and psychoanalyst D. W. Winnicott, and spending a year at London's Anna Freud Center, which specializes in child psychoanalysis. Along with developmental psychologist Ann Jernberg, Booth helped establish the theoretical underpinnings of the Theraplay approach to child and family therapy. Later she developed the training program for Theraplay and designed the certification practicum for therapists who employed the method. She has trained therapists in the United States, Canada, the United Kingdom, Finland, and South Korea and is the author of *Theraplay: Helping Parents and Children Build Better Relationships through Attachment-Based Play,* now in its third edition. In this interview, Booth recalls her childhood play experiences, talks about her mentors and intellectual progenitors, discusses advances in the theory and practice of play therapy, and recalls resistance to and rewards in the field of play therapy during her career.
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American Journal of Play: Tell us about some of your most meaningful childhood play experiences.

Phyllis Booth: My father loved to play games. He would lie on his back and put me on his knees and roar out "One for the money, two for the show, three to get ready"—[pause]—"and four to go!" He would drop his knees and I would fall onto his arms for a big hug. "More, more," I would shout. Back on his knees I crawled, and we would do it over and over again. My mother

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made even the daily task of making the beds fun. I would run ahead of her and crawl under the rumpled blankets. She would come in and playfully pat the bed saying, "There's a lump in the bed. What can it be? " Then she would find my hair and say, "It must be a mop!" Pulling back the blanket, she would peek at me and say, "Oh, no, it's a little girl! It's my Phyllis!" Then we would carefully straighten the bed and finish our task. My mother would often come to wake me up in the morning singing, "Good morning, Merry Sunshine, What makes you wake so soon? You shine away the little stars and smile away the moon."

AJP: Yours was a playful family?

Booth: We spent a lot of time playing music together in our family. My sister, two years older than I, played the piano. I played the violin. Even when we were quite young, we played duets at every opportunity. My brother, five years younger than I, played the trombone, and my other sister, thirteen years younger, also played the violin. Later my mother sang with a ladies trio, and my sister accompanied her. My father liked to entertain us singing jokey songs such as "A Preacher Went Out a Hunting." As I think about these memories, I realize that the rhythmic chants, the singing, the loving touch, the pure joy of being together filled my life with love and laughter—a very good start for me to make play the center of my life.

AJP: Are there other ways that your family experiences pointed the way forward for you?

Booth: While both my parents could be playful and funny, they also provided a clear sense of order and safety. We lived a very well-ordered life: Monday was wash day. Tuesday, ironing. Wednesday, mending. And church on Sunday. Our motto? "Everybody happy, well so am I." I grew up with a clear sense that the world was a safe, understandable, and good place. As I have had my own experiences working with children and raising my own children, the pattern of parenting that I experienced has had a powerful influence on what I do and who I am.

AJP: Has play informed your adult sensibilities?

Booth: My childhood experience with play was certainly a big factor in my choice of play as a therapeutic model for children. But I think the whole model of parenting that I experienced prepared me for a lifetime of working with children. I was five when my brother was born and thirteen when my little sister was born, so I had ample opportunity to watch how my mother cared for children. She loved to hold and cuddle all of us. I remember how

warm her welcome was when we returned from school. On cold rainy days, she had hot cocoa ready, and we played games on the living room floor. She was also very much attuned to how we were feeling. I remember more than once feeling grumpy and out of sorts (there were lots of childhood illnesses in those days, and we had our share). She touched my forehead and said, "Oh, you have a fever." She then tucked me into the nice cool sheets, and immediately I relaxed. Everything would be all right now. I was in good hands.

AJP: How did you start working with children?

Booth: I have had a very long and rewarding career, but it might have turned out differently. I had adored my junior high school orchestra director and wanted to be just like him when I grew up, so I majored in music in college. But during 1944 and 1945, I spent my summer vacations working in a Wartime Day Nursery caring for children whose mothers worked in war industries. I remember one day when all the children were napping and I had settled down to paint a wooden orange crate to be used as shelves for toys. Sitting there, I suddenly thought, "I'm being paid to do something I really like to do!" That was the start of my shift to becoming a nursery school teacher.

AJP: How did you make the shift?

Booth: When the war ended and my soldier boyfriend finally came home in 1946, we were married. I was twenty and had just finished my junior year in college. That fall we enrolled at the University of Chicago. He was working toward a PhD in English literature. I entered the Committee on Human Development at the University of Chicago and taught half time at the university's nursery school, an experience that for me was a great opening up. Helen Ross, an associate of Anna Freud's in London, led weekly meetings where we discussed our concerns and observations about particular children. She introduced me to a whole new world of psychoanalytic thinking about child development. Most of the teachers there were in the midst of their own analyses. Heinz Kohut, the Austrian psychoanalyst who later became famous for exploring and delineating narcissism, was just beginning to make a splash at the Chicago Institute for Psychoanalysis. In the postwar period, self-psychology and its emphasis on well-being was the hot new thing.

AJP: Did you meet other prominent psychotherapists in Chicago?

Booth: Yes. I took courses from the influential psychotherapist Carl Rogers, who

had come to the University of Chicago in 1945. I learned about his intriguing nondirective approach to treatment and began to share his faith in the individual drive toward health, the self-actualizing principle. A remarkably effective and popular teacher, he could lead a good discussion in a group of 120 students! However, I could see that some of the grad students were using his ideas as excuses for not setting any limits with their own children. Later, when I returned for a week-long summer course in client-centered therapy, I experienced an even more annoying result of the nondirective approach. The whole week was taken up in discussing how we wanted the week to be organized—what we wanted to talk about. For me this was a phenomenal waste of time and a distortion of what I understood Rogers to be all about.

When my husband got a position teaching at the University of Chicago, we returned there in 1962. I again took up my studies in the Committee on Human Development, but this time with the goal of becoming a clinical psychologist.

AJP: Tell us about your experiences with Head Start in its early days in Chicago.

Booth: In 1967, Ann Jernberg, who had been my nursery school assistant teacher in 1949 and 1950, was appointed chief of psychological services for the whole Head Start program in Chicago. She recruited all the people she knew who had experience working with children to join her team of psychological consultants. The expectation was that we would identify children who needed help and refer them to existing agencies for treatment. In the first summer, we identified many children who needed help, but there was no way we could find treatment for them. Agencies had long waiting lists, parents couldn't afford treatment, and there was no easy way for them to get their children to treatment centers.

AJP: Was there a remedy?

Booth: Ann was a creative, courageous person and came up with a simple solution to the problem: we would recruit and train lively young people to go into the schools and play with children who needed help. These included my daughter, who was in high school, and my husband, who by then was a professor of English at the University of Chicago and a very playful person. We asked the new mental health workers recruited for our team to engage each child assigned to them in the same way parents interact with their young children: sensitively, spontaneously, face to face, with no need for toys, simply inviting the child to join them in joyful, interactive play. In

weekly supervisory sessions, we helped these young mental health workers be more attuned to each child's needs. Together we came up with new activities to engage and delight the children as well as to calm and comfort them. We saw the children two or three times a week and averaged about fifteen sessions per child.

AJP: Did the playful approach succeed?

Booth: Yes, it worked! Sad, withdrawn children become livelier and more outgoing; and angry, aggressive acting-out children calmed down and were able to engage with others in a friendly, cooperative way. To convince people who were skeptical about our unorthodox approach, we made two films showing the progress of three children. The film maker suggested the name "Theraplay" to distinguish our approach from other play therapies. Three years later, we revisited the children to see how they were doing, and they were all thriving. For example, the teacher of an angry, acting-out little boy, could not imagine that he had been so difficult. He was now lively, cooperative, and pleasant to have in the classroom. We found a formerly very withdrawn little girl skipping rope with friends in front of her house. When we interviewed her parents, her father said, "I used to not notice her. Now she is my favorite child."

AJP: Did therapy and education coincide at Head Start?

Booth: The therapy we provided made a big difference in the children's ability to focus, interact, and learn. Teachers were very pleased with the results; they could see that the children were so much happier, and therapeutic interventions made the classrooms so much easier to manage. After the first few years of doing work with individual children, a teacher told one of our experienced Theraplay therapists that she felt all the children would benefit from what the therapist was doing with individuals. That led to the development of Group Theraplay— a way of extending the playful, accepting, and engaging experience to a whole classroom of children.

AJP: How did Group Theraplay differ from ordinary classroom procedures?

Booth: Most classrooms with young children featured regular "group" times, but we organized our groups around playing together, being aware of each other, taking care of each other, and enjoying the pleasure of shared rhythmic activities. Theraplay groups established three simple rules: "No Hurts, Stick Together, Have Fun" and held fast to one that went mostly unspoken: "The Teacher is in Charge." Our teachers became "caravan leaders" who made sure that everyone was noticed, cared for, and had a good time. We

threw behavior modification rules out the window. If children were having a hard time, we did not attempt to punish them by denying them the rewards of the group experience, because the group experience is exactly what these children urgently needed.

AJP: How did your method nurture children?

Booth: One caring activity that we often used in group sessions was the checkup: each child is asked if he or she has a hurt, and hurts can be physical or emotional. The teacher will then rub a bit of lotion on the hurt spot. After a group has been going for some time, the children themselves put lotion on the hurts of the child next to them. If there are no hurts, the whole group gives a cheer. It doesn't take long for the classroom climate to become much more favorable and caring. In one group I worked with, the teacher kept a bottle of lotion on her desk and children would come up to her to say, "Sammy needs some lotion, he just fell down." A number of schools have created a Theraplay climate throughout the school. Everyone on the staff is open to understanding, noticing, caring for, and playing with the children. In such a climate, children are able to relax, feel safe, and open their minds to learning.

AJP: How did you arrive at your therapeutic method, Theraplay?

Booth: When we first started playing with children in the Head Start program, we had very little theory to back us up. We just knew it was working. But my experiences at the Tavistock Clinic in London in 1969 and 1970 began to provide a framework. For example, I attended lectures in which John Bowlby discussed his new ideas about attachment. Also, the Scottish husband-and-wife team James and Joyce Robertson, who had worked in London's Hampstead Wartime Nurseries for Homeless Children with Anna Freud, showed their wonderful films documenting the terrible effects that abrupt separation worked on children. And I attended case conferences with Donald Winnicott in his own home—my first encounter with attachment theory was a life-changing experience for me.

AJP: Were you able to put these new insights into effect?

Booth: Coming back to Chicago, I plunged into the Head Start therapy program full of new ideas. Ann Jernberg and I began to create the secure, nurturing, structured experience that Winnicott describes as a "holding environment."

AJP: Who besides Winnicott especially influenced you and your colleagues?

Booth: From John Bowlby we began to understand the value of transforming what he termed children's "internal working models." The idea that children

learn who they are as they see themselves mirrored in their parents' eyes was not a new concept to me; I had run into it in the late 1940s at the University of Chicago when I studied the work of George Herbert Mead, the philosopher and sociologist. But after hearing the idea again from Bowlby, it made sense. We had changed children's internal working models from negative to positive by presenting them with new and more positive views of themselves and of what they could expect from others.

AJP: What else did you learn from John Bowlby?

Booth: Ours was one of the earliest therapeutic applications of attachment research, and we were thinking of our work in terms of Bowlby's theory way back in the early seventies. His ideas about attachment created a tidal wave of research into what makes for secure attachment; basically, three principal factors—emotional availability, sensitivity, and responsiveness—make it possible for parents to support their child's secure attachment and healthy development. They must also be able to reflect on their own and their child's experiences. Over the years, as this wonderful new research became available to us, we were able to think more clearly about why our playful approach had helped children, and we gained a much clearer notion of what was needed as we played with children with really difficult histories. In the early days, though, we did not have many opportunities to include parents in our work with their children. Now our therapy always includes parents or some other adult who is important in the child's life.

AJP: What is different about your method? How are its goals different?

Booth: We are distinctive in that we bring the parents together with the child and guide them to new ways of connecting with their child. We started doing it more than forty-five years ago. It just makes good sense. We work on healing the relationship, not on fixing the child, focusing more on the nonverbal aspects of the interaction than some other therapies. When we help parents reflect on their own and their child's experience, we definitely use language, but we still depend a lot on having the parent and child "experience" the new ways of interacting. We create meaning through these new ways of interacting, not through talking about them.

AJP: How has having Theraplay registered with its own service mark serve therapeutic interests?

Booth: Soon after we began using Theraplay in our own clinic, people began coming to us to be trained in the approach. Ann Jernberg saw the possibility that people might go off and do "their own thing" and call it Theraplay, so

she registered it as a service mark. Having the registration makes it possible for us to tell people who are not doing proper Theraplay that they aren't, but instead are perhaps just using the name for their own kind of playful therapy. Theraplay has so developed that we now have trained people in more than fifty countries around the world.

AJP: How did people find their way to Theraplay?

Booth: In the early days, people learned about Theraplay by word of mouth and came to our clinic seeking treatment. We spread the word by giving lots of talks about our work. Also, Ann published the first book, *Theraplay*, in 1979.

AJP: Who in particular finds Theraplay useful?

Booth: Since our approach is very helpful for children who are adopted—and desperately need help forming an attachment to their new parents—we have become one of a number of well-respected approaches to helping adoptive and foster parents in this country. Theraplay has also taken root and thrived in several countries, including Canada, Germany, the United Kingdom, Finland, Denmark, The Netherlands, Sweden, and South Korea.

AJP: What are the basic tenets of Theraplay?

Booth: Extensive research about attachment, brain development, and the elements that lead to therapeutic change underlie our core concepts. Theraplay is interactive and relationship based. Creating better relationships requires working with parent and child in a physically active, playful way. We strive to create a direct "here-and-now experience" of relationships that help forge a sense of self in adults and children, much as the original attachment relationship was formed. We follow Bowlby's advice that children need to feel they are in the hands of someone who is "stronger and wiser" and can keep the child safe, who helps the child regulate his or her feelings, and who provides clear expectations and firm rules. To strengthen attachment, we help adults attune to and show them ways to be more responsive, empathic, and reflective.

AJP: How do you help parents attune to their children?

Booth: As our model draws inspiration from the early interaction between parent and the very young child, we make use of eye contact, vocal prosody, rhythm, synchrony—all the interactions that connect at the limbic and brain-stem level to increase the sense of security. Again, this is not "talk therapy." In fact, much of this social interaction is preverbal and focused on right-brain activity involving emotions and intuition. So we find touch very

important, because touch has the power to connect, comfort, and regulate physical contact. We have found that touch is not only an essential element in the relationship between parents and their babies, it is also essential to building a loving relationship for an older child.

AJP: Does Theraplay operate beyond language itself?

Booth: We think of Theraplay as creating effects at the preverbal, brain stem, and limbic parts of the brain, at the level of development that is primary during the first two years of life when attachments are formed. Not that we don't talk with children, but we do not depend on talk to create change. Instead, we create change and new meanings in the interaction—making use of eye contact, touch, give-and-take, rhythmic sharing, and connecting through our bodies. We want the children to feel safe in these moments of meeting.

AJP: And what about the role of play itself?

Booth: Sharing a playful, joyous moment creates a connection that nothing else can do quite so well.

AJP: Is play inherently beneficial?

Booth: I think play is life sustaining, so yes, it is certainly therapeutic. The experience of playing together with someone has so many good benefits that it's hard to name them all. Being able to play with someone implies that you feel safe. I think about animal observations where two animals face each other and one gives a play signal which makes the other feel safe enough to respond. There is something very compelling about these signals to play. Sharing happy, high-energy exchanges engages the reward systems in the brain, creating connection and attachment. Play can make us feel good about ourselves and good about others. What more should we expect from therapy?

AJP: Tell us something of the kinds of games you play during therapy and what particular effects you hope to accomplish by playing them?

Booth: We have borrowed heavily from our own early experiences playing with our parents. We built into our early repertoire my father's game of putting me on his knees, of flying me around on his legs. And our basic foundation rests on all the games that parents naturally play with their babies—all the little hand and finger games, the singing rhymes, and peek-a-boo. Because we need variety and also need to adapt to older children, we have freely created games of catch, balloon toss, bubble blowing, and hide-and-seek. (Incidentally, we always hide with the children so they are not alone with their excitement about being looked for and found).

AJP: Besides the old favorites, do you make up new games?

Booth: I remember once many years ago getting ready for a session with a family by inventing a seed-spitting game, much like the summertime watermelon seed-spitting contests we used to have. This was January, though, and all I had was a tangerine. But it was full of seeds. So when the family came in, I asked if they were good at spitting. The parents looked shocked at first: Of course they don't allow their children to spit! But we were soon laughing uproariously as we tried to spit the seeds farther and farther across the room. I should explain that we generally provide a small treat such as crackers, fruit, raisins, nuts, M&Ms—all with the goal of ending a session with a quiet, shared experience where we emphasize that the adults like to take care of the children. Even though they are plenty old enough to feed themselves, we want to give them the experience of a quiet, satisfying moment in which they are lovingly taken care of.

AJP: Are all your therapeutic experiences so spontaneous and impish?

Booth: We are always thinking of what this particular child needs at this particular moment, and we are always looking for the right activity to fit the need. So we do provide opportunities to invite the child to share an exciting, engaging experience. But so many children who come for help are very easily dysregulated, so we carefully plan the sequence to keep the children within their window of tolerance. We think of this as a second chance to create situations where the adults provide the coregulation that is the essential first step before self-regulation is possible. Therefore we mix in some quiet, nurturing activities to help calm the children down after excitement. We often swing children in a blanket, for example, the parents holding one end and the therapist, the other. We encourage parents to sing their own lullabies or we lead them in a quiet song. And we sometimes follow William Steig's book, *Pete's a Pizza*, to help children relax and enjoy good touch—we have them lie on their tummies on the mat and "make a pizza" with a nice, warm back rub. This mix of active and calming activities helps children practice regulation.

AJP: How do you use play to stimulate the senses, and what is the value of play that stimulates several senses?

Booth: Because our games are patterned on the early parent-child interaction, they often include high levels of activity. Children need all the proprioceptive and sensory input they can get—they fly up in the air on Daddy's knees, crawl down on the floor through a tunnel, or rock in a blanket swing,

and so they learn how to handle themselves in space while learning the physical give and take of moving back and forth between others. We cuddle and feed children, and sometimes we rub lotion or powder on their hands to make hand prints on dark paper. When children feel the warm, caring touch and see prints of their own hands or feet, they get a clear sense of themselves as physical beings.

AJP: Is touching important, therapeutically speaking?

Booth: Touch is an essential part of our work. Touch is so absolutely necessary to the young baby, but I don't know anyone—even in my geriatric world—who doesn't long for and relish good loving touch. Tiffany Field, the University of Miami pediatrician and researcher who pioneered in the study of touch, confirms our belief in the importance of touch for preemies, adolescents, and old folks.

AJP: Is touch standard practice in therapy now?

Booth: Unfortunately, touch has become a no-no in many therapeutic circles—no doubt a reaction to the obvious dangers of inappropriate touch. When I was studying at the Anna Freud Center in London in 1992 and 1993, I attended lectures that were part of the training for young people to become child psychoanalysts. It was clear from their talk about their work that they felt a strong prohibition against touch. I was curious about where this had come from and set out to read all the Anna Freud I could find. What I found were her own descriptions of how she held children—when they cried or when they were out of control—how she touched and guided them. She was not afraid of touching children. The fear of "bad touch," however, has also led to strong prohibitions against teachers touching children in schools. While trying to eliminate bad touch, schools and therapists are leaning over backward and saying NO touch. The solution to bad touch, however, plainly is "good touch"—and plenty of it.

AJP: Are there special cautions that the therapist needs to observe in this regard?

Booth: Yes, of course. We need to be very aware of the child's response to touch. If the child is too ticklish, we use firm touch. If the child withdraws, we notice this and make sure the child is comfortable. In such a case, we might ask if it's OK to touch a hand, for example. Because it is our goal to create a strong parent-child connection, we ask parents to do most of the touching as soon as we are sure that they can touch well and safely. We video tape our sessions in order to look closely and make sure that we are catching all the child's signals and responding to the child's needs as sensitively as possible.

AJP: Why do you and other play therapists so often use musical metaphors to describe healthy adjustment?

Booth: When I was a child, I played duets with my sister. I played violin, she played piano. We followed the same rhythm. We resonated. And I have from the beginning used musical metaphors in thinking about Theraplay. When we are dancing together, we are playing together. The work of the Scottish psychobiologist Colwyn Trevarthen and others affirms that we have an innate propensity to get in rhythm and synchrony. This ability makes it possible for parents to attune to the child's affect and respond appropriately. Sharing a rhythmic activity is a great organizing, uniting experience. I remember many years ago visiting a preschool in South Africa. The classroom was full of lively youngsters who were clearly enjoying themselves. The most striking thing was that there seemed to be no moment that the group wasn't tapping and singing together to a rhythm set by their teacher. And even though they had to wait in line to go to the toilet—a potentially explosive situation in many preschools—we observed no friction.

AJP: Do all therapists you train sing to their patients and clients?

Booth: Yes, but not always. We sing lullabies as we rock children; we sing nursery rhymes. We don't generally ask children to sing along with us—that would put a demand on them that some children are not ready for. It makes the singing into a performance, and we want the children first of all to feel that their special adults can sing to them. We like to make up new, personal words to familiar songs. For example, we use a familiar tune to sing to children:

Twinkle, twinkle little star
What a special girl you are
Dark brown hair
Soft, soft cheeks
Big brown eyes from which you peek.
Twinkle, twinkle little star
What a special girl you are.

AJP: Do you sing with your patients when they start singing?

Booth: We don't always sing or use music except as it spontaneously seems to enhance the interaction. But at some point, many children and families love singing along. I remember a family where we often sang rounds together:

"Beat Your Swords into Ploughshares" or "Hey Ho, Anybody Home?" Some therapists use drums to help children get the pleasure of being in synchrony with others, or leading the pattern or mimicking the pattern that a parent or the therapist taps out on the drums.

AJP: What is the difference between attachment and attunement?

Booth: Attachment is a bond between two individuals that has lasting benefits and, if it is secure, provides the important foundation for long-term mental health. Attunement is more fleeting and does not need to be thought of as only taking place between individuals who are "attached." It is what the psychoanalyst Daniel Stern describes as the good relationship of a mother who naturally attunes to her child's noncategorical emotions—like the surge and fall of excitement. We are born with the capacity to attune to others in this way. Sensitive people can even attune to a passing stranger. Being raised by parents who are good at attuning to your moods and emotions is probably a good way to cultivate this capacity.

AJP: In the course of therapy, do you encounter instances of play deprivation? And if so, how do you spot it?

Booth: I don't suppose I can point to a child and say he's play deprived, but many of the children who come to us are very dysregulated and clearly don't know how to get into good interactive play. It helps them when we engage them in coordinated, synchronized play. When I was a child, we had lots of opportunities to play: at recess, during lunch break, learning square dancing, playing games. Many schools have cut down on the amount of time children are given to play actively like this. And, as you know, the neuroscientist Jaak Panksepp, in the *American Journal of Play,* has connected the high incidence of ADHD (Attention Deficit Hyperactivity Disorder) to play deprivation.

AJP: Is play deprivation a variety of misattunement?

Booth: Yes. Attuned adults would know immediately that children need to play, to get up from their desks, go outside and run, put away their iPhones and look at each other and laugh together. We are misattuned to their needs when we don't provide it.

AJP: Can attunement go wrong?

Booth: Attunement has its negative side—when we get swept up in a crowd mania, for example. Hitler was notoriously great at creating attunement in his huge audiences. And children who have experienced trauma do not easily allow people to signal their attunement, they misread the signals,

resist the connection. They are also very hard to read. They miscue others. And they may be compulsively compliant, and the therapist risks missing the underlying tension and terror. Attunement to me means that you are reading the other person correctly and are responding appropriately. So real attunement doesn't go wrong.

AJP: How do you involve adults and care givers in therapy?

Booth: We first describe what we are going to do, and then we give parents a chance to experience a Theraplay session. We are likely to have them play with us using the activities that we plan for the child's first session. During this session, we stop and talk a bit about how that feels to the parents and how they think their child might respond. Typically we have parents observe the first few sessions so that they can see how we interact with their child and so we can get acquainted with the youngster and begin to know what works best. Very soon, we bring parents in to sessions. Actually on the very first session, we might have the parents join us for the final snack and quiet song. Ideally the parents will have their own therapist who can sit with them as they observe and can talk with them about what is happening. This is a luxury most parents can't afford, so we meet with them after the session to talk about what happened and to answer their questions. (I should say that it is often best to have only one parent in a session at a time. Children can become overwhelmed if there are three adults in the room. However, we make sure that both parents are in on the work and understand what is going on). In the beginning, we very actively guide the parent, making sure he or she knows just what to do. I once did a demonstration session with a family in front of a large group of Theraplay trainees. We used to do all our trainings with an actual client family to demonstrate the process. This is still a great idea, but it makes teaching a four-day training a great strain, like running a two-ring circus. We have to keep the training group in focus and meet their needs. We have to keep the client family members in mind and make sure they are doing OK. After this training was over, I spoke to the mother about the experience. She said, "I was very relaxed. I knew that you would tell me exactly what I needed to do." As the sessions continue, we ask parents to plan regular sessions at home when they spend time playing with their child in a "special Mommy or Daddy time." As sessions draw to the end, we help parents take more responsibility for leading the session.

AJP: Does therapeutic play remain useful across socioeconomic lines and in various locales?

Booth: We have found that Theraplay adapts very well to many different locales. We are careful to learn the special ways in a new country, but we find the playful, engaging approach quite compatible with different patterns of parenting. As I said earlier, we have now trained therapists in more than thirty countries. As to socioeconomic differences, we do find that well-functioning, middle-class parents who had pretty good connections in their own childhoods find it much easier to take in these new ideas than parents who came from deprived, poverty-stricken situations. I remember early in the Head Start days, a young African American woman said: "Why should I play with my son? Life is serious. He needs to learn to be serious." Then too, among some working-class groups, it is shameful to need therapy.

AJP: How does Theraplay achieve such good results so quickly?

Booth: While we do experience very quick changes in children's attitudes and behavior, we can't claim that Theraplay is a magic bullet. Seriously troubled children may need many repetitions of these good experiences before they can trust that they will continue. It makes a huge difference to include parents in sessions. Encouraging parents to be playful helps troubled children overcome fears and hesitations. If children expect bad things to happen, they cannot escape their fear-based hesitation to engage. By inviting them to play, we signal that we will be accepting, that they will be safe, that they can open up. Having a real experience of being responded to in a positive way—so contrary to what many of them have experienced in the past—changes their view of themselves and of others.

AJP: How do you proceed when parents themselves are troubled?

Booth: Our main focus is on creating a safe, secure relationship between parents and their children. If parents are able to pick up on and respond to the new more attuned and playful approach, we find quick progress. However, many parents are so traumatized themselves and have had so little experience of good parenting in their own childhoods that they aren't able to meet the needs of their children. In this case, we recommend that therapists do a lot of work with the parents, sometimes doing Theraplay sessions with them individually or with their partner.

AJP: Is there an upper age limit to Theraplay?

Booth: I like to say that the oldest person we have worked with using Theraplay was eighty-five years old. This lovely, depressed woman blossomed as a result of her playful sessions with a very caring Theraplay therapist. We have used Theraplay groups in retirement communities and other group

homes with adults. In Germany, a group of older adults meets regularly in a community center and has group Theraplay sessions with four- and five-year-old children. It is a pleasure to see the smiles on the adults as well as the children. Having told you about these outliers, I should say that our typical age range for child clients is from two years to eighteen years. We also do Theraplay with expectant mothers and with mothers and their very young babies.

AJP: Does recent brain science support nonverbal aspects of psychotherapy?

Booth: Yes. The psychophysiologist Steven Porges, the Dutch psychiatrist Bessel van der Kolk, and the trauma clinician Bruce Perry all emphasize the importance of nonverbal, brain stem, limbic levels of interaction.

AJP: How have the advances in brain science contributed to therapeutic technique?

Booth: As scientists report new brain research, we have discovered reasons why our approach makes a difference, and we have learned about just what parts of the brain we are affecting. This makes it possible for us to aim our activities more precisely to meet the child's needs—though, again, we always use the basic nonverbal ways of interacting, eye contact, touch, face-to-face play. The emphasis on regulation that the neuropsychologist Allan Schore makes greatly informed the way we work. We now attend very closely to the arousal level of the child and can often prevent blowups or alter our approach before the child gets too excited. Learning more about the importance of attunement, synchrony, and moments of meeting—all these great things that brain research helps us understand—has enabled us to focus on how we can lead families to achieve such moments.

AJP: Have you encountered resistance to Theraplay? Do some clinicians regard Theraplay as unorthodox?

Booth: The answer is definitely yes! When we first began seeing children in the Head Start program, we encountered a lot of resistance, especially among the social workers who had trained in traditional psychoanalytic approaches. They looked upon our "play" with great skepticism. Were we just a bunch of inexpert people messing around? We made our first film to convince people that we were doing something that had substance and a good outcome. Ann Jernberg encountered general indifference when she presented our work to the Chicago Institute for Psychoanalysis, and she encountered outright hostility at a local training center for teachers of young children. Happily, this has gradually changed over the years. But we still toil to spread the word of the good outcomes of Theraplay so that we

can be included in the list of evidence-based treatments. In fact, it is hard to do good research into the outcome of a free-wheeling, playful therapeutic method that relies on presence, responsiveness, creativity, and going with the flow. Where do we find really good outcome measures for happiness, lifelong emotional health, and joy?

AJP: Do the principles of Theraplay extend beyond therapy?

Booth: Yes, of course. Since we are using the model of the best kind of loving, attentive interaction, any encounter with someone else can be enhanced by such an attitude. "Here is someone I find interesting, someone I might be able to play with, someone I can listen to and learn from. I can value this person and we can share good feelings." This is a great way to be in the world—it's not always achieved in the day-to-day hustle of my life, but there are moments!

AJP: We are often say to lose ourselves in play, but can we find ourselves while at play?

Booth: Because I see play as so much of an interactive and shared experience, I think we find our selves in the very process of being mirrored by those we play with.

AJP: If playing is part of the work for Theraplay therapists, how do they play?

Booth: They need to find lots of ways to play themselves. There are many ways to play that can create joyous interactive experiences suitable to each person's special interests and talents. For me, it is playing music with others—I still play the violin and love to play string quartets. There is nothing that makes me feel so good and so full of well-being as a good chamber music session. I find my better self in such experiences. There's me and three others all moving and singing in rhythm, synchrony, and resonance—all guided by the hand of a master, be it Haydn, Mozart, Beethoven, Brahms, or Stravinsky. What could be better and more life enhancing? I would recommend to others dancing, active sports, finding friends who can share your larks. Actually, just doing Theraplay itself inspires fun. A couple of years after we began playing with the Head Start children, Ann Jernberg asked me how our work made me feel. I looked at her and smiled and said, "I feel really invigorated by it. It's like playing with your own happy baby!" What a pleasure it has been to help distressed parents and children experience that joy too.