

A Practical Approach to Implementing Theraplay for Children With Autism Spectrum Disorder

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Theraplay is a counseling approach that uses elements of play therapy to help children build better attachment relationships with others through attachment-based play. This article describes a practical approach for implementing Group Theraplay with children with Autism Spectrum Disorder (ASD), particularly those that are mainstreamed in a kindergarten classroom setting. The approach uses resources that are already in place in schools today, such as mental health professionals (e.g., school counselor, social worker, etc.) and teachers. Foundational Theraplay assumptions, therapeutic goals, empirical support, and implementation guidelines are provided. Comparative effectiveness research examining the use of Group Theraplay with this population in this setting versus the use of alternative therapeutic approaches is needed. To help guide future research in this needed area of outcomes investigation, several assessment instruments appropriate for clinical research use with this population are suggested. Ethical and cultural implications pertinent to the application of Group Theraplay for children with ASD also are discussed.

Keywords: theraplay, autism spectrum disorder, counselor, mental health professional, mainstream classroom

Theraplay is a form of therapy that uses elements of play therapy to assist children in forming better attachment relationships with others. Theraplay was originally developed by Dr. Ann Jernberg and her colleagues through their work with Head Start preschoolers in the late 1960s (Jernberg & Booth, 1999). Jernberg has noted that her work was heavily influenced by Austin Des Lauriers' research on children with autism, particularly as it relates to therapeutic strategies associated with improved communication among children with autism (Des Lauriers & Carlson, 1969). At the outset of her work, Jernberg studied early infant attachment and identified the importance of physical contact in helping children increase self-regulation, particularly emotional regulation (Myrow, 2006). Consistent with attachment theory, the early attachment between a child and primary caregiver has been shown to influence the child's future relationships with others (Bowlby, 1969).

This article was published Online First August 15, 2011.

I thank Drs. Nancy Forth and Amy Goetzinger for their assistance in critiquing this article, as well as, Brijin Gardner and Dr. Rand Allen Coleman for their suggestions regarding implementing the approach.

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Theraplay rests on the assumption that a powerful, therapeutic attachment relationship can be developed between the therapist and child. The quality of that relationship can, in turn, be assessed and improved in four primary relationship dimensions: structure, engagement, nurture, and challenge. Over time, and in the course of subsequent therapy sessions, the child can learn and practice communication skills facilitated by a caring, nonjudgmental, and encouraging therapist. In the course of this work, the assumption is that the child can develop a healthy attachment relationship with the therapist. For a child who lacks a history of healthy attachments, this relationship may serve as the child's first model of a secure and healthy attachment relationship. However, there are a number of factors that could contribute to an unhealthy attachment between the child and caregiver: a stressful family life, an ill parent, separation between child and parent, or a child with autism. For children who have securely bonded to their parent(s) or primary caregiver(s), the therapist relationship serves as a supplemental attachment relationship that can be used therapeutically (Jernberg & Booth, 1999). A healthy, secure attachment is achieved when the parent(s) or primary caregiver(s) become aware of a child's cues and is able to regulate the child's emotions, which then allows the child to learn how to better self-regulate (Munns, 2008). Jernberg later introduced the family connection into this therapy by encouraging family caregivers to take over the therapist role, thereby transferring children's attachment to the caregiver (Myrow, 2006). Moreover, the overall goal is for children to develop healthy attachments and feel the security that comes from this development, which will in turn allow them to securely explore the world and develop into who they want to become (Jernberg & Booth, 1999).

Theraplay is a short-term, structured form of play therapy that typically consists of at least one 30-min session a week over several months. Although the number of sessions can vary, Munns (2008) suggested conducting 12 to 16 sessions over a 4-month period. From a practical standpoint, Theraplay requires minimal supplies and toys, thereby making it an inexpensive approach to implement (Rubin & Tregay, 1989). Theraplay follows a highly structured format, with an opening, planned activities, and a closing (Martin, 2001). The opening begins with a welcome song, followed by a brief explanation of rules, lotioning (applying lotion to a child's hands/arms or legs/feet), and check-ups. The planned activities then occur, followed by a closing, consisting of a feeding and a goodbye song. Each of the activities used in session fall under one of the four dimensions of Theraplay. The rules (e.g., "no hurts," "stick together," and "have fun") (Jernberg & Booth, 1999, p. 367) are clarified in session. An additional rule—the adult is in charge—is implied, but not spoken to the children (Jernberg & Booth, 1999).

Understanding how each dimension of Theraplay fits into the theoretical model is crucial in emphasizing the importance of different activities in Theraplay sessions. Structure, for example, provides children with clear rules and can promote children's sense of security. Structure-related activities work toward allowing children to comply with simple directions from the therapist, teacher, or caregiver (Munns, 2008). In turn, children learn that the world can be safe, secure, and predictable (Munns, 2002). Engagement activities provide time for the adult to build rapport and interact with children. Nurture is perhaps one of the most important dimensions of Theraplay. According to Munns (2008), all children need to feel nurtured and supported, and nurture-related activities allow children to feel valued, impor-

tant, accepted, cared for, and loved. Most importantly, as children feel more and more accepted, self-esteem develops and strengthens (Munns, 2002). Challenge-related activities enable children to explore new roles, and these activities allow for opportunities for success. Children are able to develop self-confidence from these activities (Munns, 2008). Ultimately, the four dimensions of Theraplay activities can help build trust and facilitate attachment-strengthening for children (Myrow, 1997). Theraplay can be implemented with children of varying ages or developmental levels and in a variety of settings, including with children with ASD. By bringing awareness to what Theraplay is, and how it can be utilized with resources that are already in place, I seek to show that Theraplay can be effectively implemented with children diagnosed with ASD in mainstream classrooms.

PREVALENCE OF AUTISM SPECTRUM DISORDERS

The prevalence of autism spectrum disorders (ASDs) in the United States is considerably large and suggests the need for empirically validated treatments to target problematic symptoms and behaviors associated with this condition. Results from the 2007 National Survey of Children's Health (U.S. Department of Health and Human Services) suggest that approximately 110 per 10,000 children aged 3 to 17 are diagnosed with ASD, totaling an estimated 673,000 children that have been diagnosed with this condition. ASD is a category of childhood disorders that includes Autism, Asperger's Syndrome, and Pervasive Developmental Disorder Not Otherwise Specified (NOS). Recent evidence suggests the prevalence of ASD appears to be on the rise (Kogan et al., 2009).

Moreover, data from the U.S. Department of Education (2009) indicates that an increasing number of students are being identified in the category of autism under the Individuals with Disabilities Education Act (IDEA). In 1992, there were 15,580 students between the ages of 6 to 21 years old that were identified with autism. This number grew to 192,643 in 2005 and 333,022 in 2009. IDEA places an emphasis on children with disabilities having a free appropriate public education in the least restrictive environment. For children with ASD, the mainstream classroom, otherwise known as the regular education classroom, if appropriate, would be the least restrictive environment. It appears that as the number of children identified with ASD increases, more regular education teachers will be working with children with ASD that are mainstreamed than in the past, as there was an increase of 317,442 children with ASD in a 17-year period. In order to assist teachers in developing relationships and facilitating a nurturing environment for children with ASD, necessary tools and strategies are needed. Theraplay is a tool that regular education teachers could utilize when working with children with ASD in a school setting.

THERAPLAY AND AUTISM SPECTRUM DISORDERS

Despite the limited number of studies focusing on Theraplay with children with ASD, positive outcomes have been reported. Rieff and Booth (1994) conducted a

case study with a 2-year-old male child diagnosed with Pervasive Developmental Disorder (PDD). He received weekly Theraplay sessions for 8 months. The goals of treatment were defined as developing a sense of self, recognizing others as separate from the self, and developing trust with others. The researchers found that Theraplay allowed the counselor to address and work through common defense mechanisms seen in the child with ASD, such as pushing others away and avoiding socialization. At the end of the study, the child's mother was interviewed, and she reported positive gains, presumably as a result of the Theraplay sessions.

Fuller (1995) conducted a case study of an 8-year-old female child with autism in a day treatment facility. The child participated in a Theraplay group for 14 months, and the goal of Theraplay was for the child to be able to attach to other people in her environment. Overall, the child made significant progress while in treatment; her social skills improved, there was a decrease in her echolalic speech, and she started to initiate contact and interactions with other children. Furthermore, Bundy-Myrow (1994) led a group with 10 five-year-old children; five of them had been diagnosed with PDD. The group met weekly for 30-min Theraplay sessions over the course of nine months. The children diagnosed with PDD worked toward the goals of increasing awareness of peers, becoming comfortable with physical proximity, acknowledging positive attention, and learning how to initiate contact with peers and adults. Bundy-Myrow reported that the children with PDD showed growth toward these goals. Additionally, the other five children in the group showed positive change.

Lindaman and Booth (2010) assessed children with ASD through examining case studies and the effects that Theraplay had for each child as a form of treatment. Each child found some success as Theraplay sessions were introduced, progressed, and ended. The researchers attributed this to the fact that ASD hinders the child from engaging with others and participating in relationships, while Theraplay works toward getting the child to engage, relate, and communicate with others. Group Theraplay was addressed with this population, as Lindaman and Booth noted that "Group Theraplay has been found to be very effective in developing engagement, interaction, communication, language, and social skills in children with ASD" (p. 357). Although positive outcomes have been found with this population, research is limited, and further research is needed to support Theraplay as an effective form of treatment for children with ASD, particularly in a classroom setting.

IS THERAPLAY EFFECTIVE?

Several studies have examined the effectiveness of Theraplay and found support for its use in the context of working with children in a variety of populations. Wettig, Franke, and Fjordbak (2006) conducted two field studies in German-speaking parts of Europe. The first controlled longitudinal study began in 1998 with a sample of 60 dually diagnosed children (communication disorders and severe behavior disorders), ranging in age from 2 years and 6 months to 6 years and 11 months, who had been referred to the Phoniatic Paed-Audiologic Center in Heidelberg. The goal of this study was to implement Theraplay to improve chil-

dren's attention, cooperation, and approachability. The children in the treatment group received treatment immediately, while children in the control group waited 16 weeks before starting treatment. Two trained clinicians coded and analyzed behavior according to the Heidelberg Marschak Interaction Method. Data were collected before, during, and after treatment with Theraplay, as well as two years after treatment termination. Upon completion of this study, hypotheses were verified with statistically significant results. Theraplay was found to be an effective treatment for the children in the study as maladaptive symptoms were reduced and the effect size of this reduction was large in most categories. Additionally, the results demonstrated high internal validity as a result of the following: the sample population's homogeneity, therapy being conducted in the same setting, and therapy being conducted with the same therapist. However, due to the sample's high degree of homogeneity, the study was found to have low external validity, suggesting that results might not generalize well to the children with different presenting concerns.

To address these limitations, Wettig et al. (2006) conducted a second field study at multiple sites both in Germany and Austria. The goal of this study was to determine the effectiveness of Theraplay in a wider range of client populations. Again, effectiveness was measured by a statistically significant decrease in maladaptive symptoms. In 2004, 14 Theraplay therapists completed treatment with a sample of 291 children with dual diagnoses of behavior disorders and speech-language deficits or delays, ranging in age from 2 years and 6 months to 6 years and 11 months. Wettig et al. used a wide range of assessments, including the German version of the Clinical Assessment Scale for Child and Adolescent Psychopathology (CASCAP-D; Doepfner, Berner, Schwitzgebel, Lehmkuhl, & Steinhausen, 1994). Theraplay treatment consisted of 30-min therapeutic sessions, with an average of 19 to 20 sessions. Based on initial assessments of symptoms, children were divided into three symptom groups: mild, moderate, and severe. Results showed a significant positive change following Theraplay treatment with respect to interactive behavior among the clinically symptomatic children. Symptoms decreased in all three groups of children, and these changes were both clinically and statistically significant. Researchers also determined that neuropsychologically relevant symptoms, such as those found in Attention Deficit Hyperactivity Disorder (ADHD) and Autism, decreased more in children in the mild-symptom group as compared to the moderate- and severe-symptom groups. Overall, the results of this study demonstrated support of Theraplay being an effective form of treatment with a wide range of populations, particularly for children with relatively mild neuropsychological symptoms.

More recently, Wettig, Coleman, and Geider (2011) assessed the effectiveness of Theraplay in treating shy, socially withdrawn children. Two studies were conducted with dually diagnosed children with language disorder and shyness/social anxiety. The first study was comprised of 22 children ranging in age from 2 years 6 months to 6 years 11 months. In the second study, there were 167 children ranging in age from 2 years 6 months to 6 years 11 months. The researchers used the CASCAP-D (Doepfner, Berner, Flechtner, Lehmkuhl, & Steinhausen, 1999) during pre- and posttreatment, as well as at follow-up. The results from both studies supported the effectiveness of Theraplay treatment in improving shy behavior. There was a significant improvement in assertiveness, self-confidence, and trust,

along with a decrease in social withdrawal. The researchers noted that therapeutic goals were met when an average of 18 sessions were conducted. Of note, neither study contained a clinical control group.

In addition, Siu (2009) conducted a study to assess the effectiveness of Group Theraplay with 46 children with internalizing behaviors from an elementary school in an urbanized area in Hong Kong. Twenty-four of the children were assigned to the waitlist group, while the remaining children immediately started Theraplay treatment. The Child Behavior Checklist (CBCL; Achenbach, 1991) was used to measure internalizing problems and was given to the mothers of the children participating in the study at baseline and posttreatment. Siu categorized the items on the CBCL into eight syndromes, where withdrawn, somatic complaints, and anxious/depressed syndromes were rated as internalizing problems. Group Theraplay sessions were conducted once a week by a certified Theraplay therapist; sessions lasted 40 minutes and were given over an 8-week period. The results indicated a significant difference between the Theraplay group and the waitlist group on the CBCL-internalizing scores, which supported Theraplay as being an effective means of treatment for children. Overall, these studies demonstrate support for the effectiveness of Theraplay, yet further research is needed to show how Theraplay can be effectively applied for use with children with ASD in a classroom setting.

GROUP THERAPLAY IN A CLASSROOM SETTING

Group Theraplay can be implemented with multiple children in a classroom setting with a mental health professional (e.g., school counselor, social worker, etc.) and teacher present. By doing so, not only do children with ASD benefit, but the rest of the children in the classroom are also able to participate in the group. During Group Theraplay, basic concepts of Theraplay are applied. By utilizing this type of treatment, teachers are able to work with children with ASD in order to help them reduce negative interaction patterns and to facilitate healthy patterns of relating within the classroom. Children's emotional and social developments are a crucial element in being able to learn and achieve academic goals. Notably, children's needs for nurture, structure, engagement, and challenge can be addressed through Group Theraplay treatment. Furthermore, Theraplay can be integrated into the classroom in order to help the teacher facilitate children's needed emotional and social development, as well as foster nurturing relationships with each child (Martin, 2001). As stated above, Rubin and Tregay (1989) provided ways to use Theraplay in various classroom settings, including with the regular education classroom teacher. By providing Group Theraplay in a classroom setting, a school is able to utilize the mental health professional and teacher in helping children with ASD.

A PRACTICAL APPROACH FOR GROUP THERAPLAY IN A CLASSROOM SETTING

As discussed, Theraplay is a short-term therapy that can be utilized in school settings, and there are many possibilities for implementing this treatment into today's schools. For instance, Theraplay can be used with a mental health professional and child, in a small group of children, or even with a classroom of children. It is important to note that school counselors and other mental health professionals that work in a school setting may be responsible for serving several hundred children. For practical purposes, implementing Group Theraplay in a classroom would be more beneficial, as the mental health professional would be able to target a larger number of children. Additionally, there are many mental health professionals already working within school systems that could access training in this type of therapy to facilitate its ongoing use in a variety of classroom settings, such as kindergarten, first grade, and special education, among others (Rubin & Tregay, 1989). It is recommended that mental health professionals and teachers receive Theraplay training through a certified training from The Theraplay Institute in Chicago; specifically the Group Theraplay training class, which can be completed in one day.

As indicated above, the number of children with ASD is on the rise (Kogan et al., 2009), as well as the number of children with ASD being served under IDEA (U.S. Department of Education, 2009). Due to this, teachers would appear to be working with children with ASD more commonly than in the past. Taking a closer look at various classrooms, it would appear a kindergarten classroom is an ideal setting to implement Group Theraplay. Starting kindergarten can be difficult for the average child, and it can be even more challenging for the child with ASD, as it involves two things that children with ASD struggle with on a daily basis: change and adjustment to a new environment (Snyder, 1998). Group Theraplay in a kindergarten classroom would allow the mental health professional and teacher to work with children with ASD on engaging and interacting with peers, as well as creating healthy relationships between the children and teacher, thereby enhancing children's attachment to the teacher. While implementing the four dimensions of structure, engagement, nurture, and challenge in Group Theraplay sessions, the mental health professional and teacher would identify certain goals for the students: developing a sense of self, recognizing others as separate from themselves, and developing trust with others, all of which are similar to Rieff and Booth's goals (1994). Additionally, an advantage to this type of group is that minimal supplies would be needed to conduct these sessions (Rubin & Tregay, 1989). For example, a sensory ball, bubbles, lotion (nonscented), cotton balls, a blanket, newspapers, and small crackers could be used during Group Theraplay activities. Moreover, implementing Group Theraplay in a kindergarten classroom could be beneficial for children with ASD and for other children in the classroom.

A suggested plan for conducting Group Theraplay in a kindergarten classroom would start with the mental health professional(s) and teacher(s), if possible, being trained in Group Theraplay by the Theraplay Institute as noted above. Once training is complete, the mental health professional would educate school personnel, such as the kindergarten teacher, principal, paraprofessionals, and other staff

members that would be involved in the implementation of providing Group Theraplay. A permission form would need to be sent home to the parents of the children participating in the group. The form would explain the purpose and goals of the Group Theraplay sessions, as well as the time frame of the sessions. These permission forms would need to be signed by a guardian and returned to the school in order for the child to participate in the group. Before starting the Group Theraplay sessions in the classroom, the mental health professional would visit the kindergarten classroom and discuss the group and the plan for when it would be occurring in order to help alleviate anxiety among all the children, particularly the children with ASD. Additionally, creating a group name with the class would be essential in helping children identify the Group Theraplay time. A proposed plan would be to conduct Group Theraplay on Tuesdays and Thursdays at the end of the school day for 30 minutes for 10 weeks, resulting in a total of 20 sessions. Also, replacing center time with Group Theraplay sessions could be a way for the classroom teacher to prevent the loss of instructional time.

At the decided Group Theraplay time, the group leader(s) (e.g., mental health professionals) would have all of the children and staff members sit in a circle on the carpet or floor, with the adults spaced out evenly around the circle. An example of a Theraplay group session with kindergarteners would be as follows: (a) welcome song, (b) going over the rules (e.g. “no hurts,” “stick together,” “have fun”), (c) lotioning (nurture) and checkups (engagement), (d) connecting eyes with other participants and changing places in the circle (challenge and structure), (e) Blind Letter on the Back (structure)—using the finger to draw shapes, numbers, or letters on a partner’s back and the partner guesses what was drawn, (f) Scotch Stick Pass (engagement)—using a piece of tape, each person sticks tape to his/her nose, and the next child in circle removes tape and puts it on his/her own nose, (g) Basketball Challenge (challenge)—adults go around and have children take turns shooting a soft ball into a basket made with the adult’s arms, (h) Pop the Bubble (structure)—children pop bubbles with nose, pinky, etc, (i) feeding of a potato chip, pretzel, cracker, and so forth—adult feeds each child one item, and (j) a goodbye song (Rubin & Tregay, 1989). Through the necessary training, planning of sessions, and items noted above, Group Theraplay could be implemented in a classroom setting utilizing the mental health professional and the teacher.

Assessments Necessary for Supporting Effectiveness of Group Theraplay

Due to the limited number of studies demonstrating the effectiveness of Group Theraplay, data collection is essential. In order to determine Group Theraplay effectiveness with children with ASD, the Achenbach System of Empirically Based Assessment (ASEBA; Achenbach & Rescorla, 2001), the Gilliam Autism Rating Scale (2nd version; Gilliam, 2006), and a 5-point rating scale (Gardner, 2010) are possible assessments that could be administered pre- and postintervention. These assessments are appropriate for use based on their validity and reliability with this population (Flanagan, 2005; Watson, 2005; Fairbank, 2007; Garro, 2007; Montgomery, Newton, & Smith, 2008). Dr. Coleman, a neuropsychologist and Certified Theraplay Therapist specializing in working with children with ASD, suggested

using these assessments to evaluate Group Theraplay in children with ASD. These were suggested due to their ability to measure social interactions, stereotyped behaviors, and communication (personal communication, September 29, 2010). In addition to these assessments, attendance, discipline referrals, and student achievement pre- and posttreatment could be compared to assess behavioral outcomes. All of these assessments are crucial in determining the effectiveness of Group Theraplay for children with ASD, particularly in a classroom setting.

ETHICAL CONSIDERATIONS

It is important to take ethical considerations into account when implementing Theraplay in the classroom. The professional school counselor or mental health professional providing Theraplay must be aware of relevant ethical standards, particularly those of the American Psychological Association (APA), American Counselor Association (ACA) and American School Counselor Association (ASCA) Ethics Codes (American Psychological Association, 2002; American Counselor Association, 2005; American School Counselor Association, 2004). More specifically, the mental health professional would be adhering to the standards in the areas of confidentiality, the counseling relationship, and group work. These would be applied when parents are informed of the group itself and of the goals of the group; a permission form containing an explanation about the group and about confidentiality expectations would be sent home, and parents would be provided with contact information so that they could ask questions about the group. The mental health professional also would have a discussion about the group and confidentiality with the children beforehand so that they would know when the group was being held, what to expect, and the goals of the group intervention. When the mental health professional is working with children with ASD and their parents, it is crucial to explain the purpose of the group and to discuss rationale for using planned assessments to measure improvement/outcomes. Setting realistic expectations with the children with ASD, as well as with their parents, is needed, and confidentiality regarding the assessment results is essential. The mental health professional must follow the ethical standards of evaluation, assessment, and interpretation when carrying this out.

Additionally, Theraplay incorporates touch in the various activities that are performed during the group. Challenges may arise in a school setting in which a staff member touching a student may be perceived as inappropriate and unnecessary. Since the children in the classroom that are participating in Group Theraplay are the clients, the mental health professional has an ethical obligation to do no harm to clients and look toward the clients' best interests. The mental health professional must determine if the Group Theraplay activities involving touch would be beneficial and fulfill a purpose in accomplishing the goals of the group. Educating staff members and parents on the purpose of the touch and how it relates to the group's goals may alleviate resistance and challenges that might arise in a school setting. Furthermore, children's varying comfort levels with touch and cultural differences regarding touch are two potential issues that the mental health professional needs to take into consideration when implementing Group Theraplay.

CONCLUSION

Theraplay is an effective form of therapy (Bundy-Myrow, 1994; Fuller, 1995; Lindaman & Booth, 2010; Rieff & Booth, 1994; Siu, 2009; Wettig et al., 2006; Wettig et al., 2011) that can be integrated into classrooms by utilizing resources that are already in place, such as the mental health professional and teacher. By providing Group Theraplay, the mental health professional is able to help mainstreamed children with ASD to form healthy attachments to their teacher (Myrow, 2006). Additionally, children with ASD can work toward academic and developmental success in the classroom setting, development of supportive relationships with teachers and the mental health professional, and improvement in social interactions with peers (Martin, 2001).

Furthermore, the four dimensions of Theraplay—structure, engagement, nurture, and challenge—are able to provide a helpful framework for children with ASD to reach these therapeutic goals. For example, through structure activities, children with ASD can learn that the world is a safe, secure, and predictable place, thereby enhancing feelings of general safety and security (Munns, 2002). Also, teachers are provided with skills to help them work with children with ASD, specifically in areas that these children typically struggle with on a day-to-day basis, such as change and transition (Snyder, 1998). Whereas children with ASD may normally avoid social interactions altogether, engagement activities facilitate positive interactions with the teacher, the mental health professional, and peers. Engagement activities could enable children with ASD to gradually ease into interacting with others while slowly and methodically learning appropriate social responses. Nurture activities, which are seen as an essential part of Theraplay, allow children with ASD to feel taken care of, valued, accepted, and loved (Munns, 2008). Children with ASD may often feel rejected by others because of social interaction and communication challenges. Nurture activities provide an opportunity for the experience of acceptance and value (Munns, 2002). Challenge activities provide children with ASD the ability to explore new things and to be successful in those attempts. Children with ASD may struggle with trying new approaches or activities, and the challenge focus can provide a safe environment in which to make attempts, potentially resulting in increased self-confidence and a sense of empowerment (Munns, 2008). Overall, children with ASD would ideally be able to build trust with those participating in the group and work on changing maladaptive behaviors that are impeding their success in forming healthy relationships with others.

Three assessment tools were proposed to evaluate the effectiveness of Group Theraplay for children with ASD (Achenbach & Rescorla, 2001; Gardner, 2010; Gilliam, 2006). It appears that a well-validated instrument is needed to assess the degree of attachment and relationship between the parent, teacher, or mental health professional and children with ASD. Theraplay can provide adults with an opportunity to see children with ASD in a different way; as people who care, engage, and accept nurture (Bundy-Myrow, 1994; Fuller, 1995; Lindaman & Booth, 2010; Rieff & Booth, 1994). In order to show that this important attachment is facilitated in Theraplay, it is imperative that an assessment tool be developed to evaluate the quality of the relationship between the adult and children with ASD.

As Theraplay continues to gain support for being an effective form of therapy, its implementation in a classroom setting can help numerous children, particularly

children with ASD, to learn and grow (Myrow, 2006). Ways to implement Group Theraplay in a kindergarten classroom by utilizing resources that are already in place, such as the mental health professional and teacher, were addressed. As mental health professionals, such as school counselors and social workers, may serve a large number of children in a school setting, tools that allow them to work with a larger number of children at one time are essential. A 1-day training in Group Theraplay can give mental health professionals a tool that they can implement on a weekly basis while serving a classroom of children, as well as children with ASD. As the number of children with ASD is on the rise (Kogan et al., 2009), and it appears more children with ASD are entering mainstream classrooms (U.S. Department of Education, 2009), it is essential that teachers are also given the tools to meet these children's needs. Group Theraplay also gives teachers a tool to use as they focus on developing a healthy attachment between themselves and the children with ASD. Through Group Theraplay, children with ASD across the world have the potential to be greatly impacted by professionals and teachers in today's schools.

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