A publication of the Canadian Association for Play Therapy (CAPT)

Playground

Spring/Summer 2019

Daring to Play

Reflections on my Play Therapy Assistant

Play Therapy with Children Affected by Conflictual Divorce

Nature Play Therapy: When Nature Comes Into Play

CANADIAN ASSOCIATION FOR PLAY THERAPY

Cutting Edge Training in Play Therapy

CAPT Foundation Play Therapy Training

The Canadian Association for Play Therapy (CAPT) presents cutting-edge training in Play Therapy throughout the year across Canada.

Training will be presented in one- or two-day trainings with individual instructors over a period of six weeks. Each day offers 6 educational units toward the 180 educational units required for Foundation Play Therapy Training for Certification as a Play Therapist.

Courses are offered in the following location:

- Toronto, Ontario: July 8 to August 16, 2019

The application deadline for the CAPT Foundation Play Therapy Training is:

- May 15, 2019

Apply soon as classes fill up quickly! Applications are accepted after the deadline for an extra $100 fee but priority is given to those who apply by the deadline.

If you are interested in applying for an individual training, there will be limited space, so you are encouraged to register early. You are welcome to sign up for as many of the individual days as you wish.

Some of our cutting edge courses include:

- Understanding Traumatized Children and Applying Play Therapy Tools in the Treatment of Trauma in Children
- Treating Disruptive Behavior Disorders
- Understanding and Treating Anxious Children Using Play Therapy
- Play Therapy With Abused Children
- Play Therapy for Children and Families Coping with Loss
- Using Sandtray in Play Therapy
- Attachment Theory and Play Therapy
- Using Theraplay in Play Therapy
- Family and Group Play Therapy
- Art in Play Therapy

For further information on courses or on becoming certified as a Play Therapist, please visit our Education webpage under **Education and Certification** at:

www.canadianplaytherapy.com

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Playground

Canadian Association for Play Therapy

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Message from the President

Dear Members,

I hope that this finds each of you well. I am pleased to share with all of you that 2019 has gotten off to a great start for CAPT. Our Board, Management Team, and Committee Members hit the ground running and it is sure to be great year ahead.

Our 2019 training is getting ready to kick off. WOW what a line up we have this year! The relevance and richness of the training being offered is a strong reflection of the incredible talent, skill, and commitment to children and families that lies within the CAPT community. With every decision made in both our foundational training and 3 day certificate programs, the Instructors, Committees, Board, and Management Team have worked tirelessly to ensure that the mission of CAPT is upheld through high standards and cross national training. I encourage each of you to take a look at the 2019 calendar if you haven't already and to share the training opportunities with your colleagues and community. Together, we can all help in the promotion and advancement of play therapy and create greater capacity. This will not only support our association in thriving but ensure that play therapy is accessible to all person across our great nation.

The Board continues to be active in what seems to be a continual evaluation of CAPT processes, standards, and policies. We live in an ever changing world and the landscape has certainly changed over the years since CAPT's inception. As such, the need to re-assess and reflect on these areas has been necessary in order to ensure that CAPT remains relevant and thriving as an Association. As a Board we would like to thank all of you who have taken the time to make your needs known and assisted us in recognizing how we can continue to grow and strengthen as an Association.

We are only a few shorts weeks away from our AGM and Conference. It is my sincere hope that you will come and play with us in Niagara Falls. The AGM provides all of you the opportunity to hear firsthand all that has gone in the past year, to have a voice in decisions that are brought to the members, to ask questions and get to know Board Members, the Management Team, and fellow CAPT members. We are so excited that this year's training on treating anxiety using family play therapy, yoga, meditation and mindfulness for children and families is being offered and know that everyone who attends will benefit greatly. See you there!

Happy Reading in the pages that follow!

Nadine Hill-Carey

President, CAPT

Update from your Executive Director

Spring 2019,

What a winter from coast to coast in Canada! I think we're all anxious to see some consistent sunshine and feel the warmth of Spring and Summer.

Despite the inclement weather, the Board of Directors engaged in some meaningful conversation and discussion over the past few months on several significant issues. We are experiencing some very challenging times in our association as legislation for mental health services changes across the country. CAPT is focussing on improving standards and serving our members with products and services that help show tangible results in the practice of play therapy. Our goal is to remain the first line professional support to you as you go about your daily work with children and families.

Thank you to all of those who took the time to complete our survey over the past year about training requirements. It was so helpful to know which modalities of play therapy you would benefit from in your work and your specific region of Canada. Also, to know that CAPT is generally on track with topics that are highest on your lists. We will continue to reach out to you for your advice on these and other topics of importance in our association.

We state in our Playground article the difference between the College that regulates mental health practices and the Professional Association. CAPT is in place to speak on behalf of play therapists and be the voice of the members for the profession federally. But this doesn't happen without your input and support. You are the voice and an important part of the ongoing conversation! Our CAPT volunteers are doing their best to grow and support the existing programs and services in Canada. We need more help on Committees, task forces and various CAPT activities across Canada.

Our CAPT Core of Ambassadors in Canada needs more members to support the promotion of CAPT in your region at high schools, colleges and universities as well as at agencies, institutions and special events. Please contact me at Elizabeth@cacpt.com if you are interested in becoming a CAPT Ambassador. All the supports are in place to ensure that you receive some compensation and provided with materials you require to do a good job. It is a wonderful stepping stone to leadership in the association and you will meet some very interesting and knowledgeable people in your travels as an Ambassador.

We look forward to seeing you at our Annual General Meeting in Niagara Falls, ON on May 3, 2019. We are excited to present our member and colleague, Tina Lackner CPT who will share her amazing expertise and deliver a 3-day Certificate on Treating Anxiety Using Family Play Therapy, Yoga, Meditation and Mindfulness . We return this year to the Doubletree Fallsview Hotel, Spa and Conference Center, a wonderful healing space, for some reconnecting with old friends, meeting new, and to delve into some current learning.

I look forward to seeing you there!

Elizabeth A. Sharpe CAE

Executive Director

Reflections on my Play Therapy Assistant

By Lucy Llewellyn

First published in British Association of Play Therapists Play Therapy Magazine, Issue Number 86, Summer 2016.

Lucy Llewellyn is a Certified Animal Assisted Play Therapist ™ from the UK. She has been trained by Dr Rise VanFleet and Tracie Faa-Thompson of the International Institute for Animal Assisted Play Therapy ®.

Play therapists in Canada are likely familiar with the work that Marie-Jose Dhaese has done with her standard poodles in play therapy.

Lucy is a member of the British Association of Play Therapists.

Here she shares with us her experiences of working with a dog in her playroom.

As my assistant is heading for retirement. I am musing on the specialness she has brought to our Play Therapy sessions and how she ignited the spark that jump started the therapeutic process.

Lykke (pronounced Luca) has golden hair, big brown eyes, a big button nose and four legs! She is a rescued Lurcher, whose warmth towards children and quirky personality has endeared her to many.

Lykke and I have trained with Dr Risë VanFleet and Tracie Faa-Thompson to become a Certified Animal Assisted Play Therapy™ team. This is so much more than having a nice dog, just as Play Therapy is much, much more than playing with children. The courses are hard work, intensive and great fun. I particularly like that Animal Assisted Play Therapy ™ considers the dogs strengths and likes, so it is mutually enjoyable for the dog and child. It is a great model for developing relationship skills and considering another's feelings as well as your own.

Some of the dogs I have met at the trainings are high energy, whose skills are in agility and learning new tricks. Others are more laid back and enjoy being groomed and read to.

Lykke is who she is. She has learnt some play skills and will drink from the tea cups at a tea party, roll the dice in board games and search for the child if they hide. She can set off a police siren to call for help and operate a shop till. She is active in the sessions and sometimes she decides just to lean against a child and be with them. This really helped an ADHD child we were working with to focus and become more grounded. Lykke is off lead during the play therapy sessions so she chooses how she wants to engage.

Lykke also brings spontaneity into the work. In a very traumatic session, the child was playing through a terrible storm where the wind blew, the rain caused rivers to form and the family all got separated and lost, she became my reflecting partner. Together we looked into the sand tray, and I reflected the play by telling Lykke about the terrible storm, how the children were lost, how they were just about to be rescued when the bridge broke and they were swept away… We had a conversation about how worried we were…it was just awful…the baby was gone…..and so on. Lykke then surprised me by stepping into the sand tray and digging the baby out. This was unplanned and I reflected to the child it was so awful that Lykke couldn't bear it (but I could put the baby back and Lykke could sit elsewhere if the child preferred). The child was overjoyed at being found. She named it "she found me!" This was a very significant point in the child's therapy and the child went on to embody the "lost baby". Lykke was initially the one to "prepare" the baby's bottle and provide nurture. The attachment relationship for the child started with Lykke, then generalised to me and to the adoptive family.

We have worked mainly with children who are looked after or adopted, aged 3-17. Some are too traumatised to trust an adult, let alone want to go into a room alone with one. These children do not come to work with me, however, as their focus is on working and building their attachment with Lykke. This then generalises to include me and other humans in their network. We have seen some amazing results. Our approach is child centred and mostly child led, though I do need to ensure the play is mutually enjoyable and safe for the children and for Lykke.

Lykke is who she is. She has learnt some play skills and will drink from the tea cups at a tea party, roll the dice in board games and search for the child if they hide. She can set off a police siren to call for help and operate a shop till.

In addition to children with other difficulties, we have worked with children who have hurt animals and who lack empathy or don't recognise their actions could be hurtful. In a more directive way we have covered touch and keeping safe, learning how to groom Lykke and watching what she likes, nurturing her with food and water, and learning how to make friends and keep them.

The AAPT training covers introducing children to dogs, how to keep safe and understand canine body language. I am always close by to ensure both the dog and child are enjoying the interaction and if I see stress signals, I can point out that Lykke is starting to look uncomfortable, allowing the children to change their behaviour or for me to intervene.

Lykke also has some "problems" for which I can ask the child for help. Lykke gets worried meeting new dogs, so

the child and I can brainstorm what I could do to help her when she gets worried or scared. Often the children we see do have trouble understanding the rules of friendships and meetings, so they have some great ideas.

A new "problem" Lykke has developed is copying her cousin dog. Her cousin, Poppet, is much more outgoing than she and doesn't mind getting in trouble. Poppet steals things she thinks no one wants. She pulls things out of the bin and eats them. Poppet was an abandoned dog who never got enough to eat and she just can't stop worrying about food. The other day, I found Lykke under the table eating broccoli out of the food recycling. With this story, based on the truth, I can ask a child for suggestions about what I can do to help Lykke be strong enough not to copy Poppet. I was actually quite happy that Lykke was eating veg!

Lykke's background as a dog who wasn't wanted, was moved from birth family to a rescue, was adopted, then returned, resonates with many children. They cannot understand why such a lovable dog had so many placement moves. Again, this is often their own experience and it can help them recognise that it is not their fault when placements don't work out. It can also give hope that the right home will come along, where they can be valued and appreciated for who they are.

It is hard to describe how much Lykke's involvement has brought a new dimension to the therapeutic process. Research has shown how involving an animal helps release oxytocin, the bonding hormone. It is the human therapist, however, who enables the sessions to work so well.

People who know me know how passionate I am about the therapeutic benefits of including animals in Play Therapy. I am very clear, however, that to do this both safely and ethically, it is essential to know what you are doing. I would highly recommend attending the Animal Assisted Play Therapy™ training run by Dr Risë VanFleet and Tracie Faa-Thompson. They provide this training worldwide. They ran the Level 1 training on Vancouver Island in 2018 (see photo below).

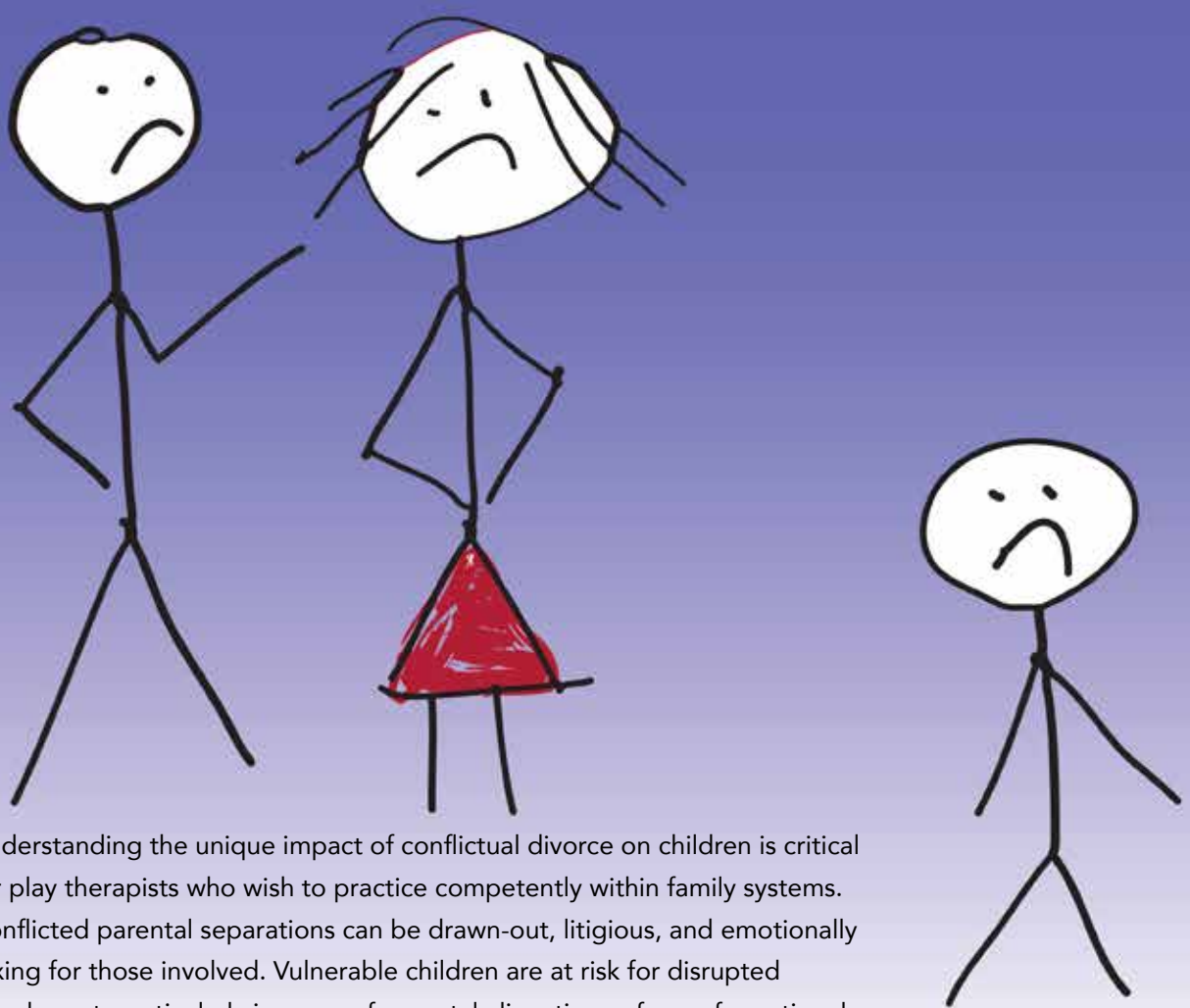
The training encompasses online theoretical training, in-person training with dogs and horses, followed by supervision leading to Certification. I became a Certified Animal Assisted Play Therapist in 2015.

Information can be found on the website for the International Institute for Animal Assisted Play Therapy ® (www.iiaapt.org) and in the book Animal Assisted Play Therapy by Dr Rise VanFleet and Tracie Faa Thompson which is available on the website.

The Canadian Association for Play Therapy (CAPT) is honoured to welcome Dr. Eric Green at the 2020 Annual General Meeting and Conference in Winnipeg, Manitoba, May 1, 2 & 3, 2020. Dr. Green will present a 3-day training on Play Therapy for Teens and Pre-teens. Be sure to mark your calendars for this training!

Play Therapy with Children Affected by Conflictual Divorce

By Eric Green Ph.D., LPC-S, RPT-S



Understanding the unique impact of conflictual divorce on children is critical for play therapists who wish to practice competently within family systems. Conflicted parental separations can be drawn-out, litigious, and emotionally taxing for those involved. Vulnerable children are at risk for disrupted attachment, particularly in cases of parental alienation, a form of emotional maltreatment present in many high-conflict families.

Research highlights the importance of the parent-child relationship, suggesting that it is the strength of the attachment, not the level of conflict between parents, which influences the impact of the divorce on the child's development, mental health symptoms, and well-being.

The integration of play therapy and experiential family systems techniques may be beneficial when working with children and parents experiencing low to moderate conflict separation and divorce. In cases of high conflict divorce (i.e., those hallmarked by protracted and contentious litigation), traditional psychotherapy is counter-indicated. Reunification therapy, where targeted parents and their kids are reunited over a 4 day/intensive, shows promise as being recognized as a legitimate treatment modality within the psychotherapy community. Through creative activities, children and parents can identify and strengthen aspects of their attachment relationship as well as recreate positive experiences of familial attachment and belonging.

Parental Divorce

The decision to divorce is a difficult one made by roughly one half of married couples. Resource-related stressors and changes can cause conflict between parties, at least initially, and for the many who are parents (American Academy of Child and Adolescent Psychiatry, 2017), ongoing contact with their former spouse is a stressful reality (Kelly, 2000; Saini, 2012). For the majority of couples, the conflict stays fairly low or diminishes over time as everyone adjusts to their new lives apart (Saini, 2012); however, a minority experience high-conflict. High-conflict divorces encompass a combination of "persuasive negative exchanges and the presence of a hostile, insecure emotional environment" (Mutchler, 2017). Conflict does not decrease; rather, it may even increase over time. These parents often demonstrate enduring hostility and criticism, engage in protracted, lengthy litigation, and triangulate their children (e.g., Amundson & Lux, 2016; Smyth & Moloney, 2016). Cases involving high-conflict parents tend to be complex, time-consuming, and costly, both emotionally and financially, for those involved (e.g., Saini et al., 2012).

The impact of high-conflict divorce on children depends on the presence or absence of protective factors, including resources available and clear communication/understanding of the divorce, as well as the risk factors to which the child is exposed. Children in these cases are at risk for temporary or long-term problems surrounding anxiety, emotion dysregulation, depression, social difficulties, and academia. The parent-child relationship also stands to suffer greatly (Davies & Woitach, 2008). Children are at risk for losing access to one parent, feeling a decline in parental support, experiencing stress associated due to ongoing exposure to conflict between the parents. Parents are often struggling with their own feelings of hurt and grief. They may not have the emotional resources to attend to their children's needs and may turn away from, dismiss, or ignore the emotional needs of their children. When parents are not able or willing to meet their child's needs, behavioral and emotional problems may arise and parental demands increase (e.g., Sandler et al., 2008). Parents who already do not have the emotional resources to parent effectively are placed in a position where they then must parent a child who is struggling; thus, a negative cycle is set into motion (e.g., Davies & Woitach, 2008; Sandler et al.). On the opposite end, parents may deny that their child is struggling and instead prefer to believe they are strong, resilient, and insulated from the divorce and its impact (Chirban, 2018). In these cases, children may feel silenced or as if no one cares about their hurt.

These negative outcomes not only impact the parent-child attachment but also mastery in other related developmental areas for the child. When a parent is struggling and is unable to provide consistency, unconditional positive regard, and emotional stability for the child, the child may have difficult regulating emotions and successfully interacting with peers (Kerns & Brumariu, 2014). For example, attachment anxiety in adulthood has been linked to parental divorce in early childhood (e.g., Fraley & Heffernan, 2013), and when high-conflict divorce and parental alienation are added factors, the ability to form healthy, secure attachments is diminished even further (Feeney & Monin, 2008).

Through creative activities, children and parents can identify and strengthen aspects of their attachment relationship as well as recreate positive experiences of familial attachment and belonging.

Parental Alienation

Parental alienation is a form of emotional maltreatment administered through psychological control that occurs in the midst of and after high-conflict separation and divorce (Baker, 2007; Baker & Fine, 2013). In cases of parental alienation, one parent (alienating parent)

intentionally or unintentionally encourages a child to distance him/herself from the other parent (targeted parent), to experience fear or discomfort when around the distanced parent, and to avoid contact with the parent (Darnall, 2011). A defining feature of alienating behaviors is the goal of terminating the relationship between the child and the targeted parent without reasonable or proportionate justification. Note that a child rejecting a parent in response to abuse or neglect is not considered alienation; rather, rejection on reasonable grounds is considered estrangement (Garber, 2011; Gardner, 2001; Reay, 2015). Some have suggested that maladaptive adult attachment patterns make it difficult for one or both parents to tolerate and cope with the loss of the relationship (Saini, 2012). In this way, high-conflict allows for ongoing interactions and an emotional relationship, albeit a negatively charged one. Parents suffering from insecure attachment may be unable to cope with their own hurt, disappointment, and grief following the dissolution of the marital relationship, leading to ongoing conflict. Despite an ongoing debate in the mental health and legal fields that Parental Alienation Syndrome exists, there is consensus that parental alienation and related behaviors does occur (e.g., Baker, 2007; Kelly & Johnston, 2001; Meier, 2009; Walker & Shapiro, 2010).

There is no definitive set of behaviors that constitutes parental alienation, as cases tend to be varied and complex and either parent can be the alienating or targeted parent. Nevertheless, Evans and Bone (2011) have talked about clusters of behaviors, tactics and family presentations commonly present in alienating situations that make the identification and understanding of such family dynamics possible. They have suggested that at times, it may feel to professionals as if the close parents are working off a "published playbook." Baker & Fine (2013) provides 17 common strategies that fall into five categories. The first is the provision of poisonous messages to the child about the targeted parent in which he/she is portrayed as unloving, unsafe, and unavailable. The second involves limiting contact and communication between the child and the targeted parent. The close parent may isolate the child such that he/she is only in contact with others who have bought into the close parent's view. In some cases the close parent may be unintentionally engaging in alienating behaviors, perhaps as an ego defense mechanism against the pain of his/her divorce, but family or friends may perpetuate the beliefs and ultimately strengthen them, even in the absence of the close parent. The relationship and shared time between the child and the distanced parent is often minimized, time together is blocked by the parent, and children are given the choice of whether or not they would like to participate in visits. Alienating parent or child behaviors that undermine the authority of the targeted parent. Disrespect towards the distanced parent, or otherwise encouraging the child to betray the distanced parent and their relationship together, is another category of alienating behaviors. Finally, the close parent aims through words and actions to effectively erase and replace the distanced parent in the heart, mind, and daily life of the child. For additional resources and behaviors, see Lorandos, Bernet, and Sauber (2013) and Childress (2015).

The Role of Play Therapy

Play therapy and the integration of experiential family systems techniques can be useful when working with children affected by conflictual families (Judge & Bailey, 2017). This developmentally-appropriate method of treatment permits the child to experience a place of belonging, free from shame, judgment, or rejection.

Play therapy facilitates the development of a therapeutic alliance built upon a trusting, emotionally safe relationship between the child and the therapist (Green, 2009). Such a trusting relationship assists children by:

- cultivating a therapeutic bond of empathy that empowers the child to practice self compassion toward themselves and others
- creating a place for safe expression
- carefully challenging and correcting distorted or inaccurate narratives formulated by alienating parents and introjected by children
- recover connections with former relationships with less favored parent and extended family members in cases of parental alienation
- overcoming challenges and considering solutions in a non-verbal way
- encouraging open communication when distrust, shame, or disbelief have historically been a part of interactions
- promoting new relational patterns

(Gil & Sobol, 2005; Green, 2009; Green & Myrick, 2014; Judge & Bailey, 2017). Judge and Bailey (2017) discuss the use of simple activities within family sessions that can facilitate open, productive communication, or at least begin shining a light on the challenges while minimizing defensiveness. In one activity, they recommend incorporating an oversized ball of string into discussions about communication patterns within the family. Each time someone speaks, they hold the ball of string. When they are finished, they throw the ball to the next person who speaks. The authors note that, very quickly, a visual representation of communication patterns emerges; that is, everyone in the room can recognize and discuss who talks to who, and who is being left out. Future sessions can include literally and figuratively untangling these patterns. Baggerly and Green (2015) recommend family art projects, such as a family storybook that outlines the family's past before divorce, present situation, and future possibilities. In one activity, aimed at teaching children that they are free to love both parents, the child creates a "passport" with a picture of him/herself and a page dedicated to both parents. On each parent's page, the child writes things he/she likes about that parent and his/her relationship with that parent. On the last page, the child and therapist write a list of "rights", including the child's right to love and be loved by both parents and to have a relationship with both parents.

In additional to providing a means to develop meaningful connections with internal and external experiences, restore attachment bonds, and promote new relational patterns that foster safe disclosure (Judge & Bailey, 2017; Myrick & Green, 2013), play therapy has also demonstrated to be an effective treatment for reducing many of the secondary emotional and behavioral issues seen in children experiencing conflictual divorce including anxiety, grief, aggression, and social problems (see Kool & Lawver, 2010 for review). One highly engaging individual play therapy intervention involves using an air hockey game as a symbol of the child's feelings of going back and forth between parents and homes. After creating an air hockey "rink" and using straws to blow the "puck" back and forth, the therapist and child spend some time identifying thoughts and feelings related to going back and forth. Instructions for creating the air hockey rink and some questions that can accompany the game are available (Lowenstein, 2006).

Conclusion

Conflictual divorce can be emotionally draining for all of those involved, including children. Such drawn-out legal battles place children at-risk for disrupted attachment from one or both parents, mental health symptoms, and decreases in overall psychosocial functioning. Research has consistently highlighted the role that healthy parent-child relationships play in a child's adjustment to the divorce and success in other developmental areas. By integrating play therapy with family therapy techniques, families can repair or reinforce attachment bonds before, during, or after high-conflict separation and divorce. Integrating play and experiential therapies can also help children become in- sync with their inner selves, harness their creativity, experience acceptance and belonging, and develop effective emotion regulation and coping skills (Green, 2009; van der Kolk, 2014).

References

American Academy of Child and Adolescent Psychiatry (AACAP). (2017, January). Children and divorce. Retrieved January 29, 2019 from https://www.aacap.org/aacap/families_and_youth/facts_for_families/fff-guide/Children-and-Divorce-001.aspx

Amundson, J.K., & Lux, G.M. (2016). Risk management in high-conflict divorce/parenting referrals: It's how you walk through the fire. Canadian Journal of Counselling and Psychotherapy, 50(3), S10-S22.

Baker, A.J.L. (2007). Adult children of parental alienation syndrome: Breaking the ties that bind. New York: W.W Norton.

Baker, A.J.L., & Fine, P.R. (2013). Surviving parental alienation: A journey of hope and healing. Lanham, Maryland: Rowman and Littlefield.

Baggerly, J., & Green, E. (2015). Play-based family counseling for children in divorced or blended families. In E.J. Green,

J.N. Baggerly, and A.C. Myrick (Eds.), Counseling families: Play-based treatment, pp.127-144, Lanham, Maryland: Rowman and Littlefield.

Childress, C.A. (2015). An attachment-based model of parental alienation: Foundations. Pasadena, California: Oaksong Press.

Chirban, J. (2018, June). Parenting quality needed most during divorce. Retrieved January 31, 2019 from https://www.psychologytoday.com/us/blog/age-un-innocence/201806/quality-parenting-needed-most-during-divorce.

Darnall, D. (2011). The psychosocial treatment of parental alienation. Child and Adolescent Psychiatric Clinics of North America, 20(3), 479-494.

Davies, P. T., & Woitach, M. J. (2008). Children's emotional security in the interparental relationship. Current Directions in Psychological Science, 17, 269–274.

Evans, R.A., & Bone, J.M. (2011). The essentials of parental alienation syndrome. Palm Harbor, Florida: Center for Human Potential of America.

Feeney, B. C., & Monin, J. K. (2008). An attachment-theoretical perspective on divorce. In J. Cassidy & P. R. Shaver (Eds.), Handbook of attachment: Theory, research, and clinical applications (pp. 934-957). New York, NY, US: Guilford Press.

Fraley, R.C., & Heffernan, M.E. (2013). Attachment and parental divorce: A test of diffusion and sensitive period hypotheses. Personality and Social Psychology Bulletin, 39, 1199-1213.

Garber, B. D. (2011). Parental alienation and the dynamics of the enmeshed parent–child dyad: Adultification, parentification, and infantilization. Family Court Review, 49(2), 322-335.

Gardner, R. A. (2001). Should courts order PAS children to visit/reside with the alienated parent? A follow-up study. American Journal of Forensic Psychology, 19, 61–106.

Gil, E., & Sobol, B. (2005). Engaging Families in Therapeutic Play. In C. E. Bailey (Ed.), Children in therapy: Using the family as a resource (pp. 341-382). New York, NY, US: W. W. Norton & Company.

Green, E. J., & Myrick, A. C. (2014). Treating complex trauma in adolescents: a phase-based,integrative approach for play therapist. International Journal of Play Therapy, 23(3), 131-145.

Green, E.J. (2009). Jungian analytical play therapy. In K.J. O'Connor & L.D. Braverman (Eds.), Play therapy theory and practice: Comparing theories and techniques (2nd ed.), 83-122.

Hoboken, NJ: John Wiley & Sons.

Judge, A. & Bailey, R. (2017). More than words: The use of experiential in the treatment of families with parent-child contact problems and parental alienation. In A. Judge and R. Deutsch, Overcomingparent-child contact problems: Family-based interventions for resistance, rejection, and alienation (pp. 91-103). New York: NY: Oxford University Press.

Kelly, J., & Johnston, J., (2001). The alienated child: A reformulation of parental alienation syndrome. Family Court Review, 39(3): 249-266.

Kerns, K.A., & Brumariu, L.E. (2014). Is insecure parent-child attachment a risk factor for the development of anxiety in childhood and adolescence? Child Developmental Perspectives, 8(1), 12-17.

Kool, R., & Lawver, T. (2010). Play therapy: Considerations and applications for the practitioner. Psychiatry, 7(10), 19-24.

Lorandos, D., Bernet, W., & Sauber, S. R. (Eds.). (2013). American series in behavioral science and law. Parental alienation: The handbook for mental health and legal professionals. Springfield, IL, US: Charles C Thomas Publisher.

Lowenstein, L. (2006). Creative interventions for children of divorce. Toronto, Canada: Hignell Book Publishing.

Meier, J. S. (2009). A Historical Perspective on Parental Alienation Syndrome and Parental Alienation. Journal of Child Custody, 6(3–4), 232– 257.

Myrick, A. C. & Green, E. J. (2013). A play-based treatment paradigm for nonoffending caretakers: Evidence-informed secondary trauma treatment. International Journal of Play Therapy, 22, (4), 193-206.

Mutchler, M. S. (2017). Family counseling with high-conflict separated parents. The Family Journal, 25(4), 368-375.

Reay, K. M. (2015). Family reflections: A promising therapeutic program designed to treat severely alienated children and their family system. The American Journal of Family Therapy, 43, 197–207.

Saini, M. (2012). Reconceptualizing high-conflict divorce as a maladaptive adult attachment response. Families in Society: The Journal of Contemporary Social Sciences, 93(3), 173-180.

Saini, M., Black, T., Lwin, K., Marshall, A., Fallon, B., & Goodman, D. (2012). Child protection workers' experiences of working with high conflict families. Children and Youth Services Review, 34, 1309–1316.

Sandler, I., Miles, J., Cookston, J., & Braver, S. (2008). Effects of father and mother parenting on children's mental health in high and low-conflict divorces. Family Court Review, 46(2), 282-296.

Smyth, B.M., & Lawrence, J.M. (2017). Entrenched postseparation parenting disputes: The role of interparental hatred? Family Court Review, 55(3), 404-416.

Walker, L.E., & Shapiro, D.L. (2010). Parental alienation syndrome: Why label children with a mental disorder? Journal of Child Custody, 7, 266-286.

van der Kolk, B. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. New York, New York: Penguin Books.

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Daring to PLAY

By Dafna Lender

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The Challenge of Embracing Our Youngest Clients

Children need our help. According to the Centers for Disease Control and Prevention, 1 in 7 young children have a diagnosed mental, behavioral, or developmental disorder, and that number goes up to one in five after age nine. Yet despite the fact that they make up nearly a quarter of the population, children are rarely a central part of therapists' practices. In fact, nearly every state in the nation – 43 of them, to be exact – is facing a severe shortage of child mental health practitioners. If my experience is any indication, most beginning therapists are also offered little to no basic training in clinical work with kids. Why is this? The kinds of interventions that are most effective with children are based in play, and maybe that seems somehow less than professional, not so sophisticated, a little embarrassing. So play therapy gets relegated to a kind of cheerful corner of practice, while purportedly deep and transformative adult-centered talk therapies take up most of the field's floor.

For me, who's made a career out of therapeutic play and seen profound clinical results, this is unfortunate. Play is a remarkably powerful therapeutic tool, backed up by cutting-edge research, and teaching families how to apply it at home can bring about profound systemic changes. Because play allows children to relate through something other than the confusing terrain of adult language, and instead engage in a mode of being that they've already mastered, family therapists could be more effective if they added it to their repertoires.

I didn't set out to practice psychotherapy with children. Work in a child welfare agency was the first job I stumbled into out of graduate school. Although it turned out to be the best residency I could've wished for, the

pay was bad, and I was overwhelmed by the gamut of the child welfare process I worked: from kids who lived with their mentally ill, drug-addicted biologic parents, to kids who were in foster care but visited their parents with the hope of returning home, to kids who were adjusting to an adoptive home because their birth parents had been deemed unfit or were nowhere to be found. Most of these children were receiving some type of individual or family therapy within the agency, but when I spoke to the parents, I discovered that most of them felt left out of the therapy, misunderstood, and resentful of the system. They told me therapy wasn't helping.

In graduate school, I hadn't learned anything about children beyond general child development and a survey of psychodynamic theories. All I knew about working with kids came from babysitting and being a camp counselor. Nevertheless, I quickly learned the type of child psychotherapy I didn't want to practice: it was the kind most children in the agency were receiving, where the therapist considered herself to be the main relational focus and placed little emphasis on working in session with the caregivers.

I asked a lot of questions when I started out. How could a therapist truly help a child she sees for only 45 minutes a week? What about the potential influence of the parents or caregivers who were with the child every day? These were the people who bathed him, comforted him when he had a nightmare, took him to the school carnival, and dealt with his destructive meltdowns. Why were they not included in therapy? The answers I got from my supervisor and the treating therapists were at polar extremes. On the one hand, I was told that many parents don't want to come to therapy – they'd rather drop the kid off and have them be "fixed" by the therapist. On the other hand, I heard that the therapists were wary of including the parent because it could "contaminate the therapeutic relationship" between themselves and the child.

On the occasions that caregivers were asked to come in, it felt as though they were guests or observers. During parent meetings, the therapist gave clinical impressions and provided guidance on dealing with problematic behaviors at home from the point of view of the expert. These meetings didn't seem useful because no real relationship existed between the therapist and the parents. The disconnect between the therapy room and the home environment was really a chasm, and considering the amount of distress the families were in, whatever therapy was happening had little relevance to the child's home life. I was bewildered and disillusioned.

Then one day the police dropped four-year-old Timmy and his two older brothers off on the agency's doorstep. They'd just watched their mother bleed to death after being stabbed repeatedly by her boyfriend. When they arrived, the older brothers looked shocked and disoriented, but they could at least nod their heads to questions like "Do you want a drink?" or "Can you come sit here?" Timmy, in contrast, was just a shell of a child, stooped low and on the verge of collapse. He found the first couch in the lobby and balled himself into it like the smallest water bug coiled against a predator. Various people tried to approach him, asking if he could sit up, telling him there was a nice playroom down the hall where there were toys. Timmy stayed in his tight ball. The minutes passed. No one could elicit the slightest response from him. The only indication that he was alive was a shallow rise and fall of his tiny back as he breathed.

That day, our clinical consultant, Sandy, happened to be in the building. Witnessing this distressing scene, Sandy approached Timmy. She crouched down by his side and started singing in a soft, rhythmic way "Timmy, Timmy, you are here today. What did you bring with you? You are here today." She hummed a few more bars. She said, "Oh, I see you brought your elbow. It's a fine elbow. I bet it's a pointy one, like mine. Or maybe it's soft or squishy. I don't know. I'm going to check and see." Sandy reached her hand out and gently cupped Timmy's elbow. Timmy didn't budge, but he didn't recoil either. "Oh!" Sandy whispered with a bit of energy. "It's pointy. Just like mine!" She continued this way, gently cooing at Timmy, finding ways to connect with him physically, like drawing a shape on his back and seeing if he could feel all five toes within his spider man sneakers. She asked him to wiggle his toes if he had all five of them, and then Timmy wiggled them ever so slightly. Sandy exclaimed quietly but with energy, "You do! You do have five toes in there!"

Then one day the police dropped four-year-old Timmy and his two older brothers off on the agency's doorstep. They'd just watched their mother bleed to death after being stabbed repeatedly by her boyfriend.

I saw Timmy's breathing slow and deepen. After about five minutes, he agreed to sit up, and Sandy offered him a piggyback ride to the playroom, where he could be more comfortable. She told him there were blankets and places to hide there. Climbing on her back, he hid his face in Sandy's hair as she carried him down the hall, walking a steady, firm pace, humming her Timmy song all the way. Once in the playroom, Timmy accepted a drink and slowly oriented to his new surroundings. All the while, Sandy sat next to him with her hand on his back or cupping her hands around his.

I watched this scene in awe. Sandy had never met Timmy before. How did she know to reach this little person? How did she have the courage to approach him so closely? And how could Timmy trust a stranger after what he'd just been through? Neuroscientist and trauma researcher Stephen Porges knows.

According to Porges's polyvagal theory, it was Sandy's singsongy, rhythmic voice that reassured him, her lack of hesitation to connect with him through touch at the right moment, with the right pacing, her focus on the here-and-now of his physical presence on this earth, her complete confidence in his humanity, and her lack of fear about what had happened to him. That's what brought Timmy out of his paralysis: nonverbal codes that transmitted the message to his brain, "You're safe, you're safe."

I thought it was magic. I thought Sandy was a magician, and my mind locked onto her like a person possessed. I wanted to be her. But how?

My great fortune was that right in Chicago where I lived was The Theraplay Institute, where Sandy had been trained. Theraplay is based on the attachment work of John Bowlby and two theories promoted by Donald Winnicott: his holding environment – the idea that good parents and therapists can create a nurturing emotional environment for children – and his theory that play is the best way a child can experience her true self.

Theraplay is also derived from intersubjectivity and interpersonal neurobiology research. It emphasizes all the nonverbal elements of Sandy's engagement with Timmy – behaviors that, in a split second, tell a child that he's safe: the rhythmic, singsongy voice; the curious, open face; the smooth, coordinated gestures; the touch and playfulness. I jumped at the opportunity to take the training, and it dramatically enhanced my work and changed my career.

A Fast Road To Connection

It's commonly acknowledged that many of us became therapists because, as children, we ourselves experienced the pain of feeling isolated, shamed, or mistreated. But if this is true, why do so few of us work in child mental health?

I have a few hypotheses. First, children don't operate with adult mores. How many times have I walked into a session geared with all my child-development knowledge and had a child reduce me to an angry fool? More than I can count! Why? Because children, like dogs and horses, can sense right away that I have an agenda, and they can run circles around me as I try to cajole, reason, or clown them into cooperating.

Second, working with children can be uncomfortable. It's the rare child who'll sit still and talk about feelings. Usually, children don't know why they do what they do. When a child comes to therapy, you have to be ready to loosen your expectations and sense of control over the session. Children don't filter their feelings as much as adults. They have temper tantrums, throw things, and tell you that you have bad breath, or that you're fat or old or ugly or stupid. They force you to get in touch with your most basic impulses. They can easily trigger the feelings of powerlessness and shame you felt as a child, or the feelings of rage you saw on your own parents' faces. Playing can make adults feel vulnerable, and I've often heard people express trepidation as if they don't quite feel playful enough to do this kind of work, or that they've "forgotten" how to play, or that only people with a lot of charisma can hold a child's attention.

Last, working with a child is twice as much work for half the pay. In addition to the time it takes to clean up the mess they make in your office, children come with parents. Parents are often needy, angry, and blaming.

They email you the ugly chronicles of their horrible weekend, upset you didn't manage to "fix" their child. They demand you talk to the teacher, the principal, the occupational therapist, and that you do a home visit. They ask for advice and then reject it.

In short, working in child mental health can be a hot mess. But I've stayed in this area for nearly two decades because of what I experienced between Timmy and Sandy, and many other dyads like them. Seeing healing connections being made that help children feel safe and seen keeps me coming back, and therapeutic play keeps proving to be the most effective medium to create these connections.

Katrina, age seven, was the middle of three sisters in foster care. Each week, they were reunited for family visits with Amy, their birth mother. Everyone on our staff suspected that Amy's parental rights would soon be terminated since she hadn't demonstrated that she could be trusted to keep herself, let alone her children, safe. It was only because of legal delays that she still had visiting rights.

I believe Amy was living too much in active trauma to know how to parent. She'd been kicked out of her birth home as a teen because of physical conflicts with her alcoholic father, and she'd run away from a series of unsafe foster homes. She'd lived on the streets and continually abused drugs. Unfortunately, Amy was making little progress with her treatment goals of staying away from her abusive boyfriend, going to parenting classes and individual therapy, and acknowledging the abuse and neglect she'd inflicted on her girls. In the few instances that she did show forward movement, she was granted unsupervised weekend visits. But during one of these visits, her eldest daughter, trying to make spaghetti, had scalded herself while Amy was oblivious on the couch, having passed out from too many over-the-counter drugs. Unsupervised visits were quickly revoked.

To her credit, Amy, who had many health problems, still showed up religiously at our child welfare agency for her weekly supervised visits with her girls. She'd heave herself up the flight of stairs to our second-floor offices, always carrying a bag of McDonald's happy meals and a tray of milkshakes. Upon entering the play room, she'd fall dramatically into a deep sofa and remain there as the girls arrived in succession from their foster homes. The oldest was usually controlled and obedient, the youngest coy, but Katrina invariably arrived in a state of fight and flight combined. She'd cry, scream, kick, cling, tear, run – a whirling dervish of distress. Every week, my colleague and I watched this drama unfold, and half the visit would be spent trying to calm Katrina down.

Amy tried the best she could to connect with the girls by offering them the fast food she'd brought, but the girls wouldn't sit at the little table to finish more than two chicken nuggets. They kept getting up to look at a toy or peer out the observation window. They'd flit around the playroom, taking out games but not playing with them. It appeared that their little bodies were vibrating with chaos inside, and they just couldn't settle down. But rather than getting up and going to them or helping them stay engaged with a toy, Amy would just sit on the sofa and drone at them to "Stop that. Get off. Sit down."

Our clinical manager told us to facilitate a game of Candy Land to give some structure to the visit. But Katrina would get mad every time she didn't advance on the board, and

> Play helps a child learn to share and expand joyful experiences and also to modulate them so they don't become overwhelming.

Amy would harp on her to play fair, muttering, "Quit it, Katrina." It'd take Katrina only a few passes at struggling to control herself before she'd look defiantly into Amy's eyes and know the board off the table, scattering lollipop and ice cream cards across the floor.

My colleague and I, having just completed our first Theraplay training, decided to step in and ask Amy if she'd allow us to lead activities with her and her daughters for the next visit. She agreed, and the next week, as soon as the girls arrived, we kicked off a sense of playfulness by suggesting we all walk to the playroom with little bean bags on our heads, holding hands to see if we could balance them all the way down the hall. Amy, it turns out, was particularly skilled with her bean bag, but Katrina refused to cooperate. With a deep scowl, she grabbed the bean bag we placed on her head and threw it as hard as she could. "Good," I said in response. "Let's throw it down the hallway!" That Katrina would do, allowing us to get closer and closer to the visiting room.

Once there, we arranged the chairs in a circle so everyone could face each other and play simple games like passing a "hello" around the circle and checking to see if everyone's hands were cold or warm. Amy and Katrina's hands were warm, but the two other sisters' hands were cold, so we had them warm their hands together as partners. We then bopped a balloon around, led a hokey-pokey dance, and copied funny sounds

that each person made in turn. We had the three adults (myself, my colleague, and Amy) decorate the girls with colorful feathers and then look at themselves in the mirror as princesses, warriors, or eagles. We then all decorated Amy with feathers, which the girls particularly enjoyed. "Take our picture as a family of princess warriors!" the girls squealed.

Toward the end of the visit, we went around the circle and named the features we saw on the person to our right. I looked at one child and said, "I notice you have rosy cheeks." That girl then looked at her mom and said, "You have soft hair." Then Amy looked to her right at Katrina, and Katrina looked at her – and looked and looked. Finally, Amy said with surprise, "You have greenish-blue eyes!" It was the first time she'd really noticed Katrina's eyes. They held each other's gaze for several moments more, and the intensity of the connection was palpable.

Right before we ended the visit, we created a group handshake to which everyone contributed a segment. We practiced it and said we'd remember it for the next visit. For the first time in two years, Katrina parted calmly with her birth mom, almost prancing out the door to her foster mom's car.

Sadly, it turned out there was no supervised visit after that. The court had finally completed the termination process, and Amy said goodbye to her girls at their respective foster homes. So does it matter for Katrina that for one moment, amid years of chaos and pain, her birth mom looked at her intently? What impact can one hour of connection and harmony with Amy really have? Will Katrina even remember it?

If I, as a witness, was able to feel the intense connection, then I believe Katrina certainly would hold that memory in her body. I believe children like Katrina, who've been tossed around like empty soda cans in the tumultuous waves of the child welfare system, need moments like these. I believe Amy wanted desperately to give her girls a sense that they were important, unique, and cherished by her, even if she couldn't raise them. She didn't know how to do it – but that one session helped. It might seem too good to be true that playing in a structured, nurturing, and fun way would dissolve such a painful family drama. But I believe it gave Katrina and Amy the opportunity to get unstuck from their troubling dynamic and redefine an aspect of their relationship.

I'm not claiming that structuring and creating the family visit as we did healed all the ripples of loss and trauma that Katrina had endured and will continue to endure in life, but I do believe that it offered this fractured family a bit of dignity, hope and meaning. And I believe that family therapists should be equipped with skills to facilitate these small but transformative moments.

The Power of Play

The quickest and most powerful way to get to transformative moments with children is through play – meaning interactive, face-to-face, reciprocal, cooperative interactions that rely on movement, rhythm, touch, a prosodic voice, and eye contact. I call this primary play because it appeals to the developmentally younger levels of the brain: the brainstem, the diencephalon, and the limbic brain. It doesn't engage the neocortex, the part of the brain that develops after the second year of life and uses logic, planning, verbal communication, and imagination. Instead, it uses tools that say to a child's limbic brain, "You're safe and worthy, and I enjoy connecting with you."

Embedded in play are moments of connection and surprise, with sudden dynamic shifts. For example, you're quietly studying a child's face when he reaches out to touch your nose and you make a resounding BEEEEP sound. The child is suddenly alert. Looking straight into your eyes, he giggles spontaneously at the surprising, funny shared event between the two of you, and you laugh in turn. This element of surprise, so important in play, is the growing edge for a child to learn that new things can happen, and that these new things can be both exciting and safe.

Something important happens when two people share this kind of dyadic state of consciousness. Such moments are often called now moments. For those few seconds after you've made the beep sound, you and the child are in a brand new, shared space, created by the two of you, and you're intensely focused on each other. You each give meaning to the event as pleasant, and the giggling both conveys and amplifies the moment. The more such moments occur, the more the child learns that it's pleasurable and safe to be completely caught up in a moment of shared joy or attention with another person. Once this has happened, a deeper sense of connection has been established between you.

Play helps a child learn to share and expand joyful experiences and also to modulate them so they don't become overwhelming. Think of the common parental game of throwing a baby in the air in the right rhythm and height and just the right number of times, so she increasingly enjoys the experiences but doesn't spit up, start to cry, or get aggressive from too much stimulation. Children crave vigorous, physical playfulness that involves body contact, and these activities help them not only expand and manage their positive feelings, but also counteract negative emotions. Amplification and modulation of positive affect is one of the cornerstones of a well-regulated self.

Play is also the arena in which all of a child's psychic drama is enacted. If a child has been hurt or mistreated by a significant attachment figure, it'll come out in these simple games. One misstep from the adult and the child will inevitably replay her feelings of shame and mistrust. The benefit is that adults can then repair with the child – which is the definitive therapeutic act in early relational trauma.

One example of this was my work with four-year-old Clara, who'd been found at age two in an empty apartment, along with her three-year-old brother. Rancid garbage was strewn about, and rats were crawling freely around them. Clara and her brother were placed in a

great adoptive home, but after a year and half, Clara's adoptive parents felt they couldn't reach her. She'd coyly ask for things and then reject them. Or she'd fall and cry for help but when her mother came, she'd start to giggle and kick her away.

My treatment with Clara and her parents focused on setting up games between them that involved movement, touch, and turn-taking. In one game, I had Clara's parents sit a few feet apart, each holding two ends of a small blanket laid out on the floor. When her parents lifted the blanket, Clara would get under it and crawl from one parent to the other, either slow or fast, depending on the rhythm of a song I'd sing. Clara delighted in crawling back and forth between her parents just in time before the blanket went down. I myself was having so much fun that I decided to up the ante, telling Clara that this time I wouldn't let her know ahead of time whether to crawl fast or slow; she'd have to guess.

My intention was to be playful, but for Clara, the intensity was too much. Instead of waiting for my cue, she first crawled slow, then fast, then veered away from her parents to the corner of the room, where she collapsed and giggled in a breathy, high-pitched way. I instantly realized that I'd increased the stimulation above her ability to tolerate it, and I changed my playful voice to one of concern and tenderness. "Ohhh." I said from across the room. "You ran all the way over there!" Clara looked away. "Was there something that scared you about that part of the game?"

"No" Clara quickly said.

"Okay, why don't you come back to sit on your mommy's lap," I suggested. Clara complied. I looked at her intently as I continued in a singsongy but concerned way, "Did something startle you about the way I played the game? I think you didn't like not knowing if you were to do it fast or slow. I think that made you feel uncomfortable." Clara stared at me with wide eyes. "Uh-huh, that makes sense. I'm not going to do that anymore. I'm going to tell you which way to crawl, okay?" Clara nodded and I started the game again with a clear, simple direction to crawl slowly. She crossed under the blanket and sat right in her father's lap.

"Oooh," I said with compassion and relief in my voice. "That's better. See, I don't think you liked it when you didn't know what to do. It made you worried so you crawled away. That makes sense. Thanks for telling me."

Clara thus learned that it wasn't her fault that she'd felt stressed. She learned that adults could identify her discomfort, take responsibility for changing their response, and make her feel more secure. Her parents learned that if she falls on the floor, rather than chide her for being silly, they should approach her gently, put a hand on her back, and wonder aloud with her what might be making her uncomfortable. In repeating that cycle of mis-attunement and repair, her parents will teach Clara that she wasn't damaged and alone, that her experience makes sense, and that they'll be there to support her.

Although it's been decades since I first watched Sandy, with her singsongy play and gentle touch, reach out to traumatized Timmy, coiled on the couch like an impenetrable water bug, I can still recall my awe at that experience. Yet there are hundreds of thousands of Timmys in this country alone, and we need to make sure there are enough Sandys among us to help.

If I've convinced you that here and now, primary play interactions are what those children need, consider trying out games that facilitate trust and connection with the families in your own practice. Many books list delightful ideas, and once you're in the zone of primary play, you can create an endless number of variations on them.

Of course, finding your courage to initiate these games may take time. So ask yourself: do you feel comfortable jumping into these games? If not, why not? Do you worry that you're not a playful person? Have you had negative experiences in your personal or professional life, where playful interactions have gotten out of control and you haven't known what to do? Are you wary of parents judging your work as not valuable because you're "just playing"?

As you explore these questions, find opportunities to look at your face in the mirror and practice widening your eyes as much as you can to show openness and curiosity. Take a deep belly breath. Put some movement in your shoulders, arms, and hands so that they can flow with your overall presentation. Practice your singsongy, rhythmic, storytelling voice. And overall, trust the process of the magic of play. It'll be worth it!

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Nature Play Therapy: When Nature Comes Into Play

By Jamie Lynn Langley LCSW, RPT-S

"In nature, a child finds freedom, fantasy, and privacy: a place distant from the adult world, a separate peace." This quote is from the ground-breaking book by Richard Love "Last Child in the Woods: Saving our Children from Nature-Deficit Disorder" originally published in 2003. When reading those words, it really is no wonder that nature and play therapy can work so well together, as they both help foster a healing place for children and adolescents. As the research continues to grow that nature has such a value to us all for our mental health, and most especially children; there is much to be excited about in terms of incorporating nature-based practices, activities and interventions in play therapy.

Despite the healing aspects of nature, at times there is a hesitancy by play therapists to incorporate outdoor activities due to concerns of liability, confidentiality and risk of harm. For those concerns, nature can be brought into the play room in various forms and interventions. These can also be given as therapeutic adventures for families to incorporate together outside of the playroom. Since nature is free of a financial cost, these interventions can also be of assistance for the therapist on a budget. The nature-based activities described in this article are those that be done both indoors as well as outside for children of all ages, including adolescents.

Another important feature of Nature Play Therapy is that it provides opportunities for the natural application of many of the Therapeutic Powers of Play as identified by Drs. Charles Schaefer and Athena Drewes in 2014 in their book of that title, particularly those that fall under the categories of Fosters Emotional Wellness and Increases Personal Strengths, and will be further identified below.

Self-Regulation (Increases Personal Strengths)

It is not uncommon for children to enter the playroom in a state of dysregulation due to events and stressors in their young lives. Mindfulness activities can assist this by providing simple measures to help calm this dysregulation. An easy way to bring this into play therapy is to have a variety of nature objects in a wooden bowl or basket that the child can take out and touch, feel and smell. Even things such as leaves can be very calming, just by having the child trace with his or her fingers along the veins of the leaf. In similar fashion, a shell can be traced along the lines, as well as feeing the smooth underside that is characteristic of some shells. Pebbles and rocks can be held for calming due the grounding nature of the stones. It is also not uncommon to have a child begin to place the nature objects in patterns and formations as another way to provide regulation in a playful yet intentional manner.

Another calming nature-based activity is to have the child or teen make a nature mandala. Mandalas have been utilized for centuries to assist with calming and are often currently included in adult coloring books. For play therapists not familiar with mandalas and their origins, the book "Finding Meaning with Mandalas: A Therapist's Guide to Creating Mandalas with Children" (T. Turner-Bumberry, 2015) is a valuable resource. Nature Mandalas can be easily made using the nature items in the bowl or basket as described earlier, or some nature objects can be brought to the session by the child. While this mandala creation is an expressive art, no artistic ability is required. This can be particularly advantageous for clients who are hesitant to engage in other expressive art activities in play therapy. The nature mandalas can be constructed on the floor, on paper or even in sand trays. For play therapists who are comfortable doing sessions outside, nature objects can be gathered together and then used to form an outdoor nature mandala on the ground.

To begin, explaining to the client, what mandalas are, can be helpful. "The Mandala Book: Patterns of the Universe" (L. Cunningham, 2010) is a book filled with pictures of mandalas found in nature as well as those human-created. The client can then create their own mandalas using the various nature items. Often children want to create several nature mandalas over various sessions, and many often use them as a way to regulate at the beginning of the session, or use at the end to help provide closure and transition out of the session. Nature mandalas can also be used as a play therapy activity for siblings, groups and families to help foster connections and communication.

Nature visualizations are also beneficial for calming. Pictures of various scenes from nature can be used to have the client choose one to visualize if they do not have one identified. Scenes from beaches and mountains are often the most chosen for their relaxing images. This mindful activity is easily adapted for children and teens of all ages and can be of various durations. Relaxing music can also be combined with these images, particularly music involving sounds from nature such as bubbling brooks and cascading waterfalls. There may be things observable in nature to use for these visualizations if able to go outside or even by looking through a window, such as with area trees whose leaves are rustling in the wind or drops of rain coming off of the roof. Play therapists who have access to devices in their playrooms can also incorporate videos of nature to assist for these visual exercises.

Self-Esteem (Fosters Emotional Wellness)

Creating nature art is a great way to incorporate nature in a fun and creative experience for clients in play therapy. Clients can be taken outside to gather items as part of a nature scavenger hunt, or this can be given as an activity for the child and their family as a therapeutic adventure outside of the actual play therapy. Once the items from nature are brought to the play room, they can used to construct all types of works of art on regular paper or colored construction paper. If lamination is available, the works of art can be saved for clients to take home if they choose. Nature art can include "creature features" where children may make various animals using their nature items, and people can be made out of sticks and stones. There are numerous other types of creations that may develop from the child's imagination. This springboard for creativity can be so transforming for a child's self-esteem. Other adaptions can include petal pictures, which are those that are constructed entirely out of flower petals, which can be a "scentsational" experience or making a picture entirely out of leaves. Children often choose to make rainbows out of the nature items as well.

Nature charades is a fun and easy game experience where the client and therapist take turns pretending to be various items in nature; such as trees, flowers, rain and even the sun, moon and stars. The game premise is to guess what each is enacting. Children have a lot of fun with this activity and it facilitates improving self-esteem when the child both guesses correctly, and when theirs is also guessed right by the play therapist. A projective activity can then be introduced of what their item in nature might say today, or what it needs.

Another fun and easy game involving nature is similar to playing catch, only breaths are used to blow the feather to each other. The goal is to keep it from dropping to the floor and it usually results in a lot of laughter. This is also a fun activity for connection and attachment for the therapeutic alliance. This can also be incorporated in a larger space or outside to use with siblings, groups or families.

Playing "I Spy Nature" or "Nature Hide and Seek" are also fun ways to incorporate nature in the play room. Before the client arrives, or while they are hiding their eyes, the therapist can place various nature items around the play room. The child can also do this for the therapist as well on their turn. For "I Spy Nature" the therapist can describe what is spied and then the child looks for that item. For "Nature Hide and Seek" the seeker simply looks for the hidden nature objects. These games promote mastery and self-esteem while also providing additional ways for connection between therapist and client or with adapted use for parent and child, and even with siblings. "I Spy Nature" is also easily done outside in nature as well and lends as a focus activity also.

Sense of Wonder, Awe and Delight

The value of incorporating nature incudes the ability to foster opportunities for wonder, awe and delight. While these are not necessarily identified as Therapeutic Powers of Play, they are often incorporated within play therapy activities. This can be especially true when nature comes in to play, as children can feel and experience opportunities for wonder, awe and delight during this nature play, both with themselves and with nature itself. These feelings can translate to help children and adolescents in play therapy improve self-esteem, be less stressed and feel more positive. Thus Nature Play Therapy can be of so much benefit for so many reasons. It is hoped more play therapists will find ways to incorporate the suggested nature play activities as well as others to truly bring nature into play, time and time again for the therapeutic benefits.

References

Cunningham, L. B. (2010). The mandala book: Patterns of the universe. New York, NY: Sterling Pub.

Louv, R. (2005). Last Child in the Woods. Saving Our Children From Nature-Deficit Disorder. Algonquin Books of Chapel Hill.

Schaefer, C. E., & Drewes, A. A. (2014). The therapeutic powers of play: 20 core agents of change. Hoboken, NJ: Wiley.

Turner-Bumberry, T. (2015). Finding meaning with mandalas: A therapists guide to creating mandalas with children. Saint Charles, MO: Turner Phrase Publishing LLC.

About the Author

Jamie Lynn Langley, LCSW, RPT-S has been a practicing child, family and play therapist in Tennessee for almost 30 years. For most of that time she worked in community mental health before going into private practice in late 2016. Ms. Langley (Jamie) also is an adjunct professor for two universities in Tennessee (Middle TN State University and Lipscomb University). She also co-founded and serves as the President of the Tennessee branch of the Association for Play Therapy and is a charter member of the Children & Nature Network founded by RIchard Louv. Miss Langley (Jamie) specializes in working with children and their families who have undergone trauma, loss, divorce and other adverse conditions and brings in nature as part of healing practice whenever possible. A former Cub Scout leader for 15 years, she especially enjoys her personal and family time in nature, especially at the beach and the breathtaking Smoky Mountains of East Tennessee.

If you would like to learn more about nature play therapy, go to this website to find out information about a wonderful Nature In Play Therapy Workshop Retreat

https://wonderscounseling.com/nature-in-play-therapy-training-event/

Healing Spaces

Healing Spaces is an ongoing article in Playground. If you would like your therapy playroom to be featured please contact lorie.walton@hotmail.com.

A Focus on CAPT's Play Therapists

This edition of Healing Spaces is happy to focus on Jodie Hiebert, MSW RSW, CPT, of Niagara Region in Ontario and works at The Play Clinic which is situated in St. Catharines, Ontario. St. Catharines is central to the Niagara region so she services children and families in St.Catharines, Port Colborne, Fort Erie, Niagara Falls, Grimsby and Beamsville.

1. How long have you been practicing play therapy?

I have been practicing Play Therapy for three years since I took my Level One Play Therapy. I have also taken two levels of Theraplay and have completed my Foundational Theraplay Certification. Additionally, I have completed Level 1 & 2 Cognitive Behavioural Therapy courses through Wilfred Laurier University and completed Neuroptimal Neurofeedback basic certification.

2. What drew you to the field of Play Therapy?

I love working with children and families. I have personal experience as a crown ward and "youth in care" and I have also been a foster parent for the past 5 years. I wanted to impact not only people seeking support but also people within the system. I feel that change needs to happen from within and play therapy helps facilitate that change, providing opportunity for children, youth and families make sense of their experiences and heal.

3. What is your primary theoretical orientation and how did you evolve in to that orientation?

I am a prescriptive and integrative therapist. I use supervision and have supervisory relationships with a few different supervisors who have expertise in various areas to ensure that I can implement various interventions to meet the needs of clients. Theresa Fraser supports me in my use of Sandtray, Carol Ahmad supports my use of Theraplay, and Greg Lubimiv supervises and supports me with family therapy. I also network with other play therapists in Canada and U.S to further enhance my skills and work.

4. What is your favourite technique and why?

That is a hard question as I like using what heals. For example, I have observed often that Sandtray is often the intervention of choice with adolescents yet I have also seen great progress with children who have attachment challenges when I have engaged them and their families using Theraplay and Dyadic Developmental Psychotherapy techniques. I also use Non Directive Play Therapy, Internal Family Systems, and Cognitive Behavioural Therapy techniques frequently.

To support play therapy shifts I use Neuro-feedback/ brain training and own a NeurOptimal brain training

system. Neurofeedback (www.neuroptimal.com) helps parents, teens and children regulate their central nervous system. For example, I am working with a 12 year old who struggled with emotional regulation and after only 6 sessions of neurofeedback, her family reported that she was more in control of her feelings. She was able to bounce back from disappointments quickly instead of experiencing long temper tantrums, she also started articulating her feelings consistently rather than reacting. With brain training she is now in a place where play therapy will be more effective. Often, I have parents who use Neurofeeback while their child is in play therapy. Parents report feeling less stressed and reactive, more organized, focused, and able to effectively support their child's emotional needs.

5. What is your play therapy environment like?

I have a play therapy office in a home where I provide service in three rooms. I have a waiting room, a neurofeedback room, a child centred play therapy room which is large and comfortable for parents and family therapy sessions. I also access a local youth centre nearby to with a big room where I can facilitate groups. The environment is warm, inviting, and family friendly. It is a gift to be able to run groups in a building that is also seen by my community as a comfortable community resource.

6. What was your Play Therapy training and supervision experience like and what would you recommend to new play therapists about it?

I greatly benefited from the CPT program. Learning various models from experts has informed my practice. Supervision has shaped my skills and also encouraged me to further professional development and self-learning. I spend a fair amount of time reading research and following other experts in the field. Supervision has been a necessary aspect of the training and has helped me build confidence and skills that just taking a course or class wouldn't. I enjoy networking with other play therapists and have been grateful for the wonderful relationships that have formed through trainings with the CAPT.

7. What do you do to practice self-care?

I work out regularly and ride a motorcycle. I have a young family with four kids spanning in ages from 17 to 18 months of age. Family time is a priority.

8. What do you envision your practice will be like in the next 10-15 years? Will you be doing the same thing, or something different?

I hope that I will have more neurofeedback machines. I plan to compete some research in the near future about the integration of play therapy and brain training. I also would like to take more formal training in Dyadic Developmental Psychotherapy, Somatic Experiencing, and Emotion Focused Family Therapy, and see how these interface with Play Therapy.

Jodie Hiebert , MSW RSW, CPT is a Play Therapist who practices in St. Catharine's Ontario. She is very proud to have completed play therapy certification with the CAPT and to pursue a career as a Play Therapist.

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https://www.facebook.com/theplayclinic/

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The Difference Between the Professional Regulated College and the Professional Association

Many Certified members of CAPT are also members of a regulated provincial "College" in the various provinces and territories across Canada. As a fully Certified member of CAPT, there is a requirement that you be affiliated with the professional regulated college or standard setting association that best represents your profession whether it be Social Work, Counselling, Psychotherapy or another mental health related discipline. It is important to understand why you would belong to CAPT as well!

In simple terms, the College is formed for the **protection of the public.** The Association is formed **to support and protect the growth, advocacy, training and ongoing support of the member** which is you.

To elaborate and more specifically:

The Value of Belonging to the Association – Canadian Association for Play Therapy (CAPT)

CAPT is in place to speak on behalf of child & family psychotherapists and play therapists and to be the voice of the members for the profession provincially and federally.

The ways in which CAPT can support its members are as follows:

- Engage with like-minded alliances and associations to advocate on behalf of the members for legislative reforms.
- Provide critical analysis of government policies and practices that will impact the profession of play therapy in each province.
- Promote and enhance the understanding of play therapists in the clinical environment
- Promote the efficacy of play therapy through research in Canada and throughout the world.
- To support the member through the provision of continuing education programs.
- To engage in the practice of knowledge management for clinicians and therapists in order that they remain current in the practice of play therapy.
- To provide a place to network with play therapists in similar areas of practice.
- To access services and products specific to the field of play therapy.

CAPT works for you, on your behalf as a professional psychotherapist and play therapist.

The Value of the Regulated College

A regulatory body's primary duty is to serve and protect the public interest. Its mandate is to regulate the professional practice it represents and to govern its members.

Regulation of a profession defines the practice of the profession and describes the boundaries within which it operates, including the requirements and qualifications to practise the profession. The primary mandate of any regulatory college is to protect the public interest from unqualified, incompetent or unfit practitioners.

Regulation brings credibility to the profession. Practitioners of a regulated profession are subject to a code of ethics and standards of practice.

Self-regulation allows a profession to act as an agent of the government in regulating its members because the government acknowledges that the profession has the special knowledge required to set standards and judge the conduct of its members through peer review.

CAPT as a Standard Setting Body

Although CAPT also sets standards and performs within a professional Code of Ethics very specific to play therapy, it goes one step further in providing its members with additional credibility specific to this field of practice.

In order to be a fully Certified Play Therapist with CAPT, you must maintain status as a certified, licensed, or registered member-in-good standing with a license to independently provide clinical mental health services in a Canadian professional (regulated) association or governing body.

Canadian Association for Play Therapy (CAPT)

is proud to present the

Training Schedule for 2019

For more information about each specific workshop and registration please visit https://cacpt.com/workshops/

MARCH 22, 23 & 24 2019

Hotel Grand Pacific
Victoria, British Columbia

3 Day Certificate

Responding to Trauma Using Play Therapy

Betty Bedard Bidwell PhD, CPT-S
Registered Art Therapist

Margot Sippel RP, CPT-S
Registered Art Therapist

APRIL 12, 13 & 14, 2019

Executive Royal Hotel
Regina, Saskatchewan

3 Day Certificate (18 CEU)

Treating Anxiety Using Play Therapy

Irena Razanas MSW, RSW, CPT-S, RPT-S

MAY 3, 4 & 5, 2019

Doubletree Fallsview Hotel & Conference Center
Niagara Falls, Ontario

CAPT Annual General Meeting & 3 Day Certificate (18 CEUs)

Treating Anxiety Using Family Play Therapy, Yoga, Mindfulness & Meditation for Children and Families

Tina Lackner BACYC, MSc, RP (CPT) (RCYT) (RYT300)

APRIL 7, 14, 21, 28 MAY 5 & 12

On-line (14 CEUs)
Play Therapy Supervisor Training Course For Potential CAPT Supervisors (CPT-S)

Theresa Fraser CYC-P, M.A., CPT-S

JULY 8 – AUGUST 16 2019

Chartered Professional Accountants – PD Institute
Toronto, Ontario

6 Foundation Play Therapy Credits per Day
CAPT Foundation Play Therapy Training Days

AUGUST 19, 20 & 21 2019

Charlottetown, PEI
(Location TBA)

3 Day Certificate (18 CEUs)

Anxiety and Play Therapy – Blending Behavioural and Psychodynamic Techniques

Donna Starling MSW, RSW, CPT-S

SEPTEMBER 20, 21 & 22 2019

St. John's, Newfoundland
(Location TBA)

3 Day Certificate (18 CEUs)

Using Sandtray in Play Therapy

Theresa Fraser CYC-P, M.A., CPT-S

SEPTEMBER 27, 28 & 29 2019

Edmonton, Alberta
(Location TBA)

3 Day Certificate (18 CEUs)

Treating Anxiety Using Play Therapy

Irena Razanas MSW, RSW, CPT-S, RPT-S

NOVEMBER 15, 16 & 17 2019

Ottawa, Ontario
(Location TBA)

3 Day Certificate (18 CEUs)

Advanced Family Interventions in Play Therapy

Greg Lubimiv MSW, CPT-S

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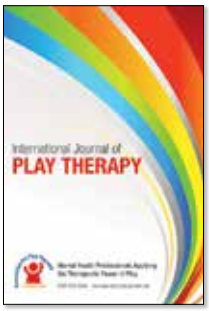

International Journal of Play Therapy

Official Journal of the Association for Play Therapy

ISSN: 1555-6824 | eISSN: 1939-0629

The *International Journal of Play Therapy*® is dedicated to publishing and disseminating reports of original research, theoretical articles, and substantive reviews of topics germane to play therapy on behalf of psychologists, psychiatrists, social workers, counselors, school counselors, marriage and family therapists, and other mental health professionals.

For more information, see: on.apa.org/CAPT_PLA.

Official Journals of the Canadian Psychological Association

CANADIAN PSYCHOLOGICAL ASSOCIATION

SOCIÉTÉ CANADIENNE DE PSYCHOLOGIE

Canadian Psychology / Psychologie canadienne

1.324 Impact Factor* | ISSN: 0708-5591 | eISSN: 1878-7304

This journal publishes generalist articles in areas of theory, research, and practice that are of interest to a broad cross-section of psychologists, along with original, empirical contributions if the research is of direct relevance to the discipline as a whole. *This journal offers Public Significance Statements and abstracts in English and French.*

on.apa.org/CAPT_CAP

Canadian Journal of Experimental Psychology / Revue canadienne de psychologie expérimentale

1.290 Impact Factor* | ISSN: 1196-1961 | eISSN: 1878-7290

This journal publishes original research papers that advance understanding of the field of experimental psychology, broadly considered. *This journal offers Public Significance Statements, abstracts in English and French, and Open Science Badges.*

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Canadian Journal of Behavioural Science / Revue canadienne des sciences du comportement

0.812 Impact Factor* | ISSN: 0008-400X | eISSN:1879-2669

This journal publishes original empirical research in various areas of psychology, including social, developmental, school and educational, and industrial/organizational psychology, among others. *This journal offers Public Significance Statements and abstracts in English and French.*

on.apa.org/CAPT_CBS

The *Canadian Journal of Experimental Psychology* offers Open Science Badges to promote soundness and transparency in scientific practice. Author who share their data or materials publicly, or who preregister their studies or analysis plans, may apply for one or more badges.

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