Playground

A publication of the Canadian Association for Child and Play Therapy (CACPT)

Spring 2011

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Playground
Canadian Association for Child and Play Therapy

Contents

Hello from the President

Hello and welcome to Playground! Spring 2011

In our last issue I identified areas that I hoped our Association and Members will support in order to continue to promote Play therapy in Canada.

One of these areas is Canadian Play Therapy Research. I am pleased to let our membership know that Dr. Nancy Riedel Bowers will be chairing this newly formed but National committee. This committee has already had their preliminary meeting to identify the initial scope and vision of their upcoming work. Thanks to each of these volunteers from various provinces in Canada. This is an exciting initiative for our Association.

Have you recently presented a workshop that is Play Therapy based for therapists, a local foster parent agency, early years conference or other community group? If so please email kip@cacpt.com. We would like to proudly list these events on the regional news pages of our web page

Again, the more stakeholders learn about what Play Therapists offer- the more children will receive necessary services. It is my belief that it is our responsibility to share what we know about the therapeutic powers of play as well as how different models are integrated to create the treatment plan needed for each client served. In doing so it is likely that we will increase our membership as we are THE Canadian association that promotes Play Therapy.

We have our Annual General Meeting and Conference at the end of April.

A dear friend and highly regarded Play Therapist Dr. Athena Drewes is coming to Guelph Ontario Canada! If you haven't registered yet please do and bring a friend of yours. This day will include meals and networking. Athena's contribution to our field includes teaching, her many written works and mentorship of aspiring therapists. In May, CACPT is also sponsoring a training regarding preparing and testifying for court. We are hoping to provide this via webinar as well as in person in Kitchener, Ontario. Check out our web page for information on how to register for this short workshop.

If you are interested in hearing radio interviews with Inspirational Canadian Play Therapy supporters go to blogtalkradio.com/changing-steps. There is already an interview posted with our own Elizabeth Sharpe talking about what CACPT offers our members.

Lastly enjoy this issue of Playground. It is now being circulated not only to Canadian Play Therapists but Pediatricians and Children's Mental Health Centers so it is a great venue in which to advertise.

Remember We don't need an Rx2play!

Theresa Fraser.
C.C.W.(C.Y.C. Cert), M.A.
Certified Child Psychotherapist and Play Therapist
President of C.A.C.P.T.

Update from your Executive Director

Executive Director's Report

With Winter almost behind us and Spring promising to bring many new and exciting programs to our members, the CACPT Board of Directors and staff are poised to enter a whole new era for CACPT.

As you know, four and a half years ago, our association embarked upon a journey to become a truly national association in Canada. We struck a Transitional Task Force with representatives from across the country to engage in talks about the future and moved to the election of a national Board of Directors. Talks pursued on how we could serve our members across the country. Many exciting plans and dreams were shared by teleconference over the past four years and much has materialized in the way of programs and services. Our membership has definitely grown and interest in CACPT has increased rapidly. However, there has been one missing piece to this journey. We needed to find a way to bring our Board of Directors together for a face to face meeting.

On April 28th, for the first time, our national Board of Directors will have its Strategy and Goal Setting meeting in Guelph ON facilitated by a consultant who provides guidance to non-profit Boards. This facilitation will guide the Board and staff through a series of discussions that we hope will conclude with the production of a formal set of Core Values for our association, documented Goals and Objectives and formal plans for the short and long term.

It is a very exciting time in the life of CACPT and we welcome you to come to our Annual General Meeting, April 29th at the Holiday Inn and Conference Center in Guelph ON. There, we will share our successes from the past year, talk about the future and solicit your input on various aspects of our CACPT activities. The AGM will be preceded by a complimentary reception so you are able to meet other professionals who are interested in and practicing play therapy.

On April 29th and 30th during the day we are honoured to welcome Dr. Athena Drewes to Guelph from New York. Dr. Drewes will present two workshops that promise to be relative and enriching. For more on these workshops see our website at www.CACPT.com.

I am also pleased to announce that our first ever Ottawa Certificate Program continues throughout the year with workshops being delivered three days a month until December 2011. The London CACPT Certificate program has had a very successful enrolment and begins on May 16th at Kings University College in London. We continue to investigate ways in which we can offer our program in the east, west and northern communities and hope this year to move forward in this area. In order to do this, we require 20 committed students who are willing to sign up for the program, and an agency or individual who will sponsor the program and act as a local coordinator. Please let me know if you have ideas on how we can take our program across Canada.

Have a Happy Spring!

Respectfully submitted

Elizabeth A. Sharpe
Executive Director
Canadian Association for Child and Play Therapy

Playground Goes to China and The CACPT Membership Meets In Beijing

September 2010
By Sandra Webb

Hannah Sun Reid, Donna Cuthbertson and I (Sandra Webb) had a very comfortable CACPT membership meeting in our hotel room in Beijing. It was quite extravagant for Donna and I to travel to Beijing to meet with Hannah just for CACPT!! We are now trying to figure out what other destinations we can choose for our CACPT membership committee meetings! The exciting thing (one of them) is that our history together (Donna, Hannah and I) of being Play Therapists is what continues to bring us together in our work. Our love of children, our commitment to helping children through Play Therapy, Therapy®, Sandtray-Worldplay® and Attachment Based Therapies gives us tools to offer to a wide range of other professionals, other organizations like the Red Cross and other facilities like orphanages.

Hannah was already in China to work with the Red Cross. Hannah was born in China and has been doing Play Therapy training in Beijing with the Red Cross for a few years. Donna and I decided to join Hannah in Beijing. Hannah was the best tour guide and translator we could have ever asked for. While we were there we visited three very different orphanages. The first one was The Philip Hayden Foundation in TianJin. One of the staff members talked to us about setting up a Play Therapy program for the orphans. They

Lang Fang orphanage owner with Sandra, Donna and Hannah

were particularly interested in hearing our suggestions about how to help the children make the transition to adoption. This orphanage takes in children who need medical procedures and eventually most of these children are placed for adoption. We visited a small orphanage run by an American couple in Lang Fang. The children were all orphans with special needs who needed medical care. Many of the children have brittle bone disease. The last orphanage that we visited was the state orphanage in TianJin. There are 800 children in this orphanage.

Donna Cuthbertson, Hannah Sun-Reid and Sandra Webb are CACPT members and great friends. They all reside in the Cobourg Ontario region and do wonderful work with children and families.

CACPT'S Annual Two Day Training Workshop and Annual General Meeting

Book Your Calendar!

April 29 and 30, 2011

Guelph Ontario

Presenting Dr. Athena Drewes, Rhinebeck, New York.

Dr. Athena A. Drewes is a licensed child psychologist and Registered Play Therapist and Supervisor. She is Director of Clinical Training and APA-Accredited Doctoral Internship at Astor Services for Children and Families, a large multi-service nonprofit mental health agency in New York. She has over 25 years clinical experience in working with sexually abused and traumatized children and adolescents in school, outpatient and inpatient settings. She has been a clinical supervisor for over 15 years. She is a former Board of Director of the Association for Play Therapy and Founder/Past President of New York Association for Play Therapy. She has written and lectured extensively in the US and internationally on play therapy. Her books include School-based Play Therapy; Cultural Issues in Play Therapy; Supervision Can be Playful: Techniques for Child and Play Therapy Supervisors; Blending Play Therapy with Cognitive Behavioral Therapy: Evidence-Based and other Effective Treatments and Techniques, and School-based Play Therapy: Second Edition.

Further details on the workshop will be provided in the near future at www.cacpt.com.

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Theraplay® – A First Step to Managing Emotional Regulation

By Lorie Walton, M.Ed, CPT/S
Certified Theraplay® Therapist Trainer Supervisor
Family First Play Therapy Centre Inc, Bradford Ontario Canada

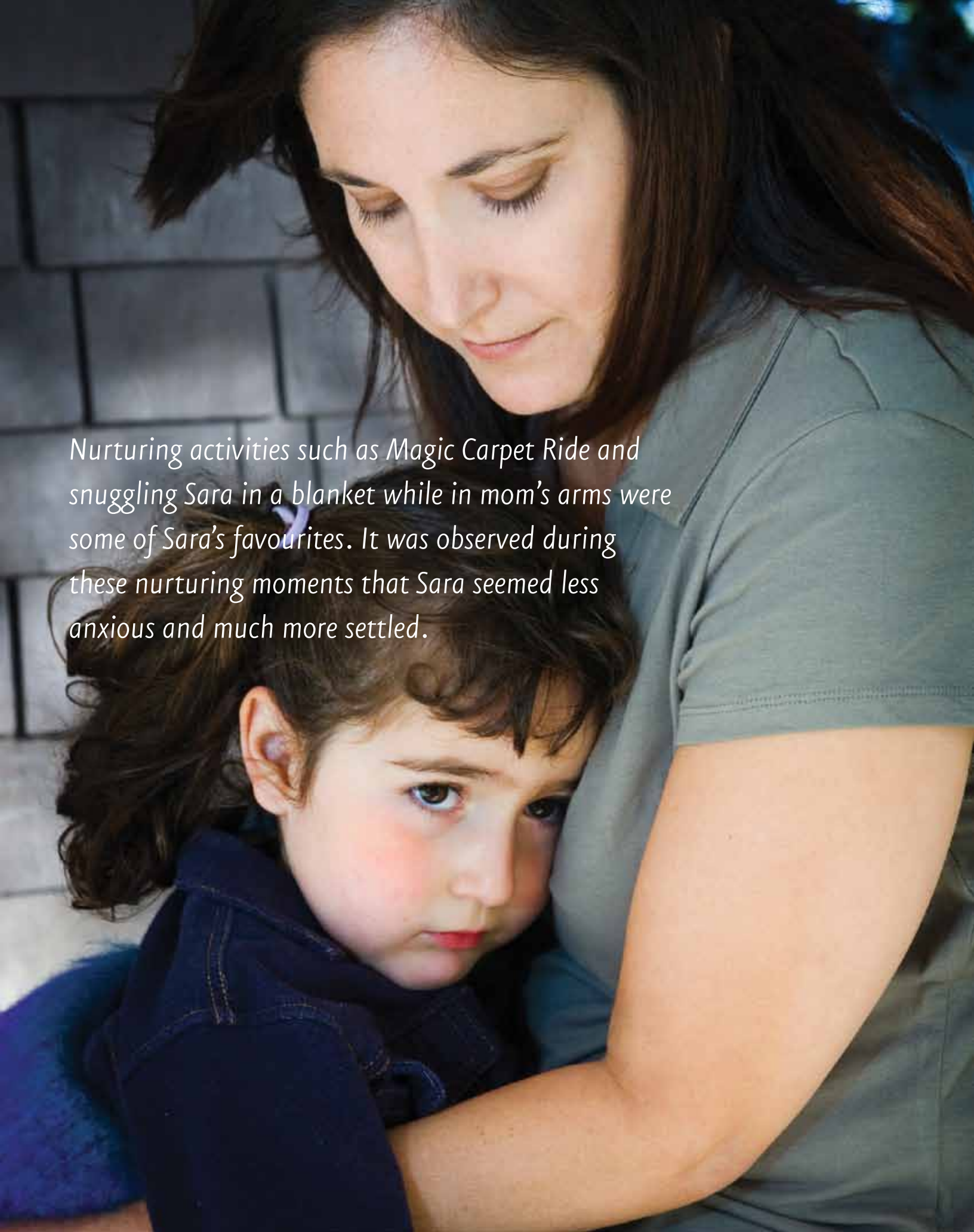
When children experience any type of challenge (emotional, developmental, educational, medical, familial) their emotional regulation systems experience a stress response. Ongoing stress reactions can impact the child's ability to maintain emotional regulation. Stress hormones such as cortisol and adrenaline, surge thru the child's body during stressful times. These hormones are negative and can impact the child's developing regulating system in inhibitive ways. The heart rate increases to power the human body during 'flight' or 'fight' responses and it must maintain its rhythmic pulse despite the varying demands placed on it. Thus, regulating heart rate during stress and controlling stress hormones are two critical tasks that require that the brain keep proper time (Perry, 2000).

Because children's emotional systems are still in the early stages of development (along with their brain and body systems), they require help in being soothed as they are often unable to soothe themselves without an attentive adults help. If left unsoothed, the child's overall emotional development may be negatively impacted long term thus potentially predisposing the child to anxiety and future mental health issues. Disturbances of the brain's rhythm-keeping regions are often causes of depression and other psychiatric disorders (Perry, 2000). Therefore if a young child's primary regulating system doesn't function well, not only will his hormonal and emotional reactions to stress be difficult to modulate, but other systems like sleeping and eating, learning motor functions, and responding to others in positive ways will be unpredictable as well.

Most often, children with dysregulated emotional systems require first an intervention which helps their body unconsciously experience soothing and calming from an external source BEFORE they are able to consciously begin to master their fight, flight, freeze responses in a controlled and motivated way. The regulation of emotions is equal to helping a child securely attach. Attachment researchers have demonstrated that attuned, engaging interactions between a baby and mother leads to secure attachment, positive internal working models of self and world and the capacity to regulate emotions and actions (Sroufe 2005).

When considering which therapeutic modality to use, it is best to consider two important aspects of the child's presentation: 1. Does the child's emotional system appear younger than his chronological age? And 2. Does the child have a significant attachment caregiver who can learn how to attune to the child's internal dysregulated states and provide soothing and nurturing experiences to effectively help the child's brain and body systems begin to 'balance'? Theraplay® is an evidenced-based intervention which helps children experience emotional regulation by participating in playful, attuned experiences with their parent or caregiver. One of its many assets is its ability to assist a caregiver use attuned nurturing and soothing responses to help the emotionally dysregulated child's body internalize new responses to stress. Below is a brief account on how Theraplay was used to help an anxious child.

7 year old Sara, was referred for Theraplay in order to help reduce the highly anxious behaviours she was presenting with.



Nurturing activities such as Magic Carpet Ride and snuggling Sara in a blanket while in mom's arms were some of Sara's favourites. It was observed during these nurturing moments that Sara seemed less anxious and much more settled.

Sara's parents spoke honestly of their own anxiety in regards to parenting Sara. They reported her behaviours as very challenging at times especially pertaining to separation when going to school. They also reported her as fearful, nervous and aggressive especially with family members.

Sara participated in 12 Theraplay sessions with her mother and father. The Marschak Interaction Method Assessment was done prior to the Theraplay sessions in order to assess attachment and relationship strengths and needs. During this assessment, Sara was observed as hyper-vigilant, controlling, aggressive and rejecting and very anxious about being left alone. This behaviour substantiated reports from home, and strongly indicated Sara's dysregulated emotional state. Thus, goals for Theraplay treatment were set to decrease her anxiety and hyper-vigilance, increase Sara's self-confidence in order to master challenges and assist Sara in strengthening the bonds of attachment with her parents. Goals were also set to help Sara's parents feel more confident about their ability to parent Sara.

The Theraplay sessions were structured so that Sara could interact with her father as much as with her mother. Nurturing and engaging techniques were introduced in order to assist in strengthening Sara's trust with her parents. Through activities such as measuring, or cotton ball soothe, the parents were encouraged to point out special qualities about Sara to help her feel noticed and to encourage body awareness. Initially, Sara appeared somewhat uncomfortable when receiving positive comments about herself. She would not make eye contact and would often become fidgety and try to change the subject. At times, during more active games she would be rough towards her mom, but once encouraged to use Feather High-5's she was able to demonstrate her ability to be more gentle and controlled.

During initial Theraplay sessions, Sara sometimes appeared unable to keep up with the pace of activities and she often seemed anxious when too many directions were given at once. She appeared challenged when more than one person was speaking to her or when information was given at a pace which was difficult for her to process. Thus, the following modifications and suggestions were made in order to address these issues:

- Modeling techniques were used in order to provide Sara with the opportunity to observe new tasks before it was her turn
- The parents were encouraged to have only one person speak to Sara at a time, so that she could process information more easily
- When providing Sara with directions, the parents were encouraged to give no more than 2 step directions at a time, in order to relieve some of the anxiety for Sara in completing the task
- Calming and relaxation techniques were modeled for Sara (ie: blowing on her fingers) in order to help Sara learn how to reduce some of her anxious feelings. The parents were encouraged to practice these techniques at home in order to assist Sara in using them when she most needed to.

During each session, the parents were invited to keep a physical connection with Sara. Sara would be placed on Dad's knee facing Mom so that Mom could massage lotion into Sara's hands and arms. Stick-together games were incorporated to help the parents remain 'physically' connected to their daughter as much as possible. Nurturing activities such as Magic Carpet Ride and snuggling Sara in a blanket while in mom's arms were some of Sara's favourites. It was observed during these nurturing moments that Sara seemed less anxious and much more settled. During one session, after being rocked in a blanket and then put into mom's arms, Sara almost fell asleep.

After each Theraplay session, a co-therapist would take Sara into another room to play in order to allow the parents and therapist to review weekly progress and challenges. During these discussions, Sara's parents were comfortable in expressing their anxiety around parenting Sara when she exhibited impulsivity, and controlling and aggressive behaviours. Parenting strategies were suggested and the parents were encouraged to attune to Sarah's younger emotional needs. Over time, the parents reported that they had begun to proactively incorporate Theraplay strategies which included attunement, nurture and structure as much as possible in order to help Sara feel less anxious and more secure.

The playful interactions within the Theraplay experience creates the opportunity to share ones bodily reality and ones emotional reality in expanded, dyadic states of preverbal consciousness (Makela, 2003). Theraplay is tailored to give corrective experiences in physical co-regulation through its extensive use of touch, eye contact and the calming and stimulating way of speaking throughout the playful interactions which include Structure, Engagement, Nurture and Challenge. At the same time it creates a resonant hum of emotions through attunement - the noticing of the minutest emotional cues of the child and responding to them (Makela, 2003). Being' noticed' makes all the difference to an anxious child's predisposition of insecurity.

There is a growing body of research which outlines the positive impact of healthy physical contact on people of all ages. Barnard & Brazelton (1990) and Field (1993) found that loving touch produces oxytocin and releases endogenous opioids, which are known to solidify infant-mother bonds. During Theraplay, touch is used in playful, nurturing and structured ways to help connect the child's unconscious brain and body systems to those of their parent's calmer ones. Incorporating touch within the Theraplay session helps to reduce the child's internal emotional stress responses. Oxytocin, opioids and endorphins counter-act the cortisol responses within the child's body and allow the child to experience pleasure and internal calm. As a child begins to enjoy playful interactions with her parent, the child's internal blueprint

eventually becomes 'rewritten' to include a calmer internal response to external stressors. As the parent becomes the co-regulator of the child, the child begins to feel internal regulation which leads to security within oneself and then eventually with others and their world.

Theraplay helps children to experience the internal capacity of 'calm' from their co-regulating caregivers at a pre-verbal level, which is lower on the hierarchy of cognitive development than other more cognitively sophisticated interventions. Once a child has cognitively and emotionally matured, more sophisticated interventions, such as CBPT, can then be considered to help anxious children begin to consciously master their internal stress reactions. Thus, Theraplay can be considered a 'first-step' in the intervention protocol to help a predisposed anxious child begin to master control over their emotional triggers.

By the end of the 12 sessions, Sara had begun to demonstrate her ability to respond with eagerness instead of with a 'fight' response such as aggression. Her parents also reported that Sara appeared less anxious, less controlling at home and appeared more confident in going to school. During a follow-up session, Sara's parents reported that she seemed calmer and more affectionate with them. Her dad said it best when he stated "Now she wakes up singing in the morning!"

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About the Author

Lorie Walton, M.Ed., is a private Child Psychotherapist Play Therapist Supervisor and Theraplay® Therapist Trainer Supervisor. She is the owner and lead therapist of Family First Play Therapy Center Inc., in Bradford Ontario where she helps children and families who are experiencing attachment issues and emotional trauma. She is also the Past-President of the Canadian Association for Child and Play Therapy (CACPT). She provides supervision, training and internship positions for Theraplay® and Play Therapy. You may reach her at familyfirstplaytherapy@bellnet.ca.

Hal and Chis Nuninger, the parents of H.I.S. Home, a Creche in Haiti

Playground Goes to Haiti

By Sandra Webb

In October 2010, Brian Nichols and I travelled to Haiti with Mission of T.EA.R.S. This Toronto based agency does humanitarian work in many countries around the world (www.missionoftears.ca). Our work was primarily with H.I.S. Home for Children (www.hishomeforchildren.com), a Crèche for children. The Crèche has 80 children in their main home. H.I.S. Home was asked by Social Services in Haiti to begin a separate home for girls who have been sexually abused in the tent camps. Brian and I were asked to look at the feasibility of setting up therapeutic programs for these girls. We feel fortunate that we were able to go to Haiti. We witnessed firsthand the devastation that this country has experienced including the effects this has had on the children of Haiti. It was a privilege to be able to go to Haiti and offer our expertise in Play Therapy, Art Therapy and Sandtray Therapy. The plan was that we would return to Haiti every three months. Unfortunately, Brian and I concluded that the staff of the girl's home was not qualified to support the therapeutic programs in our absence and that this is not their role. For now, the home and its staff are focusing on the basic needs of the children – safety, food and shelter. The board of Mission of Tears is reviewing the plan for this project in Haiti and our possible role in the future. When we began our careers, we had no idea where it would take us. It is good to trust in this process and know that our lives will take us to the places we are meant to be. Brian and I felt so blessed to have skills to offer these children and the country of Haiti.

Sandra Webb is a therapist/adoption practitioner in Cobourg, ON. For more information about Sandra's services go to www.sandrawebbcounselling.com

Play Therapy and Children with ADHD

By Siobhán Prendiville

ADHD is an Emotional Regulation issue and the most common diagnosis of childhood, with well-documented evidence that problematic long-term effects may result. Thus, interventions that occur in the early school years may reduce the impact of ADHD for children in the short and long term (Ray, D.C., Schottelkorb, A, &Tsau, M., 2007.p 109).

What is A.D.H.D?

"ADHD is characterised by an early onset (before 7 years) of the combination of overactive poorly modulated behaviour with marked inattention, lack of persistent task involvement, restlessness, impulsive tendencies, and a high degree of distractibility. These characteristics are pervasive across situations and persistent over time" (WHO, 1992).

Barkley (2006) an expert in A.D.H.D describes the disorder as a "Neuro-behavioural syndrome, characterised by core triad of symptoms, including persistent overactivity, impulsivity and difficulties in sustaining attention". He proposes that children with A.D.H.D may also present with some or all of the following symptoms;

- poor rule-regulated behaviour,
- poor delay of gratification,
- behavioural disinhibition,
- poor impulse control,
- school performance deficits,
- learning and language difficulties,
- motor and physical deficits,
- social skills deficits

These symptoms impact the child's many life spaces and relationships. According to Yeager & Yeager (2009) medical management and the combination treatment proved to be significantly superior to routine community care and psychosocial–behavioural treatment alone. Medication alone produced significant improvement but combination treatment maximised improvements and at times achieved results with somewhat lower doses of medication.

In addition important adults in the child's life, such as teachers and parents, were more satisfied with treatments that utilized behavioural therapy rather than medication alone. According to Kail (2007, 150) the MTA also emphasised the need for medication to be monitored carefully, regular visits to health care professionals and regular contact with the child's school.

Play Therapy and Children with A.D.H.D

Medications and behavioural interventions, not play therapy, have taken precedence in the treatment of children with A.D.H.D (Barkley, 2006). According to Gnaulati (2008), the primacy that has been given to medication and behavioural interventions has resulted in play therapy being marginalised as a treatment for A.D.H.D. However, there is growing evidence to suggest that play therapy can be a successful intervention for children with A.D.H.D.

According to Walcott and Landau (2004) children with A.D.H.D often have difficulty toning down the intensity of their emotional communication to successfully realize social goals. Gnaulati (2008) argues that play therapy can help children with this difficulty of handling emotional highs and lows in everyday social interactions. In order to do this Gnaulati (2008) believes that the play therapist must incorporate a high degree of activity and emotional arousal into the play therapy sessions. In such work the play therapist will not remain non-directive. Rather, she will skilfully throw herself into the play and adapt the play regularly in order to arouse and de-arouse the child. Gnaulati (2008) believes that in taking on a participatory, emotion-centred, action-orientated role in the play, the play therapist ensures a large range and intensity of emotion will enter the play. The child's engagement in such play, within the trusted therapeutic relationship, will challenge and fortify his emotion regulation capacities.

Yeager and Yeager (2009) also argue that play therapy is an appropriate intervention in the treatment of A.D.H.D. Their argument is based on the recognition that A.D.H.D is linked to poor executive functions, which allow the individual to regulate his or her own behaviour. In particular the self-regulating function of internalised speech supports the argument for the use of play therapy in the treatment of A.D.H.D. Barkley (2003) believes that children with A.D.H.D make the transition from audible private speech, to internalised speech much later than children without A.D.H.D. As private speech is directly linked to self-regulation it is important to allow children with A.D.H.D to use private speech as needed and to help them to use it more effectively. Children use private speech often during play, to direct action. Play is a natural way in which children practice moving from audible private speech to internalized private speech. Therefore, play therapy which provides children with increased play opportunities, opportunities to engage in manual manipulation of materials, and active externalised playful behaviours, can help children with A.D.H.D develop the executive function of internalized speech.

Similarly play has a significant role in the development of many other executive functions. According to Yeager (2009) play is "a natural and developmentally appropriate way that children practice regulating their behaviour". Traditional childhood games such as "Simon Says", "Statues" and "Freeze Tag", allow children to practice behaviours that are central to executive functioning (e.g. behavioural inhibition, working memory, emotional regulation, self-monitoring) in a fun, relaxed and child-centred way. The ability of play to help develop executive functions is paramount for the play therapist. As a result play therapists must ensure that they remain up to date with the emerging research on the link between A.D.H.D and executive functions. It is through this research that the critical importance of play therapy in treating A.D.H.D will emerge.

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About the Author

Siobhan Prendiville BEd, PG Ed., MEd., Diploma Play Therapy, is a teacher and play therapist who specializes in the use of play in education and in therapy. Her main research interests are in the developmental and therapeutic use of puppets, sand, and water play. She teaches widely in a number of institutions in Ireland and is involved in training teachers in pilot programmes to influence the teaching methodologies utilized. In addition to her teaching positions, she maintains a private play therapy practice. She graciously agreed to share this article with CACPT and the Canadian Play Therapy community.

Ethical Issues

Dual Relationships: When Relationships at Work Become Complicated

by Nancy Stevens MEd. (Psy); CPT; CCC
CACPT Ethics Chair

As therapists we all know that the therapist-client relationship is unique and pivotal to the healing process for our clients. In a recent workshop I attended, this relationship was described as one in which the therapist and client exist in a 'bubble', surrounded by an invisible membrane that serves to protect the relationship from outside forces, and provides a safe haven of sorts within which the work of therapy can take place (Dual Relationships Webinar; CCPA , January, 2011). And of course it is the central ethical directive of most professional codes that the therapist maintain and protect this relationship first and foremost in the decisions we make throughout the course of our work. These guidelines also apply to professional relationships with students and supervisees, although the requirements may be more flexible in certain areas.

A dual relationship exists when therapists, "simultaneously or sequentially, have one or more relationships with a client additional to the counselling relationship" (CCPA, Standards of Practice for Counsellors, 2008, p17). This may happen when a personal or business relationship is formed with an existing client, such as engaging them in a friendship outside of therapy, hiring them to provide services within our home, or joining a mutually attended club or other organized activity in the community (such as a book club or a soccer team). Dual relationships can also exist when a second professional relationship is entered into with an existing client, such as having a client become our realtor or our lawyer. In certain situations, dual relationships can arise from adding a therapeutic relationship to a preexisting personal or professional relationship, such as would be the case if our child's teacher, for example, was referred to us for counselling, or if a newly referred client turned out to be our next door neighbour, with whom we already share a 'neighbourly' relationship.

CACPT's ethical practise guidelines (and indeed those of other psychotherapy associations, such as the Canadian Counselling and Psychotherapy Association [CCPA] and the Canadian Psychological Association [CPA]) caution us to "make every effort to avoid dual relationships with clients" (CACPT Code of Ethics, Part V-32). The reason for this, simply stated, is that adding a second relationship, with different roles and expectations, and a separate agenda, presents a conflict of interest for the therapist, in that it jeopardizes our ability to protect the therapeutic relationship, with it's membrane intact and unaffected by other relationships. This conflict of interest compromises therapists' ability to protect our clients' interests increasingly as the expectations of the multiple roles diverge (i.e. conflict with one another). The vulnerability of clients and the increased personal power of therapists in the context of the therapeutic relationship are central to this concern. As therapists we must be vigilant in our protection of our clients' therapeutic needs and the therapeutic tryst, ensuring that we never put our own needs or personal gain above those of our clients. And so the greater the disparity between the needs of the therapeutic relationship and those of a secondary relationship, the greater the conflict. Engaging in such incompatible roles presents enormous risks to our clients and to our professional selves. Two primary areas of risk identified in our ethical practice guidelines include: 1) Impaired Professional Judgement- the conflicting needs of our dual roles may negatively affect the quality of our professional services to our client, by jeopardizing our objectivity and impairing our professional judgement, thereby increasing risk of harm to the client; and 2) Misuse of Power- power differences that exist and are appropriate within the context of the therapeutic relationship become problematic when other relationships (e.g., social or business) are formed. The risk of undue influence or exploitation (whether inadvertent or intentional) must be recognized.

An example may be helpful in illustrating these risks. Imagine you are providing therapy to a child and her parents for a period of some months, during which time you forge a strong therapeutic bond with all family members, and are in active therapy with them. As you learn more about the issues confronting this family, you discover that the father/husband has recently lost his job as a plumber, and that the loss of income presents an immense stressor for the family, one which is evidenced in loss of progress in therapy and overall family functioning. It would be easy to wish you could be of help to the family in a practical

way, if for no other reason than to re-stabilize them and facilitate re-engagement in the healing process. And it may just so happen that you and your spouse have been planning major home renovations and have been looking for a qualified plumber yourselves, with little or no luck. With the best of intentions, you may decide to offer the home plumbing contract to your client. He comes into your home over a period of several weeks, completes the work, receives his pay, and all is well. It could very well happen this way.

However, let us imagine that, as you continue in therapy with the family, there ensues marital conflict regarding parenting or other matters in the family. It is possible that you have gotten to know this father/husband quite well during the many hours he has spent in your home; developed increased empathy and appreciation for his hard work and efforts at making a better life for himself and his family. On the other hand, you do not have that added personal and business relationship with his wife. It may be quite difficult, if not impossible, to maintain or resume your prior objective stance with the family in addressing conflicts that arise. In this case, the secondary personal and business relationship forged with the father/husband may interfere with your capacity to exercise sound professional judgement in the therapeutic context due to increased sympathy for his point of view.

There is also the possibility that after a few weeks go by, you become aware of certain problems in the quality of service provided by the client-plumber. You have grown to like him very much, both personally and professionally, but now must address concerns, such as improperly sealed pipes, for which you must be recompensed (monetarily, with labour, or possibly with both). Of course this would prove extremely awkward, as it may jeopardize the family's financial well-being as well as your therapeutic relationship with them. Now you must decide whether to place your valid needs/expectations inherent in the business relationship ahead of your therapeutic commitment to (and therefore the needs of) the family. Clearly the roles and expectations of the multiple relationships forged with members of this family are at odds. And so this well-intended gesture evolves into an ethical nightmare of sorts.

I am certain that we can all imagine a multitude of scenarios by which we may stray into dangerous ethical waters, even with the most innocent of intentions. And we all strive to avoid these professional pitfalls. But what if situations arise that are largely out of our control? What if dual or multiple relationships are thrust upon us by circumstances outside our realm of influence? Unfortunately, many of us, particularly those living in rural or remote parts of the country, reside in very small communities in which the existence of dual relationships is virtually unavoidable. In some communities your therapy client will invariably turn out to be your emergency nurse, or the mother of your child's latest boyfriend, or a member of your son's swim team . Even in larger communities it is easy to discover, somewhat after the fact, that your client is an estranged family member of another client, or has retained your spouse as a lawyer in some legal matter. Even those of us who work primarily with children will find this to be the case. The possibilities are endless, and such cases can present complex ethical dilemmas as we endeavour to "do no harm" and to "do good" in our mandate to improve the lives of the clients and communities we serve.

CACPT's Code of Ethics and those of CCPA and CPA provide guidelines for navigating such situations. Indeed, the progression for ethical decision-making regarding dual relationships appears to be universal across psychotherapy associations. The process is as follows:

1. "Make every effort to avoid dual relationships with clients that could impair professional judgement or increase the risk of harm to clients" (CCPA , Standards of Practice for Counsellors, 2008, p 17).
2. When dual relationships arise, terminate them if ethical and appropriate. This might mean disclosing the conflict to the client and ending the professional relationship by making an appropriate referral to another professional (CACPT Code of Ethics, Part V-34)
3. In circumstances where it may be " impossible or unreasonable... to avoid social or other non-counselling contact with clients, students, supervisees...." (CCPA Standards of practice for Counsellors 2008, p 17), take the following appropriate professional precautions:
    a) clearly communicate expectations in the disparate roles to he client, with reassurances and reminders of role differences as contact moves between/across roles (for example a school counsellor would not refer publicly to any content shared during a counselling session in her role as teacher to the same student)
    b) obtain informed consent that outlines the nature of the dual roles and how they will be handled
    c) document well so that you are recording well your ethical decision-making processes and efforts at handling the conflict professionally and
    d) consult with others so as to ensure objectivity and quality service provision in spite of the risks of the dual relationship.

In the end it is the best interests of the client that must determine decisions around roles and dual relationships. Self reflection and consultation with other professionals is pivotal in all ethical decision making.

For more information, see: http://www.cpa.ca/home; http://www.cacpt.com/; http://www.ccacc.ca/home.html

If you have an ethics topic or question that you would like more information on, or to have addressed in the next edition of Playground, please forward your suggestions to nstevens@sasktel.net.

Announcing the

CACPT Continuing Education Approved Provider Program

CACPT would like to offer individuals, organizations or businesses the opportunity to provide play therapy training to those interested in accumulating credits towards play therapy certification with CACPT as well as to those who are interested in gaining play therapy training to enhance their professional skills.

Two types of providers will be offered:

Type 1: Provides play therapy training at multiple events (conferences, workshops, etc.) and programs during a 36-month approval period.

Type 2: Provides play therapy training at one event that neither extends beyond five consecutive days nor offers more than 30 hours of play therapy credit.

For more information see the CACPT Approved Continuing Education Provider Program Guide and Application Form available on the website under Education and Programs:

www.cacpt.com

Supervisor Manual

An Initiative of

The Canadian Association for Child and Play Therapy

CACPT is updating the Supervisor Manual. We need your input! Please send us your ideas on the following:

- Best Practice Tips on play therapy supervision
- Qualities of a good play therapy supervisor
- Forms on play therapy supervision
- Articles or books to add to the bibliography on play therapy supervision

Please email your ideas **to** Judith Bertoia:
jbertoia@dccnet.com

Looking For Play Therapy Supervision?

A complete listing of CACPT Supervisors is on the CACPT website. If you cannot find a supervisor in your local area, many of our supervisors conduct distance supervision. Our list of supervisors is updated periodically, so please check the website regularly for the latest info!

www.cacpt.com

Healing Spaces

by Theresa Fraser

Healing Spaces is an ongoing article in Playground. If you would like your playroom featured please contact theresafraser@rogers.com <mailto:theresafraser@rogers.com>. Theresa is particularly interested in hearing from therapists from other provinces. Thus far therapists from Nova Scotia, Ontario, Manitoba and the North West Territories have been featured in Playground. This edition of Healing Spaces is focused on Dr. Marie-Jose Dhaese who practices and teaches in British Columbia.

Dr. Dhaese was born and educated in France. She is a Registered Art Therapist (ATR), a Certified Expressive Therapist (CET), a Registered Play Therapist Supervisor (RPT-S), a certified Child Psychotherapist and Play Therapist Supervisor with our own Canadian Association for Child and Play Therapy, and a Registered Clinical Counsellor (RCC). She holds diplomas in family therapy and EMDR. Dr. Dhaese has over 35 years experience as a Counsellor and an Adult and Child Psychotherapist. Internationally, Dr. Dhaese has been teaching the therapeutic methods she has developed (particularly in the field of abuse, loss and trauma) for the past 25 years.

The Centre for Expressive Therapy

Dr. Dhaese's private practice provides service to children as young as 2 to 92 years of age. Her current centre was built two years ago. She shared that she has built a place where she wants clients to feel safe to connect with their strengths and then their pain. She believes that from the time people come from car to entrance, they should experience being on a safe journey. Therefore, centre visitors enter through an archway that has honeysuckle growing on it. She will soon add the sounds of a waterfall as she believes comforting sights and sounds are important in creating a comforting experience. She stressed that it is important that individuals to be able to first breathe when they enter the Centre. This metaphor of a path and a gateway provides a foundation for creating comfort and safety. At the end of the pathway visitors are greeted by Dr. Dhaese and her two standard poodles who may act as her co- therapists (dependent on information procured at a prior Intake meeting).

Once inside the first thing that people will see is a kitchen table where couples and older children may enjoy a snack and a cup of tea.

Art Therapy and Sand Play tools

There is an Art therapy area where everything is contained inside pine colored wood. These materials as well as other areas of the Play Therapy room open gradually according to client's individual need and level of comfort. She believes that individuals need to have the feeling of positive touch which is exemplified with the soft textures that cover shelving. The three sand trays that hold different colors of sand are covered with boards where clients who are not comfortable with the sand can still make three dimensional images and use different textures of materials as well.

There is also a glider chair at her centre that is used by all age groups in addition to a few rocking chairs. Children will sometimes sit in these and drink from a baby bottle while others will use a rocking chair as a throne. The co-therapists also have a dog bed in the playroom.

Dr. Dhaese believes that in any playroom there needs to be items that facilitate the expression of the full range of feelings. This applies to paints with the range of colors and types (watercolors to tempera) as well as musical instruments that range from little bells to rain sticks to a large drum obtained from Africa.

A Wood stove can provide heat but is only lit up for adults and older children and youth. Dr. Dhaese believes there is value in natural heat and looking at the fire while talking. Additionally, older children who have fire setting issues have an opportunity to work with this in a safe and healing way.

In one area there are baskets with different color blankets inside. These were knitted by Dr. Dhaese herself and are made of mohair and different colors and different types of wool. These blankets have been used by children as flames on a doll house, or to wrap a

Marie Jose and her co-therapists by the pond

baby doll in need. As well as using blankets and cloth of different colors and texture, she also uses felting (making balls of different colors made out of felt out of raw wool, with warm water and soap). Dr. Dhaese noted that she has found the making of these balls to be especially helpful for grounding purposes with children, youth or adults who have difficulty staying in their bodies. These felt balls can also be used for curative exercises with children, to practice back and forth reciprocity, focused release of energy etc…

In another area there is a stage and a cozy corner with cushions and curtains. On the stage there is also a dollhouse that was made many years ago. This wooden dollhouse has an attic and basement and Dr. Dhaese remarks that a lot of things happen in basements for some children. This dollhouse has a door with a key though the key was lost in her last move. Children sometimes love it because it has a fire escape and chimney. The whole house also supports the principle of healing inside out and outside in. Dr. Dhaese teaches that expressing painful experiences (healing from inside out), needs to be done in an environment that is soothing and healing (healing from the outside in). Such an environment helps to hold the expression of painful experiences and ensures that the client is not overwhelmed.

Under the stage is stored a dress-up box filled with clothes, masks, magic wands, jewelry, and face paints. On the wall nearby there is a mirror that opens and closes. There is also a large box underneath the stage that holds items for children who have experienced early trauma. This wooden box has wheels and children often pretend it is a bed and by using this enclosure they may regress and go back to whatever time they need to be in while they can do other things. For those who may have experienced trauma as a baby, they will lay in box surrounded by cushions while at the same time they can be older and perhaps would like to draw or do something in the sand tray. On these occasions Dr. Dhaese has a tray that can be laid across them and they can have a sand tray put on the tray so they are working out issues in different developmental stages at the same time. Given the box has wheels; she can move her client to wherever he/she needs to be in the room.

Tips for new therapists

Dr. Dhaese shared that when she started working with children she had a few pieces of cloth under a table and didn't have the ideal playroom. She has done good sessions with nothing and done

Let's discover what is behind those doors!

unsatisfactory work with many tools. So the tools don't dictate the quality of work. She believes that providing tools gradually so the child or adult doesn't get overwhelmed is important. She stressed that it is her belief that therapists need to be flexible and adjust to the needs of their clients but first they need to attune to their clients. When this is achieved they can observe and provide what is needed.

Children need the experience of healing touch especially those who have experienced painful touch. She noted that she recommends that Play Therapists should start with few things but the things that they are going to use, they need to know how to use them well. She recommends that Therapists spend time with each of these expressive tools and choose carefully. Therapists need to have a relationship with their miniatures and try to use them in different ways prior to making them available for client use.

Written works

Dr. Dhaese has written a chapter in a soon to be edited book by Dr. Sue Bratton, Dr. Athena Drewes and Dr. Charles Schaeffer. More information about her work and the training she provides other therapists can be found at

www.centreforexpressivetherapy.com

About the author

Theresa is a fully certified Child Psychotherapist and Play Therapist and practices in Cambridge, Ontario. She is a Part Time Professor at Mohawk College and Sheridan College. In 2009 her book Billy had to Move: a foster care story was published and is available at Amazon.ca <http://Amazon.ca/>.

Five Strategies to Prevent a Sensitive Boy from Being Bullied

By Ted Zeff, Ph.D.

Did you know that 20% percent of the population has a sensitive nervous system and the trait is equally divided between males and females? Therefore, 20 percent of all males are sensitive, or one out of every five boys has a finely tuned nervous system. A highly sensitive boy (HSB) can be easily overwhelmed by noise and crowds, fearful of new situations and shy away from aggressive interactions. He generally reacts more deeply and exhibits more emotional sensitivity than the non-sensitive boy which unfortunately could result in his being bullied.

According to the National Association of School Psychologists, 160,000 children miss school every day in the United States for fear of being bullied; more than 50 suicides have been linked to prolonged bullying; and approximately 85 percent of school shootings have revenge against bullies as a major motive. School-related bullying has led to depression and poor school performance in many children.

Although research has shown that infant boys are more emotionally reactive than infant girls, by the time boys reach the age of five, they have usually learned to repress every emotion except anger. Societal values emphasize that males should be aggressive, thick-skinned, and emotionally self-controlled, which is the opposite of a sensitive boy. When boys don't conform to the "boy code" and instead show their gentleness and emotions, they are often ostracized and humiliated.

Bullies tend to target kids who seem different from others. Since the 80 percent of non-HSBs are hard-wired neurologically to behave in a different manner than the 20 percent of HSBs, many sensitive boys do not fit in with the vast majority of boys and risk being bullied. Bullies also target kids who don't fight back and who react deeply to teasing. Research shows that 85 percent of HSBs avoided fighting and most sensitive boys become more emotionally upset from bullying than other boys.

How can we prevent sensitive boys from being bullied?

Develop Confidence in the HSB With Support from Parents and Other Adults

Unconditional love and support from parents and other adults will give an HSB the confidence he needs to face difficult situations. Unfortunately, when the burden is placed on one or two frequently stressed-out adults, it's difficult to give the unconditional love and support a sensitive boy needs. Studies have shown that boys who had positive, loving relationships with adults other than parents (grandparents, aunts, uncles, etc.) reported having more positive experiences as a child than those who did not have these additional relationships. Sensitive men from India and Thailand reported experiencing happier childhoods than those from North America, which may be due to the role of the extended family and community in raising children in those cultures. So it's important that HSBs develop positive relationships with adult extended family members, friends, teachers, counselors, coaches, and other community members.

Some people believe that boys need stronger discipline than girls. However, a sensitive boy can learn a lesson better when he is calm and receptive, so when adults are disciplining an HSB it's vital to talk to him in a gentle manner. When adults set limits in a calm, yet firm manner it will not lower his self-esteem.

Mothers generally spend more time with their children, so they are frequently in a position to bolster a sensitive boy's confidence. However, fathers (or uncles, grandfathers, or other male role models) need to spend special, positive time with an HSB. While a father (or male role model) needs to teach the HSB how to stand up for himself, the adult male also has to understand, protect, and encourage a sensitive boy. When a man accepts an HSB's trait of sensitivity instead of trying to mold him into a non-HSB, it will raise his self-esteem.

Make School a Safe Place for a Sensitive Boy

If a boy gets bullied in school it's important for adults to let him know effective methods to handle the situation. According to the Youth Voice Project, which surveyed 11,000 teens in 25 schools, the most effective solutions to stopping bullying were accessing the support of adults and peers. Less-effective strategies were ignoring the bullying, telling them to stop, and walking away.

Learning self-defense can give an HSB more confidence when confronted by bullying. The P.T.A. or the principal could arrange for a professional to come to the school to offer an anti-bullying program. If an HSB has tried the methods I mentioned above but the bullying does not stop (or becomes violent), contact the school principal since the HSB's safety and sense of well-being is of prime importance.

If the bullying continues, there may be the possibility of attending a progressive private school (i.e. Montessori, Waldorf, Steiner), that could be more conducive for an HSB's emotional and educational needs than a large public school. Homeschooling is ideal for most sensitive boys since the HSB thrives in a safe, quiet, less-stimulating environment where they are free to pursue both core and creative subjects at their own pace. To compensate for the lack of social interaction, it's important for the boy to get together with other children who are also being homeschooled, hire tutors, and enroll him in special classes.

Help the HSB Obtain Peer Support Through New Friendships

Most boys prefer to socialize in large groups, yet sensitive boys usually prefer to interact with only one friend or play by themselves. Since they shy away from aggressive, combative interactions, HSBs may have difficulties making friends with other boys.

It may be better for an HSB to have just one friend rather than trying to be accepted by a group of non-HSBs. However, it could be beneficial for a sensitive boy to learn how to navigate through the majority non-sensitive boy culture as long as the friends involved remain respectful. It's important for the HSB to create a balance between spending time alone and with friends or he may not learn successful interpersonal skills.

Help the Sensitive Boy Become Physically Fit

When a boy becomes involved in sports, he feels accepted by his peers, which increases his self-esteem. Most boys are involved in some team sports but research indicates that 85 percent of sensitive boys did not participate in team sports and most preferred to participate in individual exercise. Since HSBs do not perform well under group pressure and may be deeply hurt by the cruel culture of malicious "boy teasing" while playing sports with other boys, they generally avoid such interactions.

Regardless of athletic ability, it's important for the HSB to participate in physical exercise since it will help him become healthier, stronger, and more confident. When an HSB has someone to teach and encourage him how to play various games, he could thrive, even in the insensitive world of male sports. However, before a sensitive boy joins a team, a parent or guardian should talk with the coach and possibly other parents to make sure that the players are treated with respect and are not overly competitive. The key is to find athletic activities that the HSB authentically enjoys.

As previously mentioned, learning some form of self-defense can really empower a sensitive boy, helping him feel safe and better able to fend off bullies if needed. It's important to let the instructor know that the sensitive boy needs support from the trainer. The sensitive boy who masters some form of self-defense becomes less fearful, more confident and frequently more sociable.

...continued on page 20

Increase an HSB's Self-esteem

Research has shown that the more dissatisfied a boy is with his body, the poorer his self-esteem. Therefore, a sensitive boy who reacts more deeply to teasing about his physical appearance than a non-HSB is at risk for developing low self-esteem. Though the media can be a strong influence on a child, as an adult in his life you are the stronger influence and the power to let him know that his body is perfect exactly as it is. Discuss how the media is perpetuating myths about what a male body should look like.

An important aspect of a positive body image is good health. Stress affects health, and since an HSB may be more vulnerable to stress than the non-HSB, it's important to help him maintain a preventative health-maintenance program by making sure he eats a healthy diet, gets enough sleep, and gets regular exercise.

There are millions of parents, teachers, counselors, and therapists of sensitive boys trying to help HSBs cope in a world that does not appreciate sensitivity in males. As you begin integrating some of the suggestions in this article into your work with the HSB, you will start seeing positive changes as he becomes a stronger and more confident boy.

About The Author

Ted Zeff, Ph.D., received his doctorate in psychology in 1981 from the California Institute of Integral Studies in San Francisco, CA. He is the author of The Highly Sensitive Person's Survival Guide, The Highly Sensitive Person's Companion and The Strong, Sensitive Boy. Dr. Zeff has more than 25 years experience counseling sensitive children and adults in the San Francisco Bay Area. He currently teaches workshops and consults internationally on coping strategies for highly sensitive children and adults. For more information please visit his web site, www.drtedzeff.com or the amazon.com link: http://amzn.to/ciWRxa

CACPT Membership

The Canadian Association for Child & Play Therapy is the professional organization for those interested in child psychotherapy, play therapy and counseling with children. CACPT performs many important functions for its members, including:

Professional Standards: CACPT sets high professional standards for clinical practice. These standards help to ensure that skilled and effective therapy is available throughout the community. CACPT has a code of professional ethics to which each member must adhere. Policies and procedures are in place to govern CACPT and guide professional and ethical practices.

Specialized Training: CACPT sets standards of education and training for professional therapist as well as establishing programs of continuing education and training. CACPT examines and accredits programs and training centers in child and play therapy. CACPT has established a Play Therapy Certificate Program, which is an intensive program, in order to meet our member's needs. Information is available upon request. Bursaries are available for the CACPT Play Therapy Certificate Program. Information is available upon request.

Professional Publications: The Association periodicals are published to advance the professional understanding of child and play therapy. Articles are published on clinical practice, research and theory in child and play therapy. CACPT members receive these periodicals as a membership benefit.

Membership Benefits

1. **Specialized Training**
   CACPT members receive a discount at all CACPT sponsored conferences, workshops and other events. The CACPT Play Therapy Certificate program is an intensive program available to members.
2. **Publications**
   CACPT members receive the Association's periodicals including e-newsletters and *Playground* magazine as a membership benefit.
3. **Discounts**
   CACPT is involved in arrangements with an increasing number of organizations, i.e. bookstores, toy stores, to provide discounts to Association members.
4. **Insurance**
   CACPT provides professional liability insurance packages for its members

To join go to www.cacpt.com <http://www.cacpt.com> and click on Members.

CACPT Announces Two Play Therapy Certificate programs in Canada!!!

CACPT
Play Therapy Certificate Program

The Play Therapy Certificate Program is an intensive training course run by the Canadian Association for Child and Play Therapy (CACPT). The program is the only one of its kind in Canada, is 30 days in length.

The Program Covers

1. **Theory and Approaches:** Play Therapy Process, Theoretical Models, Assessment, Family Play Therapy, Group Work, Filial Therapy, Theraplay.
2. **Techniques:** Sandtray, Puppets, Storytelling, Games, Art.
3. **Populations:** Trauma, Abuse, Grief & Loss, Attachment, Learning Disabilities, ODD, Anxiety.

Ottawa, Ontario, January – December 2011
London, Ontario, May – June 2011

LEVEL I

The students will be introduced to the history of play therapy, rationale for the use of play in therapy, various therapeutic powers of play, theoretical approaches to play therapy, and phases of play therapy. Practical material will also be provided, including how to develop therapeutic rapport, conduct a play therapy assessment, develop a treatment plan and incorporate play into family sessions. Best-practice tips on record keeping and other ethical issues will also be provided, as well as research to support the effectiveness of play therapy.

LEVEL II

The students will be introduced to a number of play therapy techniques and approaches including Sandtray, Puppetry, Storytelling, Group Play Therapy, Art Therapy, Filial Therapy, and Narrative Therapy. Play therapy approaches to treating attachment disorders will be presented. A course on Brain Research is offered to provide students with cutting edge knowledge and theory.

LEVEL III

This level will focus on play therapy with various populations, such as trauma, child abuse, bereavement, learning disabilities, pervasive development disorders, depression, and anxiety. Students will also learn how to set up an ethical play therapy practice, and testify in court. The last day of the program will focus on self-care and students will have an opportunity to develop their own creative program to foster personal growth and prevent burnout.

CACPT is known throughout the world as the premier association for its high quality educational workshops and programs. Join us in January 2011 for this exciting new program in Ottawa.

The program will be presented in three day and four day sessions every month in 2011 on Thursday, Friday and Saturday with some alterations to the schedule in July and December. August will be open.

For further information visit **www.cacpt.com** or call **(519) 827 1506**

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Play Therapists have come from....Panama, Hong Kong, Jordan, United States, Mexico, Ecuador, Ireland, France & the UK. **Canadian Play Therapists** have also travelled to RMPTI from... Whitehorse, Hay River, Halifax, Toronto, St. Johns, Kelowna, Saskatoon, Medicine Hat, Edmonton, Lethbridge, Winnipeg, Glace Bay, Yellowknife, White Rock, Victoria and Regina.

YOUR PATHWAYS TO PLAY THERAPY CERTIFICATION

RMPTI provides a range of training programs to suit the needs of individuals and organizations. The Green Stream/Foundations program offers a solid entry point and when taken with the Red Stream, provides all of the training hours required for Certification/Registration as a Play Therapist. The Yellow Stream programs are accessible to students and practitioners. Many of our programs offer an on-line component to reduce travel time and costs. See our website for a full listing of programs OR request a copy of RMPTI's Training Programs DVD. **Note: Last year registration for Green & Red Stream Programs were sold out by May. Early registration for upcoming courses is recommended to secure a spot.**

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YELLOW STREAM

Intensive Specialized Programs

There are a number of specialized 1, 2, and 4 day intensive programs to choose from. Yellow Stream programs provide a Certificate of Completion and count toward certification or registration as a Play Therapist. Some programs require a prerequisite. Enrollment in classes is limited - we encourage early registration to secure spots.

Upcoming 2011 classes:

Certificate in Sandplay
4 day program with online component
Online component available April 1st
On-site class May 4-7 at RMPTI

Certificate in Play-Based Treatment of Trauma
4 day program with online component
Online component available Nov. 1st
On-site class Dec. 5-8 at RMPTI

GREEN STREAM

Foundations Of Play Therapy

To obtain certification/registration as a play therapist you need 150 hours of play therapy training. The starting point is the Green Stream Foundations program. This is an intensive, experiential learning program that provides 75 hours of accredited training (including an on-line component).

Come learn about:

- core play therapy theories
- the play therapy process
- the history of play therapy
- play-based observation strategies
- treatment planning using the Play Therapy Dimensions Model

You will experience at least 8 play therapy modalities such as art, puppets, music, movement and sand etc. Role play experiences are conducted in fully equipped play therapy rooms.
On Line component available May 15
On-site class July 2-10

RED STREAM

Advanced Theory And Techniques In Play Therapy

The Red Stream program is also an intensive, experiential learning program that provides 75 hours of approved training (including an on-line component). As an Advanced program, participants must have taken the Green Stream Foundations of Play Therapy program or equivalent.

The goal of this program is to expand assessment and treatment planning skills, increase competence in the use of various play therapy modalities and gain skills as a practitioner in play therapy. Emphasis is placed on the integration of theory and practice as applied to specific referral issues.

This program is highly experiential and participants will use fully equipped play therapy rooms.
Online component available July 15
On-site class August 20-28

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