

**Nurture and Play – intervention**

**Short-term, preventive mentalizing based playful intervention for parent-child dyads, families or groups**

Obs. The Theraplay Institute has approved the use of Nurture and Play-mark as a separate intervention training model. For Theraplay-therapist training, please see your local contacts or www.theraplay.org.

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* *Preventive, short-term work for improving interaction*
* *From pregnancy until 7 years of age*
* *Easily administered for parent-child dyads, families or groups (multifamily)*
* *Multiprofessionally applied*
* *Utilizes playful moments and reflective discussions*

*In short: ‘Nurture and play’ is a mentalizing based playful intervention, with roots in Theraplay therapy (*[*www.theraplay.org*](http://www.theraplay.org)*), and mentalizing theory and its clinical applications. It can be flexible used from pregnancy onwards, up to 7 years of age. It can be used in multiple settings (home, clinic). You can start already during pregnany or later, when the child is older. Siblings and both parents can be part of the intervention. N&P includes prework with parental reflective skills (Nurture & Play – Interview), planning and executing the intervention 5-6 times including play sessions and reflective discussions. The effectiveness of Nurture and Play –Groups has been tested with a RCT design (Salo et al., 2016).*

**Background**

Nurture and Play – *for Families* intervention was first developed 2008-2009 as a practical, short-term preventive way of increasing emotional availability and parental reflective capacity through playful sessions and reflective discussions (Salo & Tuomi, 2009). In 2011-2015 the Nurture and Play – *for Groups* was developed in a project called Baby Magic (Poutiainen and Salo, 2015). The aim in both modifications is to increase parent-child emotional availability as well as related parental reflective skills *among low to medium risk parent-child dyads.* *The purpose of Nurture and Play is to be a short prevention, that is easily delivered to families, and can be conducted in different levels of social and medical healthcare system by health care nurses, family workers etc.*

After a long tradition of giving parental guidance only, there has been a need to develop focused, quickly delivered models of working with interaction and involving especially the young child. Not all families need long interactional or other therapies, and these are also hard to get in many places. The training requirements often exlude many professionals who meet and work with parents and young children in e.g., baby welfare clinics, child protective preventive services. Thus, the practical aim behind developing Nurture and Play – interventions was to model a theory based way of working with interaction with enough structure in the practical way of doing it for it to be 1) easily trained for different professionals, and 2) easily delivered to families if different settings without the emphasis of participating to therapy. The hope has also been for this prevention to operate as a screener; if parent-child dyads need more help they would be more easily be guided in longer therapies after experiencing the first-hand aid from Nurture and Play-intervention.

The practical background model is Theraplay-therapy, which a registrated parent-child interaction therapy (Jernberg & Booth, 2011). Theraplay uses adult-led playful therapy sessions focusing on operating on nonverbal level of early interaction. The aim is to increase engagement, structure, challenge and nurturing within the parent-child dyad. Theraplay can be applied to children of different ages and problems, ranging from regulatory difficulties to complex trauma. Theraplay therapists are trained and supervised to conduct the process that usually lasts ca 15-20 meetings and involves intensive work through videos and as well as direct experiences with parents and children. The training to become a Theraplay Therapist involves working under supervision with about 10 cases with over 200 hours of therapy.

Second basis of Nurture and Play –intervention is mentalizing theory and its clinical applications, namely MBT-F (mentalizing based treatment for families; Midgey & Vrouva, 2011), and Arietta Slades’s work (Slade, 2005). Here, the focus is on enhancing parental mentalizing, i.e., reflective capabilities of explicitly understanding how one’s own mental states such as feelings and thougths influence interactive behavior. And vice versa, how the child’s mental states operate and influence the child’s behavior, as well as one’s own mind. Mentalizing interventions utilize various tehniques and strategies in making the link between behavior and mental states apparent. *Pausing technique*, focusing on the here and now, *active and explicit acknowledging* of feelings and thoughts, and *stopping non-mentalizing modes*, are most commonly used ways of trying to make the patterns of interaction more understandable. There are various forms of mentalizing based therapies utilizing these techniques (see Midgley & Vrouva, 2011).

*In Nurture and Play- interventions* the Theraplay based playful activities are utilized, but combined with direct reflective work, and a direct focus of parents and children interacting together. Thus, the Nurture- and Play interventionist facilitates and introduces playful sequences but lets the family members do the activities more themselves, without so intensive regulating and modulating as is possible within longer, and more intensive way of working within Theraplay. Thus, it is lighter method than Theraplay, with less sessions and more structe in activating the parental reflective mind within the session. Between activities, there is sc. reflective moment, where more explicit mentalizing based techniques are used. Thus, the reflective loop – 1) noticing and naming a moment, 2)checking the observations, and 3) generalizing (Midgley & Vrouva, 2011), are done within the Nurture and Play sessions (5) as well as between parent sessions (3).

The training includes a 4-days and working with 1 case during the training. During the training playful activities for different ages groups are practiced, as are the principles of conducting mentalizing interviews and utilizing the reflective moments within sessions. Nurture and Play- intervention – both Family and Group versions – are also manualized; i.e., each of the 5 sessions and 3 parent talk sessions are structured within the manual. Hence, the aim is to ensure that the interventions is delivered in similar ways to all families. Obviously, this structured way of conducting the intervention also separetes it from therapy, where all the sessions are invidually modulated and varied along the process according to the needs of any particular dyad.

**Early Intervention and Prevention: Nurture & Play -intervention**

Understanding the key variables underlying healthy early relationships help us in planning and implementing effective early interventions. There are many factors related to problems in early relationships. Psychological illness such as depression and substance-abuse and related psychoscial difficulties may seriously impact parental both emotional availability and reflective functioning in the relationship with the infant. Early timing may also be of importance. The basis for whom and why should the N&P interventions be given is discussed in the trainings. For example, in the Nurture and Play –Groups, mothers scoring beween low to medium risk of prenatal depression AND expressing concerns or worries about the baby of future motherhood were guide to this intervention. Mothers with more serious mental illness risk and/or severe worries relating to their pregnancies would be guided to well-baby clinic psychologists. In Nurture and Play – Family intervention, family social worker may suggest the model, when noticing that parents play little with their children and/or express concern themselves that the are not able to do so. In cases were there are more serious concerns of attachment disturbances etc. the family would be guided forwards, for example to family guidance center.

**Nurture and Play - in practice**

Nurture and Play – intervention focuses on building a template for positive way of relating with the child.. Parents and children are usually met 5-6 times, ca. 60 minutes, and there are additional parent reflective discussions (3-4). Before N&P parents are also interviewed with regard to their representations of past and present important relationships and their capability of understanding mental states and holding mind in mind using a structuren interview.

Nurture and Play - process

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| Pre (ca. 1-2 times) | Sessions (ca. 5-6 times) | Post (ca. 1-2 times) |
| Interviewing parents | 1. Emotional Engagement – affect synchrony2.Nurture – soothing/regulating3.Structure - predictability4.Challenge – developmental organization5.Playfullness – positive arousalParental Mentalization (within the sessions and videoreflections)1.Attention 2.Primary Relatedness 3. Adaptation  | Parental Discussions |

Ordinarily, when the baby expresses and emotion, she is not aware of the emotion category corresponding to the behaviorally expressed internal-state cue and must therefore rely on the mother’s empathetic reflection of the emotion to begin organizing and recognizing emotional states. Fonagy et al. (2002) have called this maternal reflection “marked mirroring” whereby the mothers conveys understanding of the infants internal state by actively responding to it with multimodal affective cues. A foundation for emotional understanding is constructed in this way over time through repetitive contingent interactions with the mother. However, additionally, Fonagy et al. (2002) have proposed that that the mother will ordinarily reflect affect back to the baby in an exaggeratd or ‘marked’ manner, similar, yet marked enough by exaggeration to prevent misattribution of the emotion to the mothers. Over time, the infant will learn to detect and group together internal-state cues that signify distinct emotional states and construct secondary symbolic representations of each emotional state that can be cognitively assessed for the purpose of affect regulation. This social interaction and the processing of affective information are suggested to build on mechanisms of stimulation and embodiment. To understand emotions in others, individuals use their own body and neural body representatons to simulate themselves making the same gestures in similar contexts (Niedenthal & Brauer, 2012), thus synchronizing own behavior with social partner.

In N&P interventionist introduces age-appropriate Theraplay-based activities to the parent and the child. There is much focus on achieving a level of embodied relations where not only the affects but physiological states, and gestures are being mirrored through repeated sequences of bodily games and modifying responses within them according to the partners ques (e.g., modifying responses in row-row-row a boat mirroring the muscular strength or affective expression on the infants face). There is a surprise, activating element behind all the activities designed to promote joint attention and to arouse positive feelings (e.g., peek-a-boo) but the main focus is on activating the maternal mirror system (see Atzil, Hendler, & Feldman, 2013).

As attachment theory highlights, the caregivers ability to detect and accurately respond to infant’s signs of stress are important in the development of internalized stress-regulatory capacity. The biochemical mechanisms explaining this link have been shown to involve oxytocin, which, in turn is related to provision of maternal touch underlying the basic bonding mechanism (Apter-Levy et al., 2013). The therapists helps the parents find, for instance, ways of calming an over-active or restless child by helping the child accept soothing physical closeness and touch. Not only increasing the amount of touch is important. The maternal (or paternal) affectionate style of using touch has been found to be of importance. Thus, maternal touch is increased not by verbal instructions but rather by doing activities together, side by side with the interventionist. In comparison to more in-depth approach in Theraplay, in N&P the focus on nurturing activities tends to much less intense, and parents are always to one’s doing these activities.

The parents’ ability to offer positive guidance is supported by coaching them to directly guide, encourage, and help the child in problematic situations. This occurs in games that are designed to reinforce the child’s self-confidence through success.

Parental mentalizing is supported by helping the parents see and feel situations from the child’s and their own perspective both during sessions and in reflective discussions. There are three goals in this work, 1) increasing parental attention to emotional and behavioral signals during interaction, 2) primary relatedness that focus on parental feelings and thoughts about the interaction, i.e., “Will I be able to have a satisfying and sustainable emotional engagement with the baby?”, and 3) adaptation that focus on recognizing those interactional patterns and infant responses that are healthy and show developmental progress (see also Stern, 2004). During sessions, the therapist wonders actively aloud what the infant might be feeling and experiencing and tries to involve the parent into this wondering. Adult emotional and behavioral responses and modifications to the activities are actively linked to these wonderings, for example by empathetically responding that some activity might have been too strong for the infant (“Let’s do it again more softly”) and helping the parent to adjust his/her response. During reflective discussions the aim is to increase self-understanding through examining parents’ own attachment experiences in relation to the new identity reorganization and current availability of social support (see Stern, 2004). However, this closer inspection of identity reorganization and/or the role of social support in providing a nurturing environment are dealt only in relation to current interaction with the infant and overall the focus is on thinking and feeling more positively about the relationship.

**Nurture and Play –Families**

Nurture and Play – Family intervention sessions last 60 min. They can be conducted in home or clinical settings. Only one parent-child dyad or the whole family can participate. If more than 3 family members, a co-worker is recommended. The sessions are preplanned with the parents after interviewing the parents with a structured Nurture and Play Interview, focusing on parent’s current experience of the relationship with the child. In the sessions 4-6 family activities are conducted together. Between the activities a check-in is done, how the parents/children felt (sk. Reflective moment). The activities are usually kept the same throughout the 5 sessions and they are selected to represent a comibation of soothing/regulating and intensive/playfull Theraplay activities (videorecording is recommendable but not obligatory). Parent discussions are held before and after the 5 sessions process, or if needed, in between the sessions. After the process, families get a reflection back from the interventionist; what kinds of ways of relating seemed to worked best, what where the things family members observed and learned from each other, and whether there is a referral somewhere to do more in-depth working still.

**Nurture and Play –Groups**

Nurture and Play Pregnancy and Baby Groups sessions lasts 1.5 hours. Four mothers and two therapists participate in each group. The groups have a preplanned structure which is manualized (Nurture and Play – Mentalization-Based Play Intervention; Poutiainen & Salo, 2015). In the sessions, we alternate interactional activitivies (e.g., singing to the fetus baby or baby) with reflective talk about pregnancy/infancy, mood, and motherhood. This structure aims to strengthen both the experiental (how the baby is felt, what can be perceived through bodily emotional and somatosensory cues) as well as imaginary (mentalized) relationship with the baby.

Thus, in practice all group sessions during pregnancy included play, talk and homework aiming to increase both the experienced level of positive affection and the capability of reverie, thinking and imagining all the possibilities a new relationship holds. A special emphasis was placed on stimulating the maternal bonding system by using touch (e.g., massage), and here-and-now experiences/reflections (”What might the baby be feeling right know”). All mothers kept a Baby Diary where impressions about the baby, pictures, feelings and thoughts were gathered between the group sessions.

After the babies were born the case workers did a home visit. During this visit the birth experience and intial settling into living with the baby were discussed. The weekly Nurture and Play – Baby Groups started when the babies were about 2 months old. Once again, both reflective talk and Theraplay activities were used in each session. Theraplay actitivies were selected according to the babies’ developmental stage, and reflective discussion themes varied in each session. Mothers also did ’homework’, e.g., observation of the baby.

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|  | Nurture and Play Pregnancy Groups | Nurture and Play Baby Groups |
| TheraplayMentalization | * Singing/playing musical instrument to the baby
* Drawing a picture of the baby
* Relaxation techniques

Reflective DiscussionBaby Diary1) Give space to imaginations (”What kind of mother I want to be”), 2) deal with ambiguity related to pregnancy (”What kind of positive/negative feelings/thoughts have you had about the pregnancy/baby this past week.”) 3) prepare for the actual meeting with the baby (”What will it be like when the baby is born”, ”What is my child going to be like”).  | Activities focused on Theraplay dimensions* Engagement
* Nurture
* Structure / Challenge
* Playfulness

Homework |

**Preliminary Results**

**Baby Magic Project**

A project called Baby Magic was launched in Lahti in Southern Finland in 2011. The project is run by a non-profit organization and has been funded by a foundation for three years. The basic aim of the project was to develop a preventive group-based intervention for mothers with prenatal depressive symptoms screened for depression from the well-baby clinics of Lahti. The three project workers were social and mental health professionals trained in Theraplay as well as mentalization theory and practice. Before launching this project in 2011, there was a pilot feasibility study made in 2010-2011 where the Nurture and Play Group model was developed and practiced with a volunteer group of depressed mothers. During this pilot phase the manual was written and refined.

As the feedback and findings from this pilot were positive, the Baby Magic project was launched in 2011 to study the effectiveness of the intervention in a randomized control trial. The sample consisted of 45 prenatally depressed mothers (Edinburgh Postnatal Depression Scale, or EPDS scores betwen 9-20) screened for depression between 22 - 31 gestational weeks from a community sample from well-baby clinics. Various standardized measurements tapping attachment style (AAI; George, Kaplan, Main, 1985), reflective functioning (PI; Slade,ibid) and interaction (Prenatal MIM-assesment; Jernberg, ibid) with the fetus/baby were conducted pre- and post-intervention. The aim of these interviews and observations was both to gather data and interventive, i.e., to focus on the mothers’ current state of mind and thinking about motherhood. After randomization, 20 mothers participated in Nurture and Play prevention groups which are based on mentalization and Theraplay techniques. There were 4 prenatal and 7 postnatal group meetings plus individual home visit after birth. The purpose of the empirical study is to evaluate the efficacy of this preventive group intervention in 1) enhancing mother-infant emotional interaction and 2) maternal reflective functioning. The empirical results are being analyzed and will be published in an international peer reviewed journal.

The initial feedback from all mothers participating in both Pregnancy and Baby Groups has been positive. Therapists’ experiences have also been positive, especially with regard to stimulating more positive feelings and thoughts about motherhood and more competence and enjoyment of being with the baby. These positive results occurred within the context of maternal depression and related issues such as marital difficulties. The Nurture and Play Group structure with varying emphasis on reflection and experiencing has also received positive feedback. The results of the RCT study design and currently being reported, and will be presented for the first time in WAIMH/Prague 2016 (World Infant Mental Health Congress).

**Current praxis in Finland**

N&P for families, and groups models have now been pilot trained for ca 40 professionals in separate trainings for both models. The trainers have all been Theraplay Trainers, trained also to use mentalizing techniques. The training model as well as the actual N&P model have been manualized. The trainees have mainly been professional working at the primary mental health care level or social family case workers.

**Thoughts**

Working with N&P has been helpful lowering the bridges between early preventive work and more in-depth therapeutic intervention work. The pilot trainings for multiple professionals and their experiences of utilizing the model have been promising. The direct way of involving the child, the practical ’tools’ of using play activities, and having a clear focus what to talk with the parents (reflective theory) have helped to keep the focus really in the interaction. Families in need have also been more motivated to get more intensive help (such as Theraplay therapy) after the intervention.

As trainers, we have felt that after modifications, the training model is now good; not too difficult and too heavily focused on theory and/or more in-depth relational therapeutic phenomena but giving the participants the needed framework and, especially, clearly modelled and structured way of working with families.

In the trainings we give a lot emphasis on not to try this model with too difficult/traumatized families.

We feel hopeful that the N&P interventions could spread, and become as a routine ways of giving the *first-hand prevention to many families* – and also being a gateway for more intensive therapies for families in need.

The results of the first RCT are prominings and should warrant attention of the political deciders of what interventions should be trained to mental and social health care workers in Finland more broadly (as opposed to current mix of sk. intervention preventions with no studies behind and mostly focusing on improving parental mental-health by parent-discussions only).

In training and applying the preventive model it is also important to keep a clear distinction to Theraplay, and to other forms of psychotherapy; when needed, families should always be guided into these more in-depth ways of imporoving relationship.

**References**

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of Attachment: A Psychological Study of the Strange Situation. Hillsdale, NJ: Erlbaum.

Apter-Levy, Y., Feldman, M., Vakart, A., Ebstein, R. P., & Feldman, R. (2013). The Impact of Maternal Depression Across the First 6 Years Of Life on the Child’s Mental Health, Social Engagement and Empathy: The Moderating Role of Oxytocin. American Journal of Psychiatry, 170, 1161-1168.

Atzil, S., Hendler, T., & Feldman, R. (2013). The Brain Basis of Social Synchrony. Social Cognitive and Affective Neuroscience, 20, 2-10.

Bartz, J. A., Zaki, J., Bolger, N., Ochsner, K. N. (2011). Social Effects of Oxytocin in Humans: context and person matter. Trends in Cognitive Science, 15, 301-309.

Benoit, D., Parker, K.C.H., & Zeanah, C.H. (1997). Mother’s Representations of Their Infants Assessed Prenatally. Stability and association with infant’s attachment classifications. Journal of Child Psychology and Psychiatry, 38, 307-313.

Booth, P., & Jernberg, A. (2010). Theraplay – Helping Parents and Children Build Better Relationships through Attachment-based Play, third edition. Jossey-Bass.

Broden, M. (2011). Graviditetens möjligheter. Natur och Kultur.

Bonari, L. et al. (2004). Perinatal Risks of Untreated Depression During Pregnancy. Canadian Journal of Psychiatry, 49, 726-735.

Boykydis, Z. (2012). Pre- and Perinatal Intervention for Substance-abusing Mothers. In: N. Suchman, M. Pajulo, & L. C. Mayes. Parenting and Substance Abuse. (Pp- 211-235. Oxford: New York.

Field, T. (2010). Postpartum Depression Effects on Early Interactions, Parenting and Safety Practices: A review. Infant Behavior and Development, 33, 1-6.

Field, T., Diego, M., & Hernandez-Reif, M. (2010). Prenatal Depression Effects and Interventions: a review. Infant Behavior and Development, 33(4), 409-418.

Flykt, M., Punamäki, R.L., Belt, R., Biringen, Z., Salo, S., Posa, T., & Pajulo, M. (2012). Maternal Representations and Emotional Availability among Drug-abusing and Non-using Mothers and their Infants. Infant Mental Health Journal, 33(2), 123-138.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). Affect Regulation, Mentalization, and the Development of the Self. Other Press, NY.

Fraiberg, S., Adelson, E., Shapiro, V. (1975). Ghosts in the Nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. Journal of the American Academy of Child and Adolescent Psychiatry, 14(3), 387-421.

George, C., Kaplan, N., & Main, M. (1985). Adult Attachment Interview. Unpublished manuscript. University of California at Berkely.

Goodman, S. H.& Gotlib I. H. (2002). Children of Depressed Parent. Mechanisms of Risk and Implications for Treatment. Washington, DC, American Psychological Association.

Houdenhove, B. V., & Luyten, P. (2008). Customizing Treatment of Chronic Fatigue Syndrome and Fibromyalgia: the role of perpetuating factors. Psychosomatics, 49(6), 470-477.

Jernberg, A. (1982). Prenatal MIM-assessment. The Theraplay Institute.

Jernberg, A. (1988).Promoting Prenatal and Perinatal Mother-child Bonding: a psychotherapeutic assessment of parental attitudes. In Prenatal and Perinatal Psychology and Medicine: A comprehensive survey of research and practice, ed. P. Fedor-Freybergh and M.Vogel, 253-266.

Kaplan, L.A., Evans, L. & Monk, C. (2008). Effects of Mothers’ Prenatal Psychiatric Status and Postnatal Caregiving on Infant Biobehavioral Regulation: Can prenatal programming be modified? Early Human Development, 84, 249-256.

Kogan, N., Carter, A. S. (1996). Mother-infant Re-engagement Following the Still Face: the role of maternal emotional availability and infant affect regulation. Infant Behavior and Development, 19(3).

Luyten, P., Fonagy, P., Lemma, A., & Target, M. (2012). Depression. In: Bateman, A., & Fonagy, P. Handbook of Mentalizing in Mental Health Practice. (pp. 385-419). APA: London.

Marschak M. A Method for Evaluating Child-Parent Interaction Under Controlled Conditions. Journal of Genetic Psychology 1960; 9: 3-22.

Niedenthal, P. M., & Brauer, M. (2012). Social Functionality in Human Emotion. Annual Review of Psychology, 63(1), 259-285.

Salo, S., Flykt, M., et al. (2016). Interrelations of prenatal reflective functioning, adult attachment, and mother-fetal attachment among depressed mothers. Manuscript submitted.

intervention for pregnant mothers.

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & human development*, *7*(3), 269-281.

Slade, A., Grienenberger, J., Bernbach, E., Levy, D., & Locker, A. (2005). Maternal reflective functioning, attachment, and the transmission gap: A preliminary study. *Attachment & Human Devlopment*, *7*(3), 283-298.

Slade, A., Patterson, M., & Miller, M. (2007). Pregnancy Interview. Unpublished manuscript. City College of New York.

Stern, D.N. (1985). The Interpersonal World of the Infant. New York: Basic Books.

Stern, D.N. (1995). The Motherhood Constellation. New York: Basic Books.

Steinmetz, S. K. (1987). Family Violence. In: M.B. Sussman & S.K. Steinmetz (Eds.), Handbook of Marriage and the Family (pp. 725-765). New York: Plenum Press.

Van Doesum, K., Hosman, M., Riksen-Walraven, J., Hoefnagels, C. (2007). Correlates of

Depressed mothers’ Sensitivity Toward their Infants: the role of maternal, child, and contextual

characteristics. Journal of the American Academy of Child and Adolescent Psychiatry, 46, 747-756