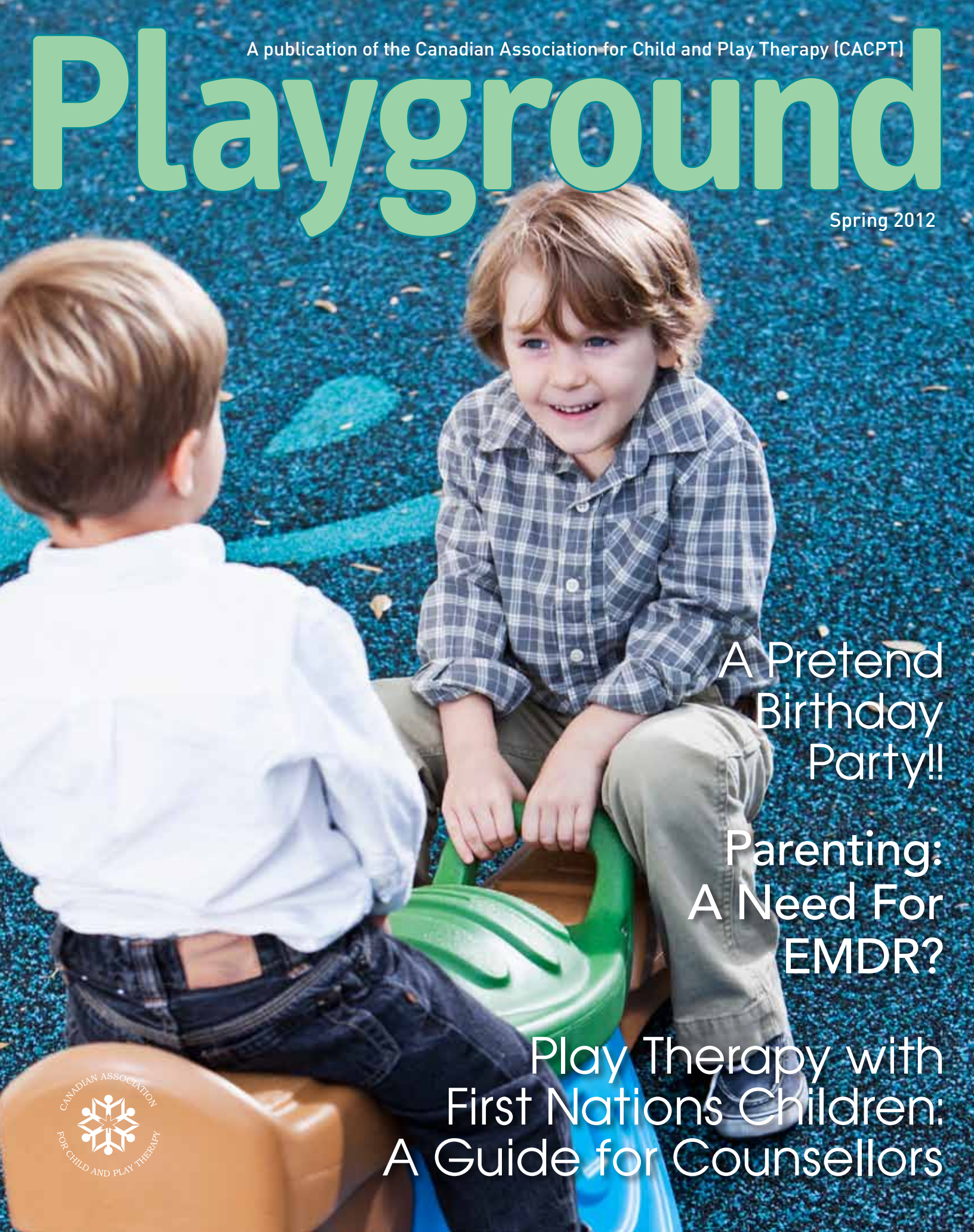
A publication of the Canadian Association for Child and Play Therapy (CACPT)

Playground

Spring 2012



A Pretend Birthday Party!!

Parenting: A Need For EMDR?

Play Therapy with First Nations Children: A Guide for Counsellors

CANADIAN ASSOCIATION FOR CHILD AND PLAY THERAPY

Cutting Edge Training in Child and Play Therapy

CACPT
Play Therapy Certificate Program

The Canadian Association for Child and Play Therapy (CACPT) offers cutting-edge training in Child and Play Therapy. Sign up for one-day courses in any of our locations, or apply to the two-week program in Toronto or British Columbia or apply to the six-week Play Therapy Certificate Program in London and obtain 180 educational units. The six-week program is one of the steps needed to become a **Certified Child Psychotherapist & Play Therapist.**

For further information on courses or on getting certified as a Child Psychotherapist & Play Therapist please visit our webpage at **www.cacpt.com** or call CACPT at **519-827-1506**.

Courses are offered in the following locations:

- London in May and June
- Toronto in July
- British Columbia in August

The application deadlines for the Play Therapy Certificate Program are:

- **April 15** for London
- **May 15** for Toronto
- **June 15** for British Columbia

so apply soon!

Applications are accepted after the deadline but priority is given to those who apply by the deadline. If you just want to attend an individual workshop, there is no deadline but limited space is available so you are encouraged to register early.

Some of our cutting edge courses include:

- Trauma-Focused Cognitive-Behavioral Play Therapy
- Autism Spectrum Disorders
- Disruptive Behavior Disorders
- Anxiety
- Sexually Abused Children
- Children with Sexual Behavior Problems
- Bereaved Children and Children of Divorce
- Sandtray
- Attachment Theory and Therapy
- Theraplay
- Family Play Therapy

CONTACT US

Please feel free to contact us at:
CACPT
Phone: 519 827 1506
E-mail: elizabeth@cacpt.com
www.cacpt.com

ADVERTISING

Advertising inquires should be directed to:
Kip Sharpe B.Sc.
Phone: 519 827 1506
E-mail: kip@cacpt.com

ADVERTISING SUBMISSIONS

Please send artwork for advertisements to:
CATALYST Creative Inc.
210 Hawkstone Manor NW
Calgary, AB T3G 3X2
E-mail: eva@catalyst-creative.ca
Phone: 403 205 6605
To upload large files, please contact:
eva@catalyst-creative.ca

SUBMISSIONS

PLAYGROUND welcomes your ideas for articles. Please send your suggestion or article to elizabeth@cacpt.com

GRAPHIC DESIGN & PRODUCTION

CATALYST Creative Inc.

Publications Mail Agreement #42054516

Playground

Canadian Association for Child and Play Therapy

Contents

Hello from the President

Welcome to Our First 2012 Issue of Playground

2012 will be a busy year for our association given that we are providing the Play Therapy Certificate Program this year in three Canadian cites, London, Toronto and Vancouver. Our national conference, in collaboration with Alberta Play Therapy Association; Playing in The West, is soon to occur in Calgary with sessions and workshops that will attract new and seasoned therapists. This conference could not have occurred without the support of the Alberta Play Therapy Association. It will be a testament to what collaboration can create when we all share the same goal.

As your CACPT President, I am beginning my third year of service in this role and have already been so touched by the commitment of members across the country to promote the power of Play as a modality of intervention with vulnerable children, teens and families.

In the Spring I will again be teaching and attending International workshops in the United Kingdom which provides me the opportunity to meet and connect with Play Therapy Association Presidents from other countries. What I have found is that we are not so different. Though our country is bigger with less members we are a resourceful bunch.

My plea to all CACPT certified members and Supervisors is that you find a Play Therapy Intern member to mentor. We have many Certificate program attendees who are looking for the opportunity to connect theory with practice. In my own community, partnerships have been created with local centers that have families and children who need pro bono service with Play Therapy Interns who are willing and able to make a long term commitment to serve clients within their area of expertise. As long as there are supports such as supervision, insurance and tools, it can be done.

I have also found that volunteering my time to present a Play Therapy based workshop not only brings more attention to Play Therapy but also those that are Play Therapists. Look around. There are opportunities everywhere to share your expertise.

Members will also see the launch of our on-line MOODLE training site for CACPT's Continuing Education opportunities. We believe that this mode of instruction will bring members together from across the country as well as provide learning opportunities for therapists in remote areas. Keep your mouse warmed up. The launch is coming!

I can't wait to see what other exciting things 2012 will bring because of the hard work and commitment of our Board of Directors and members.

It is a privilege to do this work and serve in this capacity for you and those you serve.

Theresa Fraser CYW, M.A., C.P.T.
President
Canadian Association for Child and Play Therapy (CACPT)

Update from your Executive Director

Spring 2012

Another year has flown past and we are in the process of publicizing CACPT's 2012 Conference and AGM once again. When I review my notes on the activities we engaged in over the past year, we have accomplished so much with so few resources; human and financial. Looking to the future for our upcoming strategic planning session with the Board of Directors will allow us to address not only the priorities in our planning for upcoming programs and services, but also the careful management of the existing resources.

I recently read an article in an association magazine on "Raising Awareness on a Shoestring". The writer claimed to know a lot about using association resources and membership dollars efficiently and effectively and went on to tell us how. It occurred to me that our Board and staff could have written that article and referenced personal experience. With a very part-time management team and a small group of active volunteers, here are some ways that we managed to raise awareness on the "shoestring" this year:

- Using automated newsletter platform, we sent out monthly bulletins to our members with valuable information. We are able to realize advertising revenues on this publication and cover the total costs of sending this out every time.
- Any significant information that we want to share we also posted in our Playground Magazine, all articles prepared and written by volunteers for CACPT;
- Training programs and events are published free of charge on Facebook;
- We post our programs and events on our website using our regular website posting service;
- Many volunteers offered to place telephone calls to let colleagues and others know about our training programs and our conference;
- We have reciprocal agreements with other like-minded associations in Canada that allow us to advertise our programs through their newsletters and publications free of charge.
- In partnership with Changing Steps Counselling out of Cambridge, ON, CACPT members participate in Blogtalk Radio by engaging in play therapy discussions with Counsellors, Therapists, Play therapists and consumers of play therapy.

The results:

- Membership numbers in CACPT have increased significantly in the past three months, in part due to these activities. We have received approximately 80 new member applications during this time;
- Evidence of the effectiveness of play therapy is attracting attention to CACPT throughout the world and we notice a flurry of international communication;
- Within any given week, we have nearly 2,000 visitors to our website from not only Canada and the U.S., but from places such as Asia, Africa, China, United Kingdom and South America; and
- A number of international students as well as members from across the country have registered for CACPT's Play Therapy Certificate Program in London, ON in May/June of this year.

To hear more details on CACPT's successes, challenges and reports on activities, be sure to come out to the CACPT Annual General Meeting and Conference in Calgary, Alberta,

April 27 & 28th, 2012. You won't regret it. We have a slate of speakers who are known throughout Canada and others parts of the world. It is a wonderful way to network with like minded professionals who are passionate about working with children and families in need of therapy through PLAY!

Respectfully submitted:

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

A Pretend Birthday Party!!

by Lorie Walton CPT-S &
Pam Snelgrove (MA pending 2012)

Theme: Assessment and/or Termination Session

Recommended Age: 3-8

Treatment Modality: Individual

Goals:

1. Assess child's ability to follow directive activity
2. Gather information about child's support network
3. Assess child's ability to express feelings about significant people in their life
4. Develop the child's awareness of his/her choices in creating the future
5. Engage the child into feeling safe to express themselves within a therapeutic relationship/session

Materials:

1. Cut out of a colourful birthday cake (from bulletin board package or make yourself out of construction paper)
2. Three small chairs
3. A minimum of three regular sized dolls
4. Three small birthday gifts (representations of wrapped gifts) – you can purchase tiny ones from the dollar store from the scrapbook supplies area
5. Three gift tags to adhere to the small gifts
6. Construction paper, beads and sparkles for making a birthday crown
7. Three large yellow stars
8. Black Marker
9. Crayons and markers for decorating crown
10. (optional) A cupcake or birthday treat for child to eat at end of the activity

Description:

Explain the activity as follows:

We are going to pretend that today is your birthday and we are going to have a celebration.

You are the special birthday girl/boy, so you get to wear the birthday crown. Therapist places homemade crown on the child (for older children, you may want to have the child decorate their own crown).

The Therapists says to the child "For your birthday you get to choose birthday guests who will join us for the party; Name three important real people in your life you would want to come to your party." The child then names three people in their life and chooses the dolls for each of the three important people. The dolls get placed on the chairs to join in the party.

Now that we have your birthday crown and our birthday guests, we need to make three birthday wishes. The therapist brings out the yellow stars attached to strings and asks the child to state each of his/her 3 birthday wishes. "It could be any wish you have about your family, school, friends or yourself… you can wish for anything at all."

The therapist writes the child's wishes on the yellow stars and hangs the stars on the child.

The therapist then says "Ok, birthday girl/boy, it's time for birthday presents. These are special birthday presents today because at this birthday we get to use our imagination. If you could choose your presents, anything at all; what would you choose to get for your birthday?" The therapist writes what the child says on each gift tag.

Now it's time for the birthday cake. The therapist turns the birthday bulletin board around and presents the child with their birthday cake. The child gets to put the (cardboard) candles on the birthday cake; as many as they wish. Think of your three birthday wishes and blow out your candles. The therapist and child together pretend to blow out the birthday candles.

Discussion:

Children are encouraged in this activity to use their imagination, develop decision making skills and assess the child's ability to follow therapist-directive play. Collaborative fantasy and imaginary exercises facilitates and empowers the child to make choices about significant people and events in their world, and express feelings about such people and events. The therapist then gives the child the birthday treat to eat. While the child is eating further discussion can take place about the wishes the child made, the people the child named, and other topics that may have come up during this activity.

www.familyfirstplaytherapy.ca

Filial Therapy: What Every Play Therapist Should Know

Part Two of a Series

By Rise VanFleet Ph.D., RPT-S

Reprinted by permission from: Play Therapy: Magazine of the British Association of Play Therapists; 2011; 65, 16-19.

In Part 1 of this series, I explained my desire to supply accurate information about Filial Therapy (FT) for play therapists, as this effective and empirically supported method has garnered growing interest throughout the world.

I am frequently asked about various interventions or forms of therapy that bear a resemblance to Filial Therapy most often in the form of parent involvement and the use of play (such as Parent-Child Interaction Therapy, Theraplay, or others) , if the two approaches are pretty much the same. My reply usually is no, although they do have these two characteristics in common.

At other times, I have heard statements about Filial Therapy that simply are not true. I consider these "growing pains" for a form of therapy that was created far ahead of its time in the 1960s. Also in Part 1, I described the contributions of various psychological and developmental theories that are woven into the fabric of FT. I have yet to learn of a form of therapy that more artfully integrates the relative strengths of so many theoretical orientations.

In this article, I want to explore the essential features of FT that make it unique. It is the combination of these qualities, drawn from the contributing theories, that defines FT as a distinct form of family therapy and play therapy. These features can certainly be found individually or in smaller combinations in other interventions, but it is the presence of all of them that defines FT as the Guerneys originally developed it. Other formats of FT sometimes omit one or two of these features but are still considered part of the family of FT because they include most of them and have altered their stated objectives or scope accordingly. In the third article of this series, I will review the various adaptations of FT, the types of problems and clients for which FT has been applied, and the growing body of research supporting it.

Essential Features of Filial Therapy

The Client is the Relationship, Not the Individual

Current systems of care often emphasise the identification of a single client, and that frequently is the child. Often, parents come to therapy, or are referred for help, because of the behaviour of a child. More often, the real root of the problem is something within the family dynamic—marital tension, illness or death in the family, poor parenting practices, or maltreatment. Rarely do problems arise solely from the child. Even problems that are centred within the child, such as ADHD with its biological underpinnings, influence the entire family and psychosocial problems once again reflect the functioning of the family system.

For example, when six year old Sally was diagnosed with diabetes, her parents did everything possible to ensure good medical care. Sally resisted the insulin injections and the finger pricks for blood glucose testing that were necessary several times each day for good diabetic

control. Sally also began sneaking low-lying candies and sweets into her room for later consumption. Her parents, worried, began constant supervision leading to major rebellion. They brought Sally to treatment because of her temper tantrums. Was Sally the source of the problem? Probably not—diabetes is a complicated and serious disease that causes changes for all family members and Sally's parents had shifted their parenting approach to ensure her health. All of them needed help finding equilibrium again.

In FT, therapists do not view the child as their primary client. Neither do they focus on the parent as the client. It is the relationship between parent and child that becomes the client. Therapy is applied to strengthen that relationship and to resolve weaknesses that threaten that relationship. From a pragmatic point of view, therapists sometimes must identify a single client for payment or reporting purposes, so a parent or child might be listed as "the client," but foremost in therapists' minds and guiding all decisions must be a focus on relationships.

Empathy Is Essential for Growth and Change

In FT, empathy plays a prominent role on several levels. Therapists who wish to practice FT must be highly skilled in providing empathy to adults and children alike. They provide genuineness and acceptance as shown through their empathic listening abilities. Filial therapists provide empathy at the parent level by truly trying to see things through parents' eyes without judgment. They empathically listen to the deepest levels of parent feelings and concerns, and they convey acceptance of these at the deepest levels possible. This does not mean that they accept or approve of parents' prior bad acts, but they accept the parents' underlying emotions, motivations, and hopes. A therapist would never condone a parent's use of spanking or hurting a child, but their focus is on the parent's frustration or rage that fuelled that behaviour. Deep understanding of parent feelings typically results in more engagement in the therapeutic process, enhancing the potential for positive parent change. Empathic listening with parents is not a simple restatement of their thoughts and feelings; rather, it is a commitment to understanding parent feelings at the deepest level possible. An example would be if a parent asserted, "Sometimes I just can't stand that kid. He's hateful!" A response such as "You're upset with him" would be considered empathic, but it fails to reflect the intensity of the parent's feelings. A deeper empathic response would be, "You're furious with him and feel at the end of your rope!" In FT, therapists use empathy and acceptance with parents throughout the process.

At the child level, filial therapists must first become proficient in non-directive play therapy (NDPT). They typically provide demonstrations of NDPT with the family's children while parents observe. Filial therapists also must be able to reflect children's feelings at the deepest level. They recognise that surface behaviours, such as aggression or oppositional behaviours, comprise more fundamental feelings and motivations beneath the surface, such as fear and anxiety respectively and they know how to respond empathically to all levels to convey true acceptance. Therapists also know what to expect in NDPT and how to recognise and interpret play themes within developmental and psychosocial contexts. In essence, they must practice what they preach.

Finally, the parent-child play sessions throughout the FT process remain non-directive in nature. Parents do not switch to more directive behaviours such as positive reinforcement at any point during the play sessions, as this represents a fundamental shift away from the empathy and acceptance considered critical for relationship building and parent-child change. While therapists can help parents use skills such as positive reinforcement and parent messages in daily life, this is never brought into the play sessions.

The use of empathic listening in FT belies an essential belief that people—children and adults—will move in the direction of psycho-social health when an atmosphere of safety and acceptance is created for them. In many ways, empathy is the cornerstone of the FT model because it defines so much of the therapist-family and the parent-child relationships.

The Entire Family Is Involved Whenever Possible

FT was conceived as family therapy, although family psychology was first being articulated at approximately the same time. This means that all of the relationships within the family are of importance to filial therapists. Therapists encourage both parents to participate in the process and to observe each other's play sessions and feedback. They learn vicariously from this. It is common to hear one parent use some of the same phrases and reflections they heard the other parent use in a previous play session. Efforts are made to bring reluctant parents into FT, assuring them of the importance of their input and their value to their children. Because both parents or carers are learning the same balanced approach of empathy and limit setting, FT often brings parents with radically different parenting styles to a centre place. The disciplinarian learns also how to be understanding. The nurturing parent becomes firmer with limits. It is precisely because of this process that parents, from the earliest days of FT, have reported that their marriages

seem to improve because they are more in tune with each other vis-à-vis parenting matters.

Therapists using FT also try to include all of the children in the process. For adolescents, this means the inclusion of "special times" instead of play sessions as a means of providing undivided parental attention, understanding, structure, and enjoyment on a regular basis. For children between the ages of 2 and 12 (approximately), FT works best when they are all included in weekly or biweekly one-to-one play sessions with their parents. As noted earlier, the problems that bring families to therapy affect everyone in the family. ADHD challenges with one child can easily draw parental attention away from siblings who do not show problems. Divorce may result in one child acting out, while the quieter child is viewed as being "fine", when in actuality that child is quite depressed or anxious. True to its family systems roots, FT advocates that all children be included somehow. Ideally, this would be from the start of therapy, but because of limitations current models of service delivery sometimes require therapists to become creative in the inclusion of all the children. It is quite common in FT for parents to be more challenged during the play sessions by the child they originally said did not need any assistance. In my experience, involving all the children pays dividends that strengthen the family as a whole. Parents seem to learn the skills much more quickly and solidly when they hold them with each of their children. Perhaps holding play sessions with different child personalities and issues strengthens parents' use of the skills, just as experience with more than one child enhances a therapist's competence and effectiveness. I have noticed that parents who have difficulty with one child during play sessions (for example, having to set lots of limits) take heart from their play sessions with their other children where it is more obvious to them (parents) that they are learning and doing well.

A Psycho-educational Training Model Is Used with Parents

FT uses a training model for parents that has been shown to lead to successful acquisition of the necessary skills. The model entails four elements: (1) explanation, (2) demonstration, (3) skills practice and (4) individualised feedback. Therapists explain the rationale and methods of each skill taught to parents. They demonstrate those skills at work through live demonstrations of non-directive play sessions with the family's children and/or use of videotaped demonstrations. By far, the live demonstrations seem to engage parents most quickly. Discussions afterwards help parents process their observations, questions, and doubts about the process and its relevance to their family.

Therapists train parents through the use of skills practice, including tried-and-true behavioural and learning methods. Initially this takes the form of mock play sessions in which the therapist role-plays a child while the parent uses the play session skills. The therapist can match the level of difficulty of the child they role-play to the parent's current ability, gradually increasing the challenge until the parent is fully trained. Therapists' use of in-the-moment encouragement applies the behavioural shaping principle to give parents immediate feedback on their efforts, reducing anxiety and assisting the learning process. This ingenious training method helps parents learn to use the skills rather quickly.

After each mock play session, the therapist provides more detailed feedback, the majority of which focuses on what the parent did well, adding just one or two things for the parent to try to improve the next time. This individualised feedback, done in such a supportive manner, helps parents learn rapidly and thoroughly by creating a supportive and collaborative climate. Parents are given ample opportunity to discuss their

own feelings in order to clear out misconceptions, to eliminate obstacles to progress, and to give them "ownership" of their own learning. This same process is applied after parents start their play sessions with their own children, as noted in the next section.

Therapists Provide Live Supervision of Parents' Early Filial Play Sessions

A key feature of FT is to create the circumstances through which parents are successful. One of the problems of traditional parenting skills programmes is that parents briefly learn about a new skill, such as listening, and are then expected to use it at home. It is not uncommon for parents to return to the next session saying, "I tried it and it didn't work."

It is tempting to think this response is due to lack of parent motivation, but I would suggest otherwise. It is more likely to be the result of a parent trying to implement a skill they have not mastered in a very complex environment--daily life. FT bypasses this difficulty by asking parents to refrain from using the skills in daily life until they have mastered them during the play sessions. Filial therapists then observe parents' first four to six play sessions directly, often by sitting unobtrusively in the corner of the playroom. This gives the therapist the three-dimensional vantage point to see the full sessions and the nuances that always attend. It also offers parents tacit support as they begin to apply their new learning with their children.

After the half-hour play session, the children are excused to a safe childcare location, and the therapist goes through the feedback process used during the training phase. Parents are first invited to reflect on their own use of the skills: "What was easy for you?" "What was difficult?" Therapist empathy is followed by skills feedback, again providing mostly positive reinforcement about specific behaviours and offering just one or two suggestions for improvement: "Connie, when you kept describing what your daughter was feeding all of her dolls—the lettuce and the tomatoes and the carrots—you were doing such a nice job reflecting the content of her play! Next time, if you can bring out her feelings a bit more, that would be great, such as 'You think it's funny that they have to eat all those veggies.' ".

After four to six sessions of live supervision, parents have typically developed their competence and confidence to a point where they can begin their home sessions. The therapist provides indirect supervision of these, based upon parent reports and/or home videos.

The Process Is Truly Collaborative

In every way possible, filial therapists involve parents as partners in the therapeutic process. It is a misconception, however, that FT teaches parents to become therapists. The filial therapist remains responsible for the therapy throughout the process, while parents simply learn a set of play session skills that, when eventually generalised from the play sessions to daily living, have been shown to improve parenting practices significantly. (I will report on some exciting new research relevant to this in the final article in this series). It is the therapist's responsibility to monitor and manage the therapeutic process in its many complexities. With that said, filial therapists welcome and encourage parent input at every step of the way. What parents think, feel, and say matters—a lot. Whether they are reflecting on their own play sessions or trying to determine the possible meanings of their children's play, parents' views are elicited and discussed first, with the therapist adding his or her own ideas afterwards. Therapists consider and use parents' perceptions, realising that parents know the child's context much better than they and that parent contributions to understanding the child may have more weight because of this. The relationship between a therapist and a parent during FT is one that looks decidedly collegial: sharing of ideas, listening, collaboratively deciding on options, mutual respect and laughter. Metaphorically, it is the difference between sitting side by side (or around an open circle, for groups) discussing an issue of mutual concern or sitting across a desk or table doing the same. The climate of FT is definitively an open, side by side type of approach.

> The use of empathic listening in FT belies an essential belief that people—children and adults—will move in the direction of psycho-social health when an atmosphere of safety and acceptance is created for them.

Essential Features and Adaptations of FT

FT is most truly FT when the essential features outlined here are in place. There are times, however, when families' needs, the organisation of the care system, or funding issues are such that the approach must be adapted, with some aspects altered. The key is to know

what FT is really all about so that one is in a better position to determine whether a particular method retains sufficient features to be considered FT. In the third article of this series, I will discuss some of the most useful adaptations of FT in light of these essential features, including a review of accumulated and new research that has appeared in refereed journals or critically reviewed books and reports.

References

Andronico, M.P., Fidler, J., Guerney, B.G., Jr., & Guerney, L. (1967). The combination of didactic and dynamic elements in filial therapy. International Journal of Group Psychotherapy, 17, 10-17.

Cavedo, c., & Guerney, B.G. (1999). Relationship Enhancement (RE) enrichment/problem-prevention programs: Therapy-derived, powerful, versatile. In R. Berger & M.T. Hannah (Eds.), Handbook of Preventive Approaches in Couples Therapy (pp. 73-105). New York: Brunner/Mazel.

Ginsberg, B.G. (2003). An integrated holistic model of child-centered family therapy. In R. VanFleet & L. Guerney (Eds.), Casebook of Filial Therapy (pp. 21-48). Boiling Springs, PA: Play Therapy Press.

Guerney, L. (1997). Filial Therapy. In K.J. O'Connor & L.M. Braverman (Eds.), Play Therapy Theory and Practice: A Comparative Presentation (pp. 131-159). Hoboken, NJ: John Wiley & Sons.

Sullivan, H.S. (1947). Conceptions of Modern Psychiatry. Washington, DC: The William Alanson White Psychiatric Foundation.

VanFleet, R. (2009). Filial Therapy. In K.J. O'Connor & L.D. Braverman (Eds.), Play Therapy Theory and Practice: Comparing Theories and Techniques, 2nd -ed . {pp. 163-201). Hoboken, NJ : John Wiley & Sons.

VanFleet, R., & Topham, G. (2011). Filial Therapy for maltreated and neglected children: Integration of family therapy and play therapy. In A.A. Drewes, S.c. Bratton, & C.E. Schaefer (Eds.), Integrative Play Therapy (pp. 165-216). Hoboken, NJ: John Wiley & Sons.

About the Author

Rise VanFleet, PhD, RPT-S, Psychologist and Play therapist, is well-known internationally for her books, articles, DVDs, and training programmes on Play Therapy, Filial Therapy, and Animal Assisted Play Therapy. For over 30 years she has disseminated information and trained child and family professionals in Filial Therapy and has been conducting multiple training programs in the UK each year since 2002. She is a past president/board chair of the Association for Play Therapy in the U.S. and founder of the International Collaborative on Play Therapy.

Playground magazine travelled all the way to South Africa in January with CACPT Certified Play Therapist Liana Lowenstein, who taught a four-day course on Play Therapy with Abused and Traumatized Children.

Pictured from left to right: esteemed play therapists Reyhana Seedat, Liana le Roux, Liana Lowenstein, Hannie Schoeman and Elizabeth Greyvenstein.

Cape Town, South Africa

Parenting: A Need For EMDR?

by Charlotte von Prondzinski MA

Parenting a child can be a harrowing experience – so much so, that home can turn into a battleground. The behavioural and emotional fallout from children with attachment disruptions, particularly Reactive Attachment Disorder (RAD), can have a profoundly negative effect on the caregiver's mental health. Indeed, Post traumatic Stress Disorder (PTSD) is now a very real outcome to parenting a RAD child. There is a growing body of literature demonstrating that the stressors of "small t" traumas (for example which may occur in marital discord or parenting a RAD child) can be just as stressful as "big T" traumas and can generate just as many PTSD symptoms.

This challenge is ever more present when caregivers themselves have their own history of "big T" traumas or attachment disruptions during childhood. It has been said that 'we parent how we were parented' and a childhood history of domestic violence, neglect or abuse can get in the way of a parent developing a meaningful relationship with their child. Unwittingly, many caregivers continue the negative interactional and behavioural patterns laid down by previous generations, ultimately continuing negative relational cycles. Parenting children with developmental trauma, or those with attachment disruptions, creates a unique challenge for these caregivers because the children's behaviour seems to trigger parents' emotional reactions at an often-unconscious level. For example, since very young children are not adept at regulating their emotional or behavioural responses, a toddler or preschooler's tantrums may appear quite violent and frightening to traumatized parents; helpless or frightened states of the toddler's mind, such as often occur upon separation, may prove intolerable to traumatized parents. As well, helplessness, fear, or rage in the toddler may trigger traumatic memories of the caregiver's own past experiences of helplessness, grief, loss and abandonment or curtailed rage at their abuser. Caregivers may project frightened or rageful states of mind onto the distressed child because the feelings are so intolerable, or they may defensively inhibit any reflective awareness of the child's mental state, either via dissociation or by physically removing oneself from proximity to the child.

This results in the traumatized parent being emotionally or physically unavailable to provide a secure base or to support affective regulation for the distressed child. Furthermore, ongoing maternal stress can result in a deterioration of physical and emotional health, resulting in an array of PTSD symptomatology, where they enter a defensive, hypervigilant, self-preservative position relative to other individuals.

However the caregiver experiences their own traumatic stress reactions to their child, any form of maternal psychopathology is strongly associated with disturbances in attachment, such that treatment for a specific disorder in one partner of the dyad may not be sufficient. Therefore, while the child is receiving play therapy, referring these parents for their own specific form of psychotherapy might be the answer. Eye Movement Desensitization and Reprocessing (EMDR) may hold some promise for freeing these parents from negative PTSD symptomatology by targeting disturbing material from the past, as well as addressing current dysfunction in the form of daily struggles. EMDR can also help parents develop positive future templates for managing significant situations or people (eg their child/partner) in the future, as well as identifying and reprocessing anticipatory fears. EMDR can be a complimentary treatment for parents who have children doing their own trauma work within the context of individual Child Psychotherapy sessions, because it can help the parent develop new patterns of responding to their child and allow the parent to be at peace with their own issues.

One benefit of using EMDR with a child's parent is its 'accelerated' nature. Various other forms of adult psychotherapy can be time intensive, whereas EMDR gains access to the traumatic material by rapidly activating the Information Processing System, providing an opportunity for the information to be processed to a point of adaptive resolution. Treatment effects can be rapid and, during an individual session, the therapist may witness accelerated processing of information involving a shift of cognitive structures and a desensitization of attendant traumas as new associations are forged between the traumatic memory and more adaptive memories or information.

During the Standard EMDR protocol , the first two phases of therapy collect the parent's detailed trauma and attachment history, assess readiness factors and safety, and ensure preparation for treatment. In phase 3, the parent identifies the most distressing moment of the targeted event or a present day stressor and identifies the representative image, and related cognitive, affective, and somatic components. Next, in phase 4, the parent focuses on the memory for about 20 to 30 seconds, while simultaneously engaging in bilateral stimulation (BLS) such as eye movements, auditory or tactile stimulation, after which associative information is elicited. This material typically becomes the target of the next set of BLS. This alternating pattern of focusing on the memory or event followed by associative links is repeated until all disturbances are eliminated. Then, in phase 5, a related positive self-referencing belief is integrated with the traumatic memory or event. For example, the parent may wish to believe about him or herself 'I am in control' or 'I can handle it'. During phase 6, processing is completed when sweep of the body evidences no related somatic distress. Appropriate steps are used to end each session (phase 7), and to re-evaluate treatment progress at the beginning of the next session (phase 8). To ensure that all disturbances related to the traumatic memory or present day stressor is eliminated, the Standard Protocol also involves addressing all current triggers and concerns about related future events. Parents can expect symptom relief and can therefore focus on being the parent they want to be.

EMDR was developed by Francine Shapiro in the late 1980's and is now one of the two most empirically supported psychotherapies in the treatment of post traumatic stress, although its application is widespread. EMDR is an integrative therapy that brings together elements from well-established clinical theoretical orientations including psychodynamic, cognitive, behavioral, and client-centered. It is recognized by both the American Psychiatric Association and American Psychological Association, as well as internationally among many health departments and veteran affairs organizations. Research also suggests that EDMR is an effective treatment of trauma for children and teens. The EMDR protocol can be effectively and efficiently incorporated into the play therapy context or into a family systems framework.

As one parent asserted before her own second EMDR session: "It was amazing! I had a great week, nothing seemed to bother me and I could let the little things go with my daughter. It was as though a wave of calm flowed over me. I felt at peace for the first time."

References

Shapiro, F. (2001). Eye movement desensitization and reprocessing: Basic principles, protocols and procedures (2nd ed.). New York: Guilford Press.

Shapiro, F., Kaslow, F. W., & Maxfield, L. (2007). Handbook of EMDR and family therapy processes. Hoboken, NJ: Wiley & Sons

About the Author:

Charlotte von Prondzinski, has an MA in Counselling Psychology. She is also an EMDR clinician, integrating this treatment approach into her work with children, teens and families. She works predominately with traumatized and attachment disordered children, and their families. She is working towards becoming a Certified Child Psychotherapist/ Play Therapist with the CACPT and is a member of the OACCPP.

Play Therapy with First Nations Children: A Guide for Counsellors

by Carly Goetting

In an attempt to understand the strategies of play therapy with First Nation children, it is essential to comprehend the diversity of approaches to play therapy as well as their cultural implications. In today's culturally diverse world, counsellors need to have multicultural competence coupled with an understanding of the intricacies of acculturation, generational differences and culturally distinctive issues (Fielding, 1996).

First Nations History

To understand First Nations children, it is essential to comprehend the pain and suffering that has taken place in recent Aboriginal history. Starting in the 1930's there was a covert battle against First Nations (CBC news, 2008). Canada introduced the residential schools, essentially an aggressive assimilation into Canadian culture, language and life (CBC news, 2008). It has been reported that 50,000 First Nations children died in these residential schools (O'Rorke, Lawless & Annett, n.d.). Many stories of abuse, both sexual and physical, were not reported to the authorities, as it was these same authorities that placed the children in the residential schools (O'Rorke, Lawless & Annett, n.d.). Horrific sterilization occurred, where doctors would drug both women and men against their will to complete the surgeries (O'Rorke, Lawless & Annett, n.d.). These events took place within the last 80 years, with the last residential school shut down in 1996 (CBC news, 2008). Many survivors still live with the painful memories and trauma, and subsequent generations are feeling the effects. In addition to the residential schools, there are also other historical events including military action, missionary pressure, Indian Self-Determination and Education Assistance Act, relocation, and isolation that have all changed the lives and outcomes of the First Nations (BigFoot & Schmidt, 2010). These events have impacted all spheres of their lives including economic, social, education, employment, physical, and family (BigFoot & Schmidt, 2010).

BigFoot and Schmidt (2010) have indicated that modern poverty rates are more than double that of Caucasians (26% compared to 10%), while suicide rates are more than four times higher in men and three times higher in women. First Nations women are twice as likely to be victims of domestic violence and instances of child abuse and neglect are extremely high. First Nations peoples have a very high prevalence of PTSD compared to the general population (BigFoot & Schmidt, 2010). These increased vulnerabilities and trauma exposure can lead to severe mental health problems. Consequently, there is a need for therapy in First Nations communities. In many cases, lack of resources and funding prohibit this (BigFoot & Schmidt, 2010).

First Nations Culture

First Nations people value the balance of mind, body and spirit with the natural environment, and symbolize this as the circle of life (Hunter & Sawyer, 2006). An individual who is in harmony values nature and respects elders (Hunter & Sawyer, 2006). A disequilibrium, which may be expressed as low performance at school or lack of friends, will lead to loneliness and withdrawal. Being out of balance with nature is believed to cause sickness. Nature is key in First Nations philosophy and personal growth (Hunter & Sawyer, 2006). The importance of listening, watching and waiting is something the First Nations elders have taught the generations after them to ensure that experience was not detached from knowledge, and wisdom from spirituality (Edwards, 2001).

Play Therapy Techniques for First Nation Children

Through empathic understanding, authentic reception, harmonious warmth and behavioral limits, children can work towards adaptive behaviors (Fielding, 1996). Although the term adaptive in this sense, does not imply the meaning of adapting to white mainstream culture (Fielding, 1996). Successful play therapy techniques with First Nations include pet therapy, talking circle, harmony circle, spirit animal, filial therapy and gardening (Fielding, 1996; Hunter & Sawyer, 2006; VanFleet, 2011). Children that avoid relationships can gain comfort and connectedness from animals. Pet therapy is compatible with First Nations philosophy and allows children to form bonds, develop empathy, express feelings, and understand the needs of others (Hunter & Sawyer, 2006). Pet therapy can yield other benefits, including; increased self-esteem, self-control, affection, autonomy and reduction of alienation and loneliness (Hunter & Sawyer, 2006). Hunter and Sawyer (2006) believe that children treat their pets, as they want to be treated. Having a small group walk a leashed pet can also help children develop control, responsibility and sharing (Hunter & Sawyer, 2006). Mourning the death of a pet allows children to build healthy coping skills for when they lose a friend or loved one (Hunter and Sawyer, 2006).

Being out of balance with nature is believed to cause sickness. Nature is key in First Nations philosophy and personal growth

Many First Nations children are drawn towards earth objects, such as rocks, pinecones, eggs, leaves, and important animals such as the eagle or hummingbird (Fielding, 1996). Children are apt to particularly enjoy art, music, playing in sand, and clay, thus in combination of these earth objects and animals is ideal for First Nations children (Fielding, 1996). Talking circle is a group activity that can teach sharing, encourage

children to express their feelings, and help young clients develop patience and self-confidence. For the talking circle, one child holds a special stick or totem. Whoever is holding it gets to speak; everyone else must listen. Once everyone has had a chance to speak, the circle is closed. The children should be told that all the information that was shared is confidential (Hunter and Sawyer, 2006). A Harmony Circle can blend independence and belonging (Hunter & Sawyer, 2006). Each child can use an instrument or a container to make noise. The leader establishes a rhythm, and one person at a time adds in his or her own noise. Discussions afterwards can include appreciating each person's contribution as well as recognizing the power of the group (Hunter & Sawyer, 2006).

The First Nations peoples believe that each animal possesses a unique strength (Hunter & Sawyer, 2006). Asking children to name their favorite spirit animal and describe its relation to them is a good starting point for learning more about them. Examples of spirit animals include dog (loyalty), turtle (perseverance), hawk (watchfulness), ant or bee (cooperation), and squirrel (thriftiness) (Hunter & Sawyer, 2006). This theme can also be brought into narrative therapy by having children tell stories using spirit animals to represent each character (Hunter & Sawyer, 2006).

Gardening activities such as starting plants from seeds and growing flowers or vegetables can be therapeutic and informative for children. Such experiences with nature give extrinsic rewards for being generous (Hunter & Sawyer, 2006). This not only encourages patience, but demonstrates life cycles and the interconnectedness between all living things, which First Nations deem meaningful (Hunter & Sawyer, 2006). Most abused and neglected children have great difficulty expressing them selves, and may lack the verbal ability to do so (Landreth et al., 2005). Puppet play therapy is usually very helpful with expression.

Filial therapy, also known as parent-child therapy, is a family-based therapy allowing the parent to be in the room with the therapist (VanFleet, 2011). This allows the therapist to include the parent, who may then use these techniques at home (VanFleet, 2011). Fielding (1996) stresses the importance of involving the parents, especially when working with clients from non-white cultures. Not only will this benefit the child's progress, it will also allow the therapist to obtain information about family and cultural experiences.

To a Caucasian therapist, a First Nations child may seem quiet and timid, but in actuality this is the cultural difference in communication (Edwards, 2001). Children are encouraged to be independent and to make their own decisions, solve problems and be responsible. Counsellors can facilitate this process by encouraging self-management traits such as recognizing and managing emotions, behaviors and thoughts (Edwards, 2001).

To conclude, cultural differences should be considered prior to commencing therapy. Play therapy is a helpful tool to assist children to act out their feelings and work through their troubles. Therapists using play therapy with First Nations children should take steps to include aspects of First Nation culture as a part of the play process. This will increase the children's comfort with therapy and enable them to concentrate on themselves, thereby facilitating their progress.

References

BigFoot, D. & Schmidt, S. R. (2010). Honoring children, mending the circle: cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. Journal Of Clinical Psychology, 66(8), 847-856.

CBC news (2008) Residential schools, a history of residential schools in Canada. Retrieved from: http://www.cbc.ca/news/canada/story/2008/05/16/f-faqs-residential-schools.html

Edwards, W. (2001). Why our eurocentric school system fails First Nations students. In H.

France, (Ed.). Readings in multicultural counseling in Canah. Victoria, British Columbia: University of Victoria.

Fielding, L (1996). How do individuals of Color and First Nations individuals conducting play therapy with children of color and First Nations children view their play therapy practice in terms of multicultural competence. Thesis Simon Fraser university. Retrieved from https://dspace.library.uvic.ca:8443/bitstream/handle/1828/715/fielding_2005.pdf?sequence=1

Hunter, D., & Sawyer, C. (2006). Blending Native American spirituality with individual psychology in work with children. Journal Of Individual Psychology, 62(3), 234-250.

VanFleet, R., (2011) Filial therapy: what every play therapist should know. CACPT, Playground, fall 2011. Retrieved from http://www.cacpt.com/site/assets/uploads/forms / PlaygroundFall2011.pdf

About the Author

Carley Goetting has a Bachelors of Arts in Psychology, minor Sociology, currently completing her Masters of Counselling Psychology at Yorkville University. This comprehensive cultural paper was completed with the help from her professor Dr. Linda Sonna. Carley is currently completing her practicum in Calgary with First Nation children, with supervision from Sherryl McLeod.

Rules Versus Principles: The Process of Ethical Decision-Making Part Two

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

In Rules Versus Principles: The Process of Ethical Decision-Making Part One (Playground, Fall 2011) we began with a review of the ethical principles guiding our work as therapists. Based primarily on the Companion manual to the Canadian code of ethics for psychologists, 1991 (Canadian Psychological Association {CPA}, 1992) this discussion highlighted the commonalities across professional associations (including CACPT) with respect to the values and principles underlying ethical behaviour. We then took an initial look – also using the CPA (1992) volume – at a seven-step process for implementing these values throughout the course of our work. Whether it be weighing out the options for addressing potential ethical concerns about a colleague, or a decision to override a commitment to client confidentiality in the face of concerns over safety, the need for a process for resolving ethical quandaries is clear, particularly in complex situations where ethical principles come into conflict with one another. In these situations, rules are not helpful, and a more complex process of considering and weighing the benefits, drawbacks, and ethical consequences of various courses of action must be engaged in.

The CPA (1992) process for ethical decision-making is not unique, in that it is common for professional bodies to include a process for ethical decision-making in the ethical resources provided to their members, some even incorporating the use of ethical scenarios that serve to illustrate the recommended process. And, much like the commonalities found among the ethical values and principles across therapeutic organizations, similarities exist among professional associations with respect to the processes outlined for resolving ethical dilemmas. Although CACPT's ethics resources do not include specific steps for addressing difficult or complex situations, our Code encourages members to be mindful and deliberate in considering the impact of the ethical choices we make, and in how we apply the guidelines provided in our Code.

The Canadian Counselling and Psychotherapy Association (CCPA), however, has developed a model for ethical decision-making in their Counselling ethics casebook 2000, written by William E. Schulz (Canadian Counselling Association{CCA} , 2000). In this casebook, Shulz reviewed a number of models for ethical decision-making, including CPA's seven step process, and indeed encouraged members to "examine various models of decision-making, and then attempt to use a model that makes the most sense, or integrate ideas from several models" (CCA, 2000, p 11). The author went on to develop a "Canadian Counselling Association Integrative Model", comprising a six-step process for ethical decision-making, and incorporating six fundamental principles the author found to be common to all of the decision-making models reviewed. It is this integrative model we will utilize now to further explore the process of ethical decision-making. And since the CCPA volume also employs the use of ethical scenarios in demonstrating its model, we will work through the six-step process using an adapted version of one such scenario. Our hope is to enhance our own capacity to address the ethical complexities encountered in our work with children and families. The decision-making steps are presented below, along with the six ethical guidelines incorporated, followed by a scenario-based illustration of the model:

The CCPA (CCA, 2000, pp 11-12) Process of Ethical Decision-Making:

1) The key ethical issues of a particular situation are identified
2) The Code of Ethics is examined to determine whether the ethical issue is dealt with there
3) The moral and ethical principles that are

important in the situation are examined. The author has condensed the principles from the models reviewed to these six:

a) respect for the dignity of persons
b) not wilfully harming others
c) integrity in relationships
d) responsible caring
e) responsibility to society
f) respect for self-determination

4) The most important and relevant ethical principles/considerations are identified for the particular situation, and the process of arriving at a solution is begun by:
   a) generating alternatives and examining the risks and benefits of each
   b) securing additional information including possible discussion with the client
   c) consulting with colleagues or other appropriate resource people
   d) examining the probable outcomes of each course of action being considered
5) An emotional component is introduced into this otherwise cognitive/rational process, whereby the therapist acknowledges and includes in the decision-making process the feelings and intuitions evoked by the ethical challenge. Techniques suggested for this technique include:
   a) Quest- a solitary walk in the woods or park where your emotions evoked by the ethical challenge are brought into full awareness
   b) Incubation – "sleep on it"
   c) Time projection – projecting the ethical situation into the future and thinking about the various probable scenarios
6) Action is taken, following a concrete action plan, evaluating the plan, and being ready to correct any negative outcomes that might arise out of the action taken.

Adapted Scenario:

A Certified Play Therapist has been working with three year old Janie and her mother, Susan, for about three months. The family has engaged well with the therapist, and mother and daughter seem to be making meaningful progress in addressing a history of painful life experiences, including community violence, safe housing issues, and poverty. The family currently receives Social Assistance benefits from a government agency, and through the course of conversation with Susan, the therapist has learned that her client has a new boyfriend who has recently moved in with her and Janie. Susan has also disclosed that her boyfriend is employed at a local business, and that she has not reported her new living arrangements to her social worker as she will likely lose her benefits upon reporting her common-law partner's income. The therapist is very concerned about this disclosure, due to the fraudulent nature of misreporting income to the agency involved. However, she has promised confidentiality to her client family, and believes Janie in particular would be adversely affected by any action on her part that may jeopardize her relationship with the family.

Step One: What are the key ethical issues in this situation?

The therapist has promised confidentiality, yet Susan's actions are fraudulent. If Susan's misrepresentation is discovered, there will be legal implications affecting both mother and child, and possibly the therapist. If the therapist violates her promise of confidentiality, Susan and Janie will likely leave therapy.

Step Two: What ethical guidelines are relevant to this situation?

The CCPA AND CACPT ethical guidelines require that the therapist respect the privacy and confidentiality of the client unless there is danger to the client or to others. It is also the therapist's job to inform the client of all exceptions to confidentiality before the therapy begins. Our guidelines also state that the therapist's primary responsibility is to help her clients.

Step Three: What ethical Issues are of major importance in this situation?

The principles from the model identified as important in this situation by the therapist include 'integrity in relationships',' responsible caring', 'not wilfully harming others', 'responsibility to society', and 'respect for self-determination'.

Step Four: What are the most important principles, and what are the risks and benefits if these principles are acted upon?

The therapist examined each of the principles identified in Step Three, and considered what would happen if she reported Susan's failure to disclose her living situation and additional income, what might happen if she said nothing and continued to work with Susan and her daughter, and what course of action

would be best for this family. Without identifying the family, she consulted with her trusted colleague, who told her she should cover herself by contacting Susan's social worker and informing her of the disclosure. The therapist was concerned about her own possible liability should she not report her client, but felt uncomfortable with the idea of violating Susan's confidentiality in a situation where, to her knowledge, there were no safety risks. The therapist sympathized with the difficulties her client must face in living on such little income, and was concerned about the possibility of Susan removing herself and her daughter from therapy once she discovered her privacy had been breached. The therapist saw the work they were doing together as very important for Janie and her mother, and believed Susan would be unlikely to seek therapy elsewhere. If Susan's living arrangements were discovered by her social worker at some later point, there would likely be repercussions, and Susan may face being cut off from eligibility to receive financial assistance, but this outcome may not negatively affect the therapist's relationship with the family. The therapist was unsure as to whether she had any legal obligation to report this client's behaviour, and what if any consequences she may need to face if her protection of Susan's privacy should come to light.

Step Five: Will I feel the same about this situation if I think about it a little longer?

The therapist realized she needed time to sit with this complex dilemma prior to making a final decision. She went home and took a long walk with her dogs, ate supper, then soaked in the tub and went to bed early. By the following morning, she continued to feel uncomfortable with any decision to report her client's disclosure to the social worker, and was considering the possibility of holding off on any action for the time being, in hopes that Susan would resolve the situation on her own. There was always the possibility of reporting her client at some later point, and after all, protecting her client felt much more important to the therapist than any duty to report her for not disclosing her change of circumstances. Susan's social worker could take responsibility for monitoring that. The therapist decided to make a decision chart of her ethical processing in order to further clarify her options and her thoughts prior to making any final decision. This is what she came up with:

Options for Action	Benefits	Risks	Probable Outcomes
Option 1: Do not report Susan	Protect therapeutic relationship , client confidentiality and client's right to self-determination;protect Janie's access to therapy.	I may get myself into trouble; Susan may get herself into trouble.	Susan's situation may change, or her social worker may discover her change in circumstance and deal with it herself. I could be called upon to justify my ethical decision.
Option 2: Hold off on reporting Susan	Protect therapeutic relationship, client confidentiality and client's right to self -determination; protect Janie's access to therapy; leave open the option of continuing to monitor situation and use my professional judgement.	Susan may continue to disclose dishonest behaviour; I may be held accountable if the social worker finds out about Susan's live-in boyfriend.	Susan's situation may change, or her social worker may discover her change in circumstance and deal with it herself. I could be called upon to justify my ethical decision.
Option 3: Report Susan now	May protect myself from legal risk; modelling honest behaviour.	I may lose Susan and Janie as clients; They may not seek help from another therapist.	Susan will be angry and may lose trust in therapists. She may eventually believe I did the right thing.

Step Six: What plan of action will be most helpful in this situation?

The therapist in this scenario would likely have decided to protect her client's confidentiality, and thereby, her relationship with Susan and Jamie, and the family's access to therapy. Her evaluation of the plan might have been to continue monitoring Susan's disclosures, and to engage her in further discussion around issues of confidentiality, and the limits of confidentiality in circumstances where illegal or dishonest behaviour crosses into an area of placing the therapist and indeed society at risk. This may limit the likelihood of Susan disclosing questionable information in the future, information that may place the therapist in a similar or even more difficult dilemma in the future. The therapist would also likely have kept ample records of her ethical decision-making process in this situation, including her decision chart, by which she had determined that the value of her client's privacy and the protection of the relationship with Susan and Janie outweighed concerns associated with Susan's dishonest dealings with her social services agency. These records might become necessary at some point should the therapist be called to task regarding her ethical choice.

This final step in the ethical decision-making process was intentionally formulated to be inconclusive regarding the therapist's choice of action. The intent was to convey the importance of the process over the outcome, and to reemphasize that it is not simple rules that guide our ethical practice, but a set of principles that must be thought through, balanced, and often prioritized, in order to arrive at a defensible outcome. In fact, in a similar scenario in the CCA (2000) casebook, the one on which the present scenario was based, the therapist decided to report an adolescent boy for shoplifting, after concluding that it was his 'responsibility to society', in the interest of 'responsible care' for the child, and "might actually be helping him" (p 13).

To conclude, there is not necessarily one single `right` answer, but more a need to engage in an ethical process with emphasis on balancing and prioritizing ethical obligations in complex situations in order to arrive at the best possible decision, one that can be articulated and validated in the future if necessary. And this kind of decision-making process alone is insufficient to guarantee sound ethical practice. Each of us must take steps proactively in order to be appropriately equipped ahead of time for the ethical quandaries that will inevitably arise in our work. These steps include:

1. Educating ourselves in the ethical resources available to us through our professional association, as well as resources from other professional and community sources.
2. Being self-reflective in our own ethical practice, with an openness to learn and develop our capacity for ethicality in our growth as professionals.
3. Consulting with other professionals, and spending time reflecting together on hypothetical and/or real life ethical scenarios in our efforts to learn from one another and deepen our understanding of ethical principles and how they are reflected in our work.
4. Being willing to challenge others (as individuals and as systems) and to be challenged by others regarding the ethicality of certain practices, even if these challenges may at times take the form of complaints to professional associations.
5. Cooperating and collaborating with individuals, organizations, and institutions who are working towards building best ethical practices in our field.

Only by engaging in all of these strategies (adapted from CPA, 1992) can we move with confidence towards our best possible ethical practice.

Nancy Stevens M Ed. CPT; CCC

References:

Canadian Association for Child and Play Therapy. (2011). Playground, Fall 2011.

Canadian Counselling Association. (1999). Code of ethics. Ottawa, Ontario: Author.

Canadian Counselling Association (Shulz, William E.). (2000). Counselling ethics casebook, 2000. Ottawa, Ontario: Author.

Canadian Psychological Association. (1992). Companion manual to the Canadian code of ethics for psychologists, 1991. Ottawa, Ontario: Author.

Further information on this and other Ethics topics can be found on the following sites, as well as information on ordering materials published by these professional organizations:
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 a future edition of Playground, please forward your suggestions to nstevens@sasktel.net.

Healing Spaces

by Theresa Fraser CYW, M.A., C.P.T.

Healing Spaces is an ongoing article in Playground. If you would like your playroom featured please contact 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 Robin Pucci who practices in Bradford, Ontario.

Robin in the playroom.

When Robin Pucci was a high school student at Holy Trinity High School in Bradford Ontario – an inspiring Play Therapist was invited to speak to her ***Introduction to Psychology*** class on Play Therapy and the career of a Child Psychotherapist Play Therapist. This presentation inspired Robin to learn as much as she could about the role that a Play Therapist plays in the life of children and families whose lives have been touched by trauma or attachment disruptions.

Robin identified that she was instantly captivated by what seemed to be the best job in the world. She decided then and there to become a Child Psychotherapist Play Therapist.

Seven years later, after graduating from her undergraduate degree in psychology, Robin contacted that same Play Therapist to inquire about future steps. The first recommendation was to enroll in the CACPT certificate program which Ms. Pucci promptly did while pursing her Master's degree in Counselling Psychology.

The inspiring Play Therapist was CACPT Past President Lorie Walton (who owns and operates Family First Play Therapy Centre Inc in Bradford Ontario). Lorie explained the certification process to Robin and then later interviewed Robin for an Internship position.

Robin has enjoyed learning different approaches to play therapy and how to use techniques with children who have various issues. She stated that after attending Level One of the Certificate program she has met "inspiring instructors who are engaging and have an extensive knowledge in the field". Robin has also participated in Introductory Theraplay training given Theraplay is a big part of the work that is done at Family First. It helps to create nurturing relationships between children with attachment issues and their parents as well as support in the regulating of the child's emotionally dysregulated presentation.

Robin is gaining her clinical hours and supervision hours from working at Family First under the supervision of Lorie Walton. She also identified feeling very fortunate to be working in her chosen field in her home community.

This Intern's supervised practice includes clients who are between the ages of infants to 16 years of age. These children are referred for a variety of reasons, such as, attachment issues (pre or post adoption or foster care) neglect, physical abuse, ADHD, anxiety, depression, sexual abuse, PTSD, autism, medical or developmental issues . Consequently therapists at Family First are trained and certified to use evidence-based models such as: Cognitive Behavioural Play Therapy (CBT), Dyadic Developmental Psychotherapy (DDP), Theraplay, Sandtray, Filial Therapy and client centered (non-directive) to name a few. Parent counselling and psycho-educational support is also provided along with incorporating the caregiver/parent into sessions is a main practice.

Family first has several play therapy rooms as well as a Theraplay room utilized by a team of clinicians. When using a therapy room, Ms. Pucci stated that she has been trained about the importance of keeping the therapy room tidy and clean. Each therapist is trained to put away anything that was used during the session, such as refilling paint containers, cleaning paint brushes, and making sure all items are placed on the shelves where they belong so that the room is ready for the next therapist and client. One of the philosophy's at Family First is that if the clinicians show respect for the therapy rooms and the items in them, then the child clients will model that respect as well….because 'all things and people are 'safe' and are taken care of at Family First.'

Robin finds that the female client's who attend Family First tend to gravitate towards the dollhouse. She has observed that the dollhouse helps children express and play out their perception of their family's experience. She has many male clients who tend to gravitate towards the sandtray, where they most often engage in fantasy play.

Ms. Pucci is working on her Masters of Counselling Psychology degree (MA) through Yorkville University and is happy to be practicing Play Therapy at the Family First Play Therapy Centre Inc while working on her dream of becoming certified as a Child Psychotherapist and Play Therapist.

Robin with Mentor Lorie Walton from Family First Play Therapy Centre.

Robin wants other CACPT Interns to know that getting started can be scary which can sometimes mean aspiring Play Therapists doubt their capabilities.

Her mentor, Lorie Walton, has told her that it takes experience to be a confident therapist but you will get there if your intentions are good and your goal is to help children and families. She has found it easy to find mentors because she has found CACPT members and supervisors to be helpful and supportive. She also identified that she has found that while learning how to help others, it is amazing how much you learn about yourself in the process.

When Robin was asked which resources she likes to refer to in her practice she shared articles and books by Dr. Bessel van der Kolk, Dr. Bruce Perry, Paris Goodyear-Brown and Garry Landreth. She has found that these authors/therapists/scientists offer important direction to the aspiring Play Therapist about supporting the healing process of the children who often attend Play Therapy.

If you wish to contact Robin Pucci to dialogue further in regards to her journey in becoming a Certified Child Psychotherapist, you may contact her at: r.pucci@rogers.com

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.

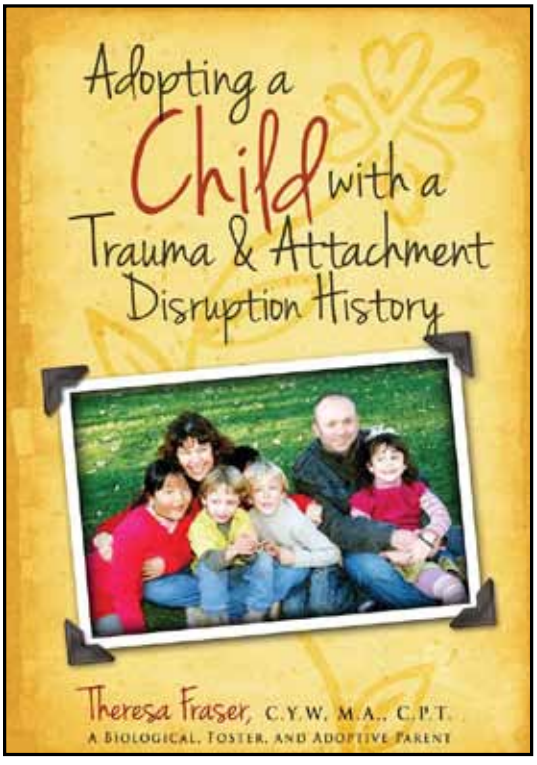
Specialized Training: CACPT sets standards of education and training for professional therapist as well as establishing programs of continuing education and training. CACPT examines and accredits programs and training centers in child and play therapy. CACPT has established a Play Therapy Certificate 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 and click on Members.



Available at www.amazon.ca in print or e format.

CACPT's 2013 Conference and AGM

Watch for the updates on location and dates after your AGM at your 2012 Conference in Calgary Alberta.

HOLMAN
INSURANCE BROKERS LTD.

New Insurance Provider for CACPT Members

CACPT & Holman Insurance Brokers Ltd. Have partnered together to offer a very affordable & comprehensive insurance program to cover members for professional liability & general liability. Premiums start at $130.00 per year, with 90 additional modalities members can add to their specific "scope of practice."

For additional information, please contact:

Peter Fetherston, Associate Broker
Tel. 905-886-5630 Ext 1428 • Fax 905-886-5622
Email: peter.fetherston@holmanins.com

Holman Insurance Brokers Ltd.
3100 Steeles Ave. East, Suite 101, Markham, Ontario L3R 8T3

www.therapistinsurance.ca

The information is also available on the CACPT website at:
http://www.cacpt.com/site/www/membership02

ROCKY MOUNTAIN PLAY THERAPY INSTITUTE

Join other Play Therapists from Around the Globe!

Play Therapists have come from . . .

- Panama
- Jordan
- United Kingdom
- Hong Kong
- Ecuador
- Croatia
- United States
- Mexico
- France

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.

CACPT Approved Provider 09-104 • ACSW Category A Approved • APT Approved Provider #06-179

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 classes:

Certificate in Play-Based Treatment of Trauma 2012 - On-line component available Nov. 1 with on-site class Dec. 3-6, 2012

Certificate in Sandplay 2013 - On-line available April 1, 2013 with on-site class April 30 – May 3

Certificate in Play-Based Treatment of Trauma 2013 - Online Nov. 1, 2013 with on-site class Dec. 3-6

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 June 1, 2012 with 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.

On-line component available July 1, 2012 with on-site class August 18-26

www.rmpti.com

1318 15th Avenue SW, Calgary, AB • T3C 0X7 • 403-245-5981 • rmpti@telusplanet.net