PLAYTHERAPY™
VOLUME 15, ISSUE 1 • MARCH 2020

Using Stories and Metaphors in Play Therapy

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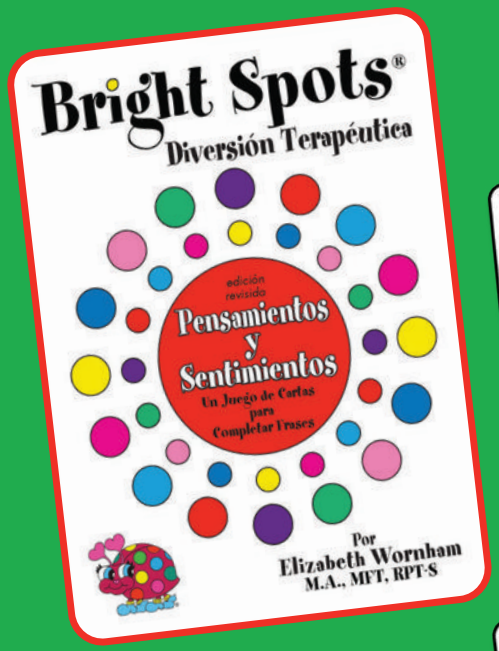

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SPECIAL SECTIONS

FEATURES

CLINICAL EDITOR

Sarah D. Stauffer, PhD, LP (Switzerland), LPC, NCC, NCSC, RPT-S, is a play therapist with children and families facing sexual maltreatment at the non-profit Association ESPAS and a member of the Scientific Committee for the University of Lausanne's Child Maltreatment Observatory. She is a Leadership Academy Graduate and member of the *International Journal of Play Therapy* Editorial Board and Research Committee.
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Editorial

Kathryn Lebby, CAE, CMP
APT President/CEO

A new *decade* has begun! With 2020 vision, we look back on what that the Association for Play Therapy (APT) community has accomplished and forward with a renewed sense of purpose to where we are heading as a professional association.

Since 1982, APT has been comprised of play therapy researchers, teachers, and practitioners. With four play therapy meta-analyses, 25 randomized control studies, and more than 50 qualitative and case studies published to date (Ray & McCullough, 2016), APT members continue to celebrate the effectiveness of the therapeutic powers of play and advance the field to further solidify its place in the world of child psychotherapy across professional disciplines.

In December 2018, the American Counseling Association recognized staff writer Bethany Bray's cover story, "The therapy behind play therapy," as the #5 most downloaded article in *Counseling Today* that year. Several APT members interviewed for that story underscored play therapy's importance in child counseling. In December 2019, the American Psychological Association published its top 10 most downloaded articles to date. From their 89 journals, which had published more than 4,500 articles, Jennifer Hall's "Child-centered play therapy as a means of healing children exposed to domestic violence" ranked #4 on that list. Dr. Hall has been an RPT since 2015.

Eliana Gil eloquently reminded us, it is time that play therapy takes its rightful place as a strong and respected psychotherapy modality (APT, 2016) – and continues to claim, through supporting research, that it is the most developmentally appropriate form of child therapy.

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The Association for Play Therapy (APT) exists to advance play therapy and provide a professional and diverse community to support those engaged in play therapy practice, instruction, and supervision.

Chair Anne L. Stewart, PhD, RPT-S

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Call for Nominees!

APT Board of Directors

Calling all leaders! The nominations committee is looking for candidates who are committed to the goals of the association, have great collaborating and listening skills, and are passionate about APT. Director candidates must have extensive play therapy knowledge; have been a Professional member in good standing for the past five (5) years or more; maintained an active Registered Play Therapist (RPT), Supervisor (RPT-S), or School Based – Registered Play Therapist (SB-RPT) credential; demonstrated a working knowledge of the Policy Governance Model; and have a temperament that contributes to and generates group consensus, wisdom, and vision.

For more information and to access the Director Candidate Questionnaire, call candidates are encouraged to visit the Board of Directors page of the APT Website. Don't wait – submit your questionnaire by the **March 31, 2020** deadline!

Call for Award Nominations

APT sponsors several Awards of Excellence for individuals who embody its values of service, leadership, and contribution to the play therapy field and community. Nominate your fellow play therapists for one of the following awards before the **March 15, 2020** deadline:

- **APT Service Award:** Individual demonstrates outstanding organizational service in the play therapy field and community.
- **Emerging Leader Service Award:** Emerging leader whose contribution to APT, Foundation for Play Therapy, and/or its chartered branches is leaving a positive mark in the field of play therapy.
- **Research Award:** Individual has published research that significantly develops, promotes, or advances the value of play, play therapy, and credentialed play therapists.
- **Student Research Award:** Research conducted by graduate or doctoral student that significantly develops, promotes, or advances the value of play, play therapy, and credentialed play therapists.
- **Lifetime Achievement Award:** For 25+ years, the individual has contributed and significantly advanced the field and image of play therapy and/or the programs and activities. *Must be endorsed by two past Lifetime Achievement Award recipients.

All nominations must satisfy minimum criteria and will be evaluated by Awards Committee Chair Renee Turner, PhD, LPC-S, RPT-S and the Awards of Excellence Committee. Visit the Awards of Excellence page of the APT Website for application and more information.

Culture, Metaphors, and Play Therapy:

Rainbows of Resilience in Life's Storms

JOYCE C. MILLS, PHD, LMFT, RPT-S

The award-winning American poet, author, and civil rights activist, Maya Angelou, inspired us to "become a rainbow in someone else's cloud." By illuminating the power of resiliency, we can help our clients overcome the darkness evoked by life's storms.

Researchers have related the effects on neurophysiology to behavior, emotions, and relationships (e.g., Courtney & Nolan, 2017; Doidge, 2007; Goodyear-Brown, 2019; Mellenthin, 2019; Perry & Szalavitz, 2006; Siegel, 2012; van der Kolk, 2003). However, two areas often overlooked or minimized are the *sociocultural* view of trauma and attachment and how historical oppression and cultural resilience have impacted the healing process with children, adolescents, and families (Crenshaw, Brooks, & Goldstein, 2015; Crenshaw & Hardy, 2005; Crenshaw & Stewart, 2015; Duran, 2006; Duran, Duran, Yellow Horse Brave Heart, & Yellow Horse-Davis, 1998; Gil & Drewes 2005; Mills & Crowley, 2014).

The Culture of Healing

The definition of culture is complex, and includes ideas, beliefs, and shared history that manifests in a society's language, art, routines, and moral codes and guides people's behavior (Psychologist World, n.d.). As an Ericksonian, resiliency-focused play therapist and transcultural psychotherapist for over forty years, it has become increasingly evident that there has been a preponderance of attention placed on identifying clients' traumatic events, attachment history, accurate diagnosis, and prescriptive treatment planning for children and families seen in play therapy (Goodyear-Brown, 2019; Kaduson, Cangelosi, & Schaefer, 2020). Equally important, if not more so, is expanding this viewpoint on trauma to include the significant role *resilience* and *mindsets* play in the process of healing (Dweck, 2016). Crenshaw et al. (2015) posited that nurturing a resilient mindset in children would help them resolve problems and display courage, perseverance, and mastery in the face of challenges.

Providing a *culture of healing* in the playroom is more than tending to the physical space. It is an environmental attitude, a mindset that focuses on recognizing, utilizing, and nurturing inner strengths and hope as catalysts for healing through posttraumatic growth (Calhoun & Tedeschi, 2013). Masten (2001) elucidated that "resilience does not come from rare and special qualities, but from everyday magic of ordinary, normative human resources in the minds, brains, and bodies of children, in their families and in their communities" (p. 235). As play therapists, how do we keep that mindset of resiliency and hope in the face of trauma and oppression?

Cultural Elements that Impact Play Therapy

Culturally informed play therapists look beyond what is linear and experience the journey. By exploring clients' world, their beliefs, traditions, stories, cultures of origin, and spirituality, we can expand our professional insights, deepen the therapeutic relationship, and create culturally responsive play therapy approaches to inspire positive outcomes in the process of healing with our clients. These elements impact our own lives and allow us to create a sense of *relational familiarity* with our clients, which facilitates positive rapport and cultural respect.

We Are the Playroom

As play therapists, we carry the essential heart and soul of play therapy within each of us, leveraging the child's resiliency and the play therapy relationship as therapeutic powers of play (Schaefer & Drewes, 2014) that we can use no matter where we are. *We are the playroom.*

While there are valuable suggestions and guidelines regarding how to set up a playroom, such as choosing the right toys, games, or techniques (Crenshaw & Stewart, 2015; Kaduson et al., 2020; Landreth, 2012), there may be financial and logistical limitations that impede a play therapist from creating an ideal playroom, such as limited space, environmental challenges, or surviving a natural or man-made disaster (Mills & Crowley, 2014). However, these limitations or challenges are metaphorical teachers, helping us to connect with the true playroom that exists within each of us.

After living through Hurricane Iniki, a category five storm that ferociously hit the garden island of Kaua'i on September 11, 1992, I worked in a converted utility room, outside in a community neighborhood center, and wherever space was available. Generously donated by the local community, the furniture had survived the hurricane. It became the "Talk-Story Center" in which I provided counseling and play therapy with the help of BT (Big Turtle), my long-time puppet/co-therapist. After Iniki, there were no formal "debriefing" sessions. No one was asked to relive anything. The metaphors we designed through creative activities provided healing intention (Mills & Crowley, 2014). *We are the playroom!*

CLINICAL EDITOR'S COMMENTS:

Cultural metaphors may lay the groundwork for building resilience.

StoryCrafts: Natural Healing Activities

In addition to the Talk-Story Center, we also offered weekly StoryCrafts, creative activities that expand the storytelling metaphor into physical form through artistic expression. StoryCrafts use the story the way a sculptor uses clay as the medium through which her sculpture is formed (Mills, 2011).

EarthCrafts

The natural environment serving as playroom, we used shells, fallen branches, driftwood, and found debris to create *EarthCrafts.* The metaphor of transforming what was broken into beautiful works of art was the heartbeat of this and all such activities (Courtney & Mills, 2016; Mills, 2011).

Heart Drums

Heart drums were made out of large, empty juice cans, inner tubes cut into circles used as hides, rope-cords to fasten the hides, and wooden dowels as drumsticks. The metaphor of drumming is the connection to the heartbeat of life. On a physiological level, helping children and adolescents connect to their own heartbeat can improve issues related to sensory and emotional regulation (Moore, 2011). Drumming in a group inspires children to communicate through rhythm and connection.

Cultural Cookouts

Cultural cookouts consisted of Elders who came to the neighborhood center and shared stories, taught the spiritual meaning of the foods they prepared, and "talked story." Like a tiny pebble tossed into a pond, a story can be offered in the river of experience and the ripples can be felt in many ways. This reinforces a hope and resiliency-based mindset (Brooks & Goldstein, 2001) rather than clients "reliving the trauma repeatedly in therapy, [which] may reinforce preoccupation and fixation" (van der Kolk, 2014, p. 32). By promoting the power of the metaphor, and delivering it in culturally grounded ways, play therapists can nurture the reconnection to a resiliency pathway and posttraumatic growth (Calhoun & Tedeschi, 2013) within each client (Crenshaw et al., 2015; Mills & Crowley, 2014).

Reconnecting to Cultural Values for Healing

The importance of helping children or families reconnect to deep cultural values can often be overlooked or minimized when dealing with the effects of historical oppression (Duran, 2006; Duran & Duran, 1995). However, these cultural values contain roots of resiliency that can help

ignite a sense of attachment and grounding (Gil & Drewes, 2005; Mills, 2011). Two such examples illustrate this point on an individual level (Clayton) and at a broader cultural level (Indonesia's Movement of Play).

Clayton and His Heart-Drum

Clayton (pseudonym), a male adolescent, lived in a residential treatment center due to extremely aggressive and self-harming behavior. His mother was deceased. All his father told him about her was that she was from the Lakota Nation and that she was an alcoholic. Clayton knew nothing of the tribal stories, beliefs, or traditions. He didn't know his mother was sent to live in a boarding school as a young girl where she was forbidden to speak her language or pray in her traditional way. She endured what Duran (2006) called "soul wounding."

By not connecting to her beliefs, spirituality, culture of origin, stories, or traditions, Clayton was disconnected from an essential part of himself. His mother was not just an alcoholic, she was born a Native American woman who endured cultural trauma and historical oppression. She went to her grave unable to tell the stories of her people to her son. Siegel (2012) stated, "We are storytelling creatures, and stories are the social glue that binds us to one another... *the mind,* as a fundamental part of our humanity, is shaped by story" (pp. 31-32, italics in original). The implication is that without stories, healthy attachment cannot be formed. Stories come in many forms, such as oral, music, movement, dance, art, etc. Clayton experienced an intergenerational soul wounding unintentionally passed down from the historical trauma his mother endured.

Over the years of experiencing personal relationships, learning from, and working with many people from different Native American nations, my office held numerous feathers, drums, pottery, stones, and pictures, given to me as gifts and often in payment for our work together. Clayton noticed these items with interest. I shared the stories I had learned about these sacred objects and healing ceremonies. Although not all from the Lakota Nation, the spirit of the stories began to touch something in Clayton that seemed to ignite a sense of determination to know more, an awakening of what I call "sleeping story memories," or memories resting in the unconscious. With the belief that we all have invisible umbilical cords, I hypothesized that Clayton was experiencing a reconnection to his mother's soul.

During our sessions, Clayton was especially drawn to several drums. I had learned the drum is not just an instrument, but the heartbeat of Native American culture; the heartbeat of Mother Earth. At times we drummed together and at other times we took turns creating drumbeat sounds in nature, such as thunder, rain, and wind. My client made a special connection to the drum. Rather than buying one, a drum-maker from a nearby Nation made a large drum with my client. In a sense, his "heart-drum" was beating in rhythm with his new discoveries of life.

The Magic of Play for Awakening Joy

Spearheaded by Dr. Alice Arianto, the *Movement of Play* plan has received Indonesia's recognition of the essential need for play to be included in therapeutic and educational program development benefiting children and families throughout the country for several generations. On October 13, 2018, 1,400 children, adolescents, and parents gathered in Jakarta, Indonesia to celebrate a day devoted to the *Movement of Play.*

Transported by buses from one of the most impoverished areas in Jakarta, numerous volunteers, students, and play therapists greeted everyone with welcoming smiles. Groups of children could enjoy cultural storytelling, puppetry, expressive arts, dance, and traditional cultural games in designated areas. One such activity involved providing a large outline of a heart and butterfly on which children could dip their fingers in colored paint and imprint their hopes and wishes with their fingertips. Hundreds of children eagerly joined in this experience. Their little fingerprints metaphorically brought their hopes and wishes to life.

Along with dignitaries who gave blessings to the occasion, I was invited to open the gathering by telling the Hawaiian story, "The Perfect Bowl of Light" (Lee & Willis, 1990; Mills, 1999, 2006 [pp. 207-213]), which was simultaneously translated as I spoke. After telling the story, I asked the children to hold out their hands in front of them and to imagine they were holding their bowls of light. After retelling the story, I led them in turning their hands over symbolically, emptying the stones in the story. We then brought our hands to our chests, patted our hearts, and ended by repeating, "the light is always there."

During this occasion, a combination of cultures, from experiencing Indonesian blessings to hearing and sharing a traditional Hawaiian story underscored the *Movement of Play* missions. Playing and creating story-

related crafts promoted joy, restored the value of togetherness through social activities, and strengthened relationships between children and across generations. Although all of the children were living in conditions of extreme poverty, the richness of their laughter, enthusiastic participation, and gleaming smiles prevailed.

Summary

Jung (1934/1959) suggested that people overcome darkness by becoming "bringers of light" and "enlargers of consciousness" (p. 169). As play therapists continue to explore effective approaches in their practice for clients who have experienced trauma, it behooves them to include the effects that historical oppression leaves in the healing process. Additionally, by recognizing and leveraging cultural resiliency, healing pathways residing within clients can be activated and manifested. By doing as Jung suggested, we can see past life's storms and embrace the rainbows of resilience that are destined to emerge within all with whom we are graced to work.

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Puppet Play Therapy - A Practical Guidebook

Edited by Athena A. Drewes and Charles E. Schaefer
2018: Routledge.
ISBN: 978-1-138-70722-1

Puppet Play Therapy is a well-rounded guidebook that describes the basic skills, techniques, and applications for working with puppets in play therapy. Edited and authored by leading voices in the play therapy field, the book's five sections and nineteen chapters offer helpful guidance on selecting, using, and assessing puppet-based therapeutic interventions. It aims to comprehensively prepare play therapists to skillfully weave puppet play into their practice.

Readers will gain advanced knowledge on multiple puppet assessment techniques, including the Berkeley Puppet Interview (Ablow & Measelle, 1993), the Family Puppet Interview (Irwin & Malloy, 1975), and the Puppet Sentence Completion Task (Knell & Beck, 2000). The editors thoughtfully included four major theoretical approaches that underlie puppet play therapy so the reader could understand how puppet play could fit within their chosen theory. Several useful puppet play therapy techniques are described, spanning storytelling, problem solving, and symbolism. The guidebook concludes with how to use puppet play therapy with different populations and in diverse settings, such as in family therapy, in trauma and sexual abuse treatment, in play therapy with adults, and within school and medical settings.

The editors have created a thorough, practical publication that provides research-backed methodology to give mental health professionals a solid foundation from which to assess, conceptualize, and implement puppet play therapy in their work with children. Mental health professionals of all experience levels should find this guidebook to be a valuable, informative, and helpful resource.

ABOUT THE REVIEWER:

Parie Faridnia, PsyD, RPT-S, RYT, is a psychologist in private practice in Irvine, CA, and the current President-Elect of the California Association for Play Therapy. **connect@drparie.com**

CREDENTIALING:

Answers to Common Questions

Welcome to APT's new Credentialing Column, dedicated to keeping you well-informed on credentialing requirements so you can successfully navigate your way through the application process. We will be addressing questions commonly asked by applicants and supervisors. You can get the information you need from the Credentialing Standards, FAQs, and from this column. If you need further clarification, please contact the APT credentialing department.

Documentation: Using the Phase or Appendix forms?
Applicants who began accruing their hours before the changes to the credentialing requirements were announced on April 1, 2019 will likely not meet all of the requirements as outlined in the Credentialing Application and Standards. Use the Appendix I form to document any play therapy instruction, experience, and supervision completed prior to January 1, 2020.

Through documentation, applicants must demonstrate an integrated and well-rounded attainment of the credentialing requirements. This is accomplished by integrating play therapy instruction, clinical experience, and supervision. The three-phase approach is aligned with the educational/developmental model of how psychotherapists develop in knowledge, skills, and personal capacities. In order to obtain competency in the practice of play therapy, direct instruction must be followed by periods of application to clinical cases and be accompanied by supervision.

Applicants may provide a cover letter explaining any departure from the credentialing requirements to aid APT in eligibility determination. You are encouraged to provide as much information as possible, more information is better than not enough.

The flexibility of the phase approach lies in the demarcation of a) the date range and b) hours for each phase. Applicants may choose to shorten or lengthen the time period of any phase to best align play therapy trainings, supervised play therapy experience, and supervision with the range of hours set forth in each phase. With that in mind, remember that applicants must complete the requirements in no less than two years and no more than seven years from start of accruement.

Helpful Tips and Reminders

- Make sure you are using the most up-to-date version of the application
- Be sure to include a copy of your current license displaying the expiration date, as well as a copy of your graduate transcripts (unofficial copies are accepted)
- All play therapy experience and supervision hours earned in 2020 and hereafter must be under the supervision of an RPT-S
- Whether you finished your hours prior to or after January 1, 2020, all applicants must complete and document 5 observations with their supervisor

A Tribute to My Trusted Puppet Assistants

| SHOSHANA LEVIN FOX, EdD, LP, RPT-S

Years ago, during a challenging child-centered play therapy session, my use of puppets within the playroom took an unexpected yet productive turn when I, rather than my young client, needed the power of puppet expression. Puppets have long been a critical component of a therapeutic playroom (Drewes & Schaefer, 2017; Irwin, 2002; Landreth, 2012) with their use extensively documented in play therapy (e.g., Butler, Guterman, & Rudes, 2009; Gil, 2016; Hartwig, 2014). That day, I realized that I had never really made full use of "puppet power" for therapist expression. Feeling particularly stuck that pivotal session, I grabbed puppet Rachel, with her yellow yarn hair, colorful skirt, and blouse. To my surprise, Rachel expressed with ease what I had been struggling to formulate verbally in nondirective fashion. Since then, Rachel and Sammy have been my trusted assistants, fulfilling myriad roles in play therapy treatment as my right-hand helpers. In this article, "Joey" and "Miri" serve as generic client names.

CLINICAL EDITOR'S COMMENTS:
Puppets can help play therapists deepen metaphorical work in nonthreatening ways.

Easing Entry

Rachel and Sammy often assist from the first moments of contact with a new child, *easing the child's entry and transition* into a new setting. A tentative knock on the clinic door signals that parent and child are waiting outside, often anxiously. A puppet helper cautiously peeps around the slightly opened door at the child's eye level. A common response to this unexpected puppet welcome is the child's relieved laughter (usually the parent's, too), as initial tension is dispelled. Puppet presence at the door communicates nonverbally that the child is entering an unconventional, child-friendly place of emotional safety. Although this will not dispel all the child's fears, puppet presence is a wonderful assist.

Depending on information gleaned from parents about the child's difficulties and temperament, Sammy may blurt out loudly, "Are you looking for the special playroom?" Or Sammy may hesitantly tell me, "I feel shy. Who is this boy?" "That's Joey, Sammy. He's come to play." Still attuned to the child's degree of shyness or pent-up aggression, Sammy may insist that *he* wants to be the one to show Joey the playroom. Therapist: "Great idea, Sammy. That's important, because this is Joey's first time. Maybe you also want to show Joey's mother where she can wait for him." Such dialogue helps the child sense that this setting is not one of automatic adult control. There is room for discussion.

If the child has significant aggression or obstinacy issues, Sammy may argue with me at the outset. "*I* want to show Joey the toys. You *always* get to do that, Shoshana. Now it's *my* turn!!" Appearing surprised but not critical of Sammy's mood, I calmly communicate understanding: "I see that's important for you, Sammy. Go for it," demonstrating that anger and aggression are not off-limits in this new setting. Although building genuine trust with young children takes time, Sammy and Rachel are instrumental in setting the tone.

Enabling First Steps

Ensconced in the playroom, with Sammy or Rachel literally on hand, I may begin with the customary: "In this special playroom, you can choose when, what, and how you want to play." Having Sammy or Rachel *introduce the room* adds depth to the communication. Rachel: "*I'm* telling Miri about this special playroom!" Listening to my dialogue and tone of voice as Rachel does so, Miri has the opportunity to assess the therapist and to gather first impressions. Is the therapist warm? Accepting? Understanding? Patient? Is this really a safe place?

Sammy and Rachel *enable children to take their first steps* in this primarily nondirective setting. Rachel has been particularly helpful with shy, withdrawn, or selectively mute children. If Miri sits shyly, quietly, even fearfully opposite me at the table, I usually rule out more direct, obvious tracking or reflection options, such as, "You'd like to sit quietly," or, "I wonder if you're feeling a little fearful." At the moment, these responses feel too heavy, too direct, too fraught with assumptions, too quickly placing the child in a position where she has to process her thoughts and feelings and, even more threatening with a stranger, verbally respond.

Rachel to the rescue. As Rachel and I look around the playroom, Rachel whispers to me, "What's there to do here?" Directing my communication to Rachel while barely looking at the shy child, I patiently give Rachel a general inventory of the toys. Sometimes this is enough to induce a shy, withdrawn child to move (literally) and initiate play.

If the child doesn't initiate, Rachel and I might lapse into a comfortable silence, respectful of the child's degree of hesitancy, communicating that "doing nothing" is also an acceptable choice. To cue-dependent children, such acceptance signals that the existential choice is ultimately theirs. If the child's apprehension level remains high, I may ask Rachel what *she* feels like doing. Rachel usually prefers "safe" activities, such as scribbling or bubbles, activities which do not hint at what the child "should" do and that do not involve much emotional investment. Rachel may attempt to blow bubbles but may succeed only in making a rude noise. This puppet maneuver helps dispel initial tension! The child might reach for more bubbles on the shelf, taking the first step toward initiative and self-definition in the playroom, or stand up and happily begin to pop Rachel's bubbles. We have liftoff – interaction.

Puppets provide *additional degrees of freedom for therapist responses.* With highly anxious children, Rachel might tell me in a barely audible whisper: "Maybe Miri isn't sure what to do. Is she waiting for you to tell her?" Rachel's questions give me an opportunity to indirectly address Miri's apprehension, to communicate understanding, and to clarify that I will not be solving the existential problem of what Miri "should" do in the playroom. Perhaps: "Rachel, this is Miri's first visit. She might be feeling unsure." Or: "Rachel, this is Miri's own special time. It's fine if she feels like

sitting and looking at the toys." Rachel might respond: "Isn't that boring for her?" Therapist: "Possibly, Rachel. But Miri will decide if and when she feels like playing." Or clarifying: "Rachel, I can't tell Miri what to play. In her class, the teacher tells the children what to do. But I'm not a teacher. I'm a play lady in this special playroom. Here, Miri will decide what she feels like doing." The implicit messages to the child are many and nuanced. The *puppet dialogue creates a more comfortable triad* (therapist – puppet – child client) for reflection and interaction, whereas, without a puppet, therapeutic options remain dyadic (therapist – child) and perhaps even predictable or prosaic.

Although girls express anger, my experience is more frequently that little boys enter loaded with energy and aggression. The *therapist-puppet dialogue enables a safe distance in handling the child's aggression,* helps the child internalize reflections about feelings more readily, and helps neutralize power struggles with which aggressive children are painfully familiar. Sammy to the rescue with reflective comments: "Joey has tons of power today! Shoshana, do you think Joey might be upset? He's hitting Bobo hard!" Sammy helps me tease out the nuances of the child's aggression. Is aggression rooted in anger? Sadness? Through therapist-puppet dialogue, the therapist can reaffirm acceptance of angry feelings, redirect anger to safe outlets, and therapeutically set limits.

Deepening Therapeutic Processes

In the depth of therapeutic process, Sammy and Rachel have been indispensable in assisting the children with the expression of their conflicting feelings, as *the puppets adopt the roles of antagonist or protagonist.* As antagonists, puppets may argue with me – constructively – to help the child. Sammy: "Don't you understand anything, Shoshana?! Joey is sad!" Or, puppets oppose the child while actually serving as child protagonist. Joey: "You're stupid, Sammy. You never get it right!" Sammy: "Not true! Maybe I'm not as smart as you are but remember I'm just a kid. I'm trying my best. Like you, I'm not stupid and I'm not bad!"

The child is revealing the criticism to which he or she may be exposed, or revealing self-doubts or self-hate projected onto the puppet. In dialogue with the child, Sammy performs a crucial role. By opposing the insults through projection, Sammy stands up for the struggling positive self of the child. As an object toward which young clients can project and discharge their frustration, anger, and aggression, Sammy has been stomped on, choked, drowned, beaten, bitten, hidden, punished, abandoned, bound in handcuffs, sent to jail without food, and told he's not loved. Such play reflects children's hurt and anger. It raises questions about where imagination ends and where the child's own endangered experience may begin. Meanwhile, of course, I'm standing up for Sammy (and, by proxy, the child's wounded self), expressing the child's fragile hope that he is of worth in the face of a scary and hurtful world.

When I feel awkward or stilted in my reflective responses or sense that I am missing something during challenging conversations, the puppets "dialogue" with me to *help fine tune what is transpiring.*

> Rachel: "It can be really scary in the dark. Shoshana, you forgot that Miri might be scared at night."
> Therapist: "Thanks for reminding me, Rachel."
>
> Or, therapist: "Sammy, if your dad got hurt badly in a car accident, how would you feel?"
> Sammy, in a tremulous whisper: "It would be really hard to talk about it. Do I have to say?"
> Therapist: "No, Sammy, you don't have to. But talking helps you feel better inside, because then you aren't so alone with all those feelings."
> Sammy, thinking: "OK. I'll tell you one thing. I would feel sad and mad mixed together. That's all I'm saying today!"
> Therapist: "It takes courage to say that, Sammy."

By asking me questions, puppets enable me to *step back, consider, reframe, or even correct an in-session error.* However, I marvel most at my puppets' ability to help me when I feel stuck or sense that I'm missing something. I may suddenly ask a puppet: "What do you think?" So often, my puppet assistant seems to find the right words for the situation when I had failed! Rachel and Sammy are often able to speak from a more fluid, intuitive place when I had been struggling to figure things out.

Most young clients love interventions that include the puppets helping them *express and clarify their thoughts and feelings,* sometimes verbally, sometimes by participating in the child's play metaphor. Naturally, some children find puppets too "babyish" or "stupid." I usually respect the child's wishes. Yet sometimes children who initially say, "You're talking for him!!" later express great affection for Sammy or Rachel. When uncertain

whether a puppet's involvement is welcome, I check with the child. "Is it all right if I talk to Sammy while you're playing?" Or: "Is it ok if Rachel and I watch while you play?"

Terminating

If a puppet played a significant role in a child's therapy, that puppet is certainly present in our termination session, as "the three of us" recall the child's favored or disliked activities, summarize progress, enjoy simple treats, and I (we) give the child a small play or art material that reflects our time together. In a colorful letter, I summarize the child's progress, highlight the child's positive qualities, and wish the child future success. But there's one more thing – another small envelope. Children are delighted to find inside a portrait photo of Sammy or Rachel, on which is written in indelible ink: "Good luck in all you do! From your friend, Sammy."

Summary

Puppets, as therapist assistants and child allies, have functioned significantly in my play therapy work. Puppets can bridge the child's entry into the world of therapeutic play; ease initial communication; add color, humor, nuance, and depth to therapeutic reflection and dialogue; enrich and enliven the metaphor in which the child is working; contribute degrees of freedom in clarifying and developing feelings and issues; ask key questions; offer gentle interpretations; serve as protagonist standing up for the child, or constructively as antagonist; help explore difficult feelings and topics; and create a less threatening triadic rather than dyadic atmosphere for the therapy to unfold. Thank you, Sammy and Rachel, for your steadfast assistance.

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Constructing One's Niche:

Offering Play Therapy to the Deaf Community

| GABRIEL I. LOMAS, PHD, LPC, RPT-S

CLINICAL EDITOR'S COMMENTS:
The author explains how play therapy has helped him benefit the Deaf Community.

In graduate school, I attended a Saturday workshop presented by Registered Play Therapists (RPT) who are still active in the Association for Play Therapy and know the field very well. The day was fascinating, and the handouts were really helpful. That single workshop was the only play therapy training I had in my graduate program, yet the impact was far-reaching.

After graduate school, while under supervision, I began counseling children and adults, many of whom were in the child welfare system. I struggled to find the words to help children process their experiences. I have a unique niche, as I am fluent in American Sign Language (ASL). Agencies were referring large numbers of Deaf and Hard-of-Hearing children to my practice, and I leaned heavily on that one workshop I had in play therapy. My wife, who is also a counseling graduate, and I were fortunate that training was plentiful in Houston, TX. We quickly connected with wonderful mentors and advanced our training. I earned a doctorate and became an RPT-S, which was important for my clinical work. It was clear that words were not needed, and play was the language I needed to use in sessions.

> ***"Using ASL in play therapy has allowed me to construct a niche that has positively impacted my career and the lives of countless children with whom I have crossed paths!"***

For nearly 10 years, I was contracted by Child Protective Services (CPS) to do risk assessments with adults and therapy with victims of child abuse and neglect. I was often called by child advocates and social workers to assess parenting skills and evaluate children's need for treatment on short notice, then make recommendations for the court or for CPS. I recall meeting with a young girl who had been wandering around a community alone. Her parents were drug-addicted and had left her to fend for herself while they binged on drugs. The police brought her in, and CPS took her into custody in the months prior to our meeting. The caseworker noted that the child did not speak and hypothesized that she may be intellectually disabled. They could not locate anyone who could see her and give a professional opinion on her treatment needs or placement recommendations.

She was reticent to interact with me. She followed my puppets back to the playroom, but she didn't immediately play with the toys. For the first few minutes, she moved around the room, examining all of the toys. When she finished visually exploring, she selected a doll family and a doll house and began to process her experiences. In that first session, she told me about her parents, being removed from them, hating it, going to a shelter, and feeling she had done something wrong. She had no idea what a shelter was. No one knew sign language, so no one could tell her what was happening.

It was clear from her use of signs that she was bright, had been educated in a school, and could take some direction from adults. She wore a dress, which she adjusted during the play to ensure modesty. When she got hungry, she asked for some pizza and told me a joke. She was thrilled to meet me, and I was honored to interact with her in play therapy for that one session. Unfortunately, CPS relocated her to a town that was too far for me to treat her in play therapy. Although I never saw her again, I hope my one-time interaction and recommendations helped.

Play therapy was a gift given to me like a small plant. I grew, nurtured, and used it as my tool to work with hundreds of children in the child welfare system. Without play therapy tools at my disposal, I am doubtful I would have reached many children, and I am certain I would not have reached the child described above. Play therapy has helped me reach Deaf children that others could not reach. Using ASL in play therapy has allowed me to construct a niche that has positively impacted my career and the lives of countless children with whom I have crossed paths!

ABOUT THE MEMBER

Gabriel I. Lomas, PhD, LPC, RPT-S is a professor in the department of Educational Psychology at Western Connecticut State University. He currently serves as the President of New York APT. Lomas is an avid scholar in the areas of child welfare, adverse childhood experiences, and psychological issues with Deaf people.
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POINT

Supporting Aggressive Play: Allowing Handcuffs in Session

CONSTANCE B. RATCLIFF, PHD, LMFT, LPC/MHSP-S, RPT-S

Aggressive play has been defined as an "adaptive strategy in the face of unmanageable experiences of fear and pain" (Dion, 2018, p. 1) and is considered developmentally appropriate for achieving emotional expression, regulation, understanding, mindfulness, trauma reenactment, balanced perspectives, coping skill acquisition, exploration of aggressive instincts and integration of painful life stressors/experiences/events (Smith, Ferguson, & Beaver, 2018). During aggressive play, children frequently choose play handcuffs, toy swords, weapons, shields, play guns, rubber knives, toy soldiers and aggressive puppets (Dion, 2018; Landreth, 2002; Smith, Ferguson, & Beaver, 2018).

When children request to utilize play handcuffs and/or to handcuff self or the therapist in session, the play therapist may be unsure how to proceed and/or may experience emotional flooding. Emotional flooding, characterized by avoidance, denial, or shutting down, is a normal part of being in a relationship. It can occur as the therapist observes and/or actively participates in a child's aggressive play and serves as an indicator that the play therapist is moving outside their own window of tolerance, which must be larger than the child's window of tolerance (Dion, 2018).

To decrease emotional flooding in session, therapists are cautioned to "create a neuroception of safety and help the child return into their window of tolerance" (Dion, 2018, p. 46) through therapist self-regulation. When a child seeks to handcuff the play therapist and/or engage in similar aggressive play themes, therapists can limit their own emotional flooding by remaining grounded, connected, highly attuned, genuine, self-aware of fear triggers, and can self-regulate their feelings, responses, and triggers by leaning into the discomfort, staying with and naming the feeling, calming the reactive amygdala, staying engaged, utilizing mindfulness, tracking through observational statements, acknowledging the child's frustration and/or emotional flooding, and setting boundaries and/or redirecting when the aggressive play moves outside the therapist's window of tolerance (Dion, 2018).

Instead of automatically responding to handcuff play with a "No" response, which can trigger child feelings of shame, guilt, and confusion, play therapists are cautioned to intentionally acknowledge the child's intense feelings and redirect by saying, "Show me another way," or conveying, "I don't need to hurt to understand" (Dion, 2018, p. 140). Additionally, when handcuff play poses safety concerns in the playroom, appropriate limits can be set by "acknowledging the child's feelings, wants, and wishes; communicating the limit, targeting acceptable alternatives, and when a limit is broken, stating a final choice" (Crenshaw & Mordock, 2005, p. 36; Landreth, 2012).

When a therapist perceives that an aggressive play situation was not handled optimally and/or notices therapist-child mis-attunement, they can employ relationship repairs to realign with the child, restore the rupture, reestablish trust, facilitate attachment, and increase the depth of emotional connection (Dion, 2018). Dion (2018) encouraged therapists to be congruent, authentic, and to facilitate child self-reflection and integration of emotional experiences, life stressors, and bodily sensations.

Aggressive/handcuff play is often utilized by children in the play therapy room to "project their inner world onto the toys and therapist, setting them up to experience their perception of what it feels like to be them" (Dion, 2018, p. 101). Therefore, play therapists who allow handcuffs in session and for children to handcuff them may gain greater understanding of the child and their therapeutic process.

THE **MIDDLE** GROUND

To Cuff or Not to Cuff… That is the Question

BRIJIN GARDNER, MSW, LSCSW, RPT-S

Play therapists have personal guidelines and therapeutic boundaries for their playroom. However, not all boundaries are hard and fast. Frequently, playroom decisions are based on children's presenting clinical and therapeutic needs and play therapists' capacity. There are certain children whose narrative may require specific props or symbols present for play; while other children are able to create what they need with the toys available. Working with complex clients requires flexibility and authenticity in the playroom. When setting boundaries, that means becoming clear on one's personal and professional windows of tolerance (Malchiodi, 2016, 2020; Siegel, 2010).

Therapists rely on clinical, personal, physical, and historical motives to make choices. Consultation or supervision can help the practitioner get clear on the reason behind their "no." Is it out of fear of being hurt or restrained? Are the cuffs too uncomfortable and dig into their skin? Is there a physical limitation that may inhibit abilities if cuffed? Is the client presently unpredictable or aggressive – and the therapist is pregnant or recovering from an injury?

Once a therapist is clear on the reason for their boundary, they can explore if the boundary is inhibiting the child's process or ability to delve deeper into their narrative, experience, or process. If being the handcuffed object in the play pushes the therapist outside their window

When Countertransference Handcuffs the Play Therapist

SARAH STAUFFER, PHD, LP, LPC, RPT-S

Attending to safety and security concerns provides a solid foundation for all human relationships, particularly therapeutic ones. For 25 years, Ausloos (1995) has argued that therapists must assure a personal equilibrium in session that allows their creativity and originality to be useful and beneficial to the therapeutic system. In fact, comfort for the therapist underlies comfort in the intervention (Ausloos, 1995; Mainguet, Mousnier, & Vanneste, 2011), and play therapy is no exception.

Based on research about toy guns in the playroom (e.g., Winburn, Dugger, & Main, 2017), Winburn (2018) argued that some children "need aggressive toys to fully express themselves and that therapeutic value outweighs therapists' personal beliefs or attitudes towards guns" (p. 16). But what happens when a potentially triggering event for the play therapist outweighs the potentially therapeutic value of using an aggressive toy, handcuffs for example?

Munns (2008) cautioned play therapists to be attentive to their reactions to children's play behaviors and any countertransference that may arise. The present author (2019) advised play therapists to examine any previously difficult or traumatic personal or professional experience that might give rise to negative countertransference in supervision or personal therapy. Protecting the therapeutic relationship by preserving the therapist's own sense of emotional safety may be a valid reason to exclude handcuffs in play therapy.

Several play therapists have recounted adverse experiences with toy handcuffs on the Association for Play Therapy general discussion board. Zelinger (2020) shared how a locking mechanism malfunction on her toy handcuffs during a play therapy encounter necessitated a locksmith's intervention and resulted in painful ligature marks on her hands. Gestal (2020) stopped offering toy handcuffs after a client's nanny had to seek help from a fire department to remove them from the child's wrists. Although both of these instances were stressful for the therapists, consider the impact they had on the children involved.

Beyond these situation-specific instances, having one's hands partially or fully bound may trigger the therapist and transport them out of the session and into their personal history with relationship violence. It might impact their capacity to offer encouraging responses, to recognize play themes, or to be fully present in session, all manifestations of traumatic stress within the play therapy relationship (Turner, 2019).

No clinician would debate the importance of providing a broad range of toys and creative outlets for children to express needs, fears, lived experiences, and concerns. An essential part of limit setting in play therapy is offering acceptable alternatives to the targeted behavior (Kottman & Meany-Walen, 2018; Landreth, 2012). To express a need for constraint or to convey helplessness in play therapy, children may use miniature handcuffs in the sand tray or other materials that could be manipulated easily or removed in an emergency, such as pipe cleaners, rubber bands, or hair ties on stuffed animals or puppets. These options allow play to continue unencumbered to promote abreaction, catharsis, or emotional regulation, and allow the play therapist to remain attuned with the child.

Clinicians may choose which toys, for very personal reasons, should be excluded from the play encounter. Once they have addressed potential countertransference issues related to the use of particular toys in supervision or personal therapy, they can decide not to let countertransference handcuff them.

of tolerance, they can brainstorm alternatives. For example, cuffing a large stuffed animal, using a soft fleece rope or scarf instead, or even substituting the metal/plastic handcuffs for a pair of stretchy plastic cuffs could bridge therapist capacity and child need.

Some therapists feel strongly about allowing children to handcuff them and believe this is important to the child's play and trauma narrative. Play therapists work with populations that experience community and interpersonal/family violence. Children witness family members being taken away in handcuffs, and some children have been handcuffed themselves.

Therapists that may feel comfortable being cuffed by one client, but not by another. This experience of intuitively feeling or knowing that a child needs to "go there" has happened to many of us. We cannot quite explain why "yes" to this child, but "no" to another. Perhaps it is the depth, intensity, or necessity of the child's play in that session; maybe it is the clinical understanding of the child's trauma narrative. Experience and personal awareness in the playroom allows therapists to stretch their own window of tolerance to accommodate the needs of the child, staying regulated and calm during intense or scary play.

The realities and experiences of the children we serve need to be honored and present in our playrooms; it is essential to provide culturally relevant toys and symbols that signify the world in which they live and help provide the toy "vocabulary" for their narrative. Regardless of the choice "to be or not to be" handcuffed, taking time self-reflect and be curious about our boundaries and reasons (for or against) having a certain prop or supply in the playroom is critical. As play therapists, we ultimately have a duty to find ways to be present and partner with the child in their play, honoring the windows of tolerance for both child and therapist, while respecting our clients' cultures and lives.

POINT, COUNTER POINT, THE **MIDDLE** GROUND

Handcuffed in session: Within the limits or out of bounds?

CLINICAL EDITOR'S COMMENTS:
This column features insights and differing perspectives on important play therapy issues. Contributors' views are their own.

Guest Editor: Lawrence Rubin, PhD, ABPP, LMHC, RPT-S

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It's Magic!

Using Magic as Metaphor in Play Therapy

| MARGO A. NAPOLETANO, PHD, RPT-S

"Children understand magic as a way to make things happen that ordinarily cannot happen. It can give children a sense of control and mastery in situations which seem hopeless and does so with delight and joy… magic restores hope" (Linden, 2003, p. 247). Even before the success of the *Harry Potter, Lord of the Rings,* and *Frozen* books and movies, magic had a unique and universal appeal across cultures for centuries and captured the interest of people of all ages. Magic is a powerful and playful metaphor for change, that can facilitate use of the play therapist's theories of choice.

Metaphor as a teaching method has been widely used for centuries with children and adults. It uses the child's natural language and can be understood by clients of all ages (Mills & Crowley, 2014). The play therapist's office is full of metaphoric tools in the stories, books, art, games, and toys. Magic materials and tricks are rich with hidden meaning and can metaphorically represent information not easily accessible to children.

Although the use of metaphor for teaching and magic dates back to earlier centuries, only a small amount of research exists on its therapeutic use. Several authors provided information on the therapeutic use of metaphors (e.g., Crenshaw & Green, 2009; Frey, 1993; Friedman, 2008; Mills & Crowley, 2014). Wiseman and Watt (2018) wrote a comprehensive review of magic-based interventions within healthcare and educational settings, citing studies that documented effectiveness for psychological and physical well-being, including the benefits of teaching magic tricks to children and adults. Other authors described the therapeutic use of magic with children (e.g., Gilroy, 1998, 2001; Hart & Walton, 2010; Schaefer & Cangelosi, 2016).

Therapeutic Benefits of Metaphor and Magic

Performing a magic trick enhances the transformative power of a metaphor. Metaphors and magic symbolically represent treatment issues and can be used to reach a variety of goals, such as establishing and maintaining rapport; bypassing resistance, because they are less threatening; increasing cognitive functioning (e.g., attention, memory,

problem-solving); facilitating emotional functioning (e.g., increasing self-esteem and motivation, decreasing anxiety and depression); bringing unconscious material into awareness; and reframing experience to view things from another perspective.

Magic provides multisensory modalities (i.e., visual, auditory, kinesthetic). These appeal to children who prefer action to talking and can accommodate children with special needs. In group settings, magic facilitates social interaction, group cohesion, and social skills development.

Magic-based interventions also may be used in combination with established, standardized techniques including testing for assessment of emotional and cognitive symptoms such as anxiety, depression, hyperactivity, and learning difficulties (Gilroy, 1998). Observing a child's reaction to a trick can provide meaningful information. For example, is the child scared, passive, or surprised? Does the child with poor impulse control demand to be told the secret to the trick? Finally, magic tricks may promote engagement in the therapeutic process. Revealing the secret to a trick helps build rapport and trust.

Magicians and Play Therapists: A Comparison

Magicians and play therapists are professionals skilled at quickly developing rapport and creating positive change. Based upon neuroscience research, both apply neurological principles to their work. Play therapy has the potential to create new neural pathways, influence mirror neurons and oxytocin, and increase interpersonal trust (Stewart, Field, & Echterling, 2016).

Magicians also take advantage of these neurological processes to direct others' attention. However, magicians are entertainers who use magic tricks to narrow or misdirect attention to amuse and mystify their audience. By contrast, play therapists, are committed to authenticity and transparency, and use theory-based therapeutic techniques to increase attention and expand awareness toward a transformative experience.

Magic Tricks

Many magic tricks are simple, easy to learn, available on YouTube, and use common, household materials. Before proceeding, play therapists should consider clients' culture, religion, age, cognitive level, and diagnosis, and use caution in light of contraindications. Magic should not be used in cases of psychosis, paranoia, or allergy to materials (i.e., latex). Due to the level of cognitive development needed to understand their functioning, magic tricks are not recommended for preschool children; and the teaching of tricks that involve reversals are not for children seven years or younger. When indicated, magic can promote learning and development. The decision to use magic as an intervention and the selection of a specific magic trick need to be guided by theoretical orientation which, in turn, guides therapeutic goals. For example, using a magic trick within the context of a non-directive approach to build rapport and trust may bypass the resistance and capture the attention of an impulsive, oppositional child.

CLINICAL EDITOR'S COMMENTS:

When embedded within play therapy theory, magic may provide bases for trust and moving past resistance.

Learning from failure when things go wrong with a trick can promote perseverance and problem-solving skills. Teaching a trick to a child who can later successfully demonstrate it to peers and adults promotes self-confidence and self-esteem. Magic can become a coping technique and a hobby. The following tricks combine magic and metaphor to promote play therapy objectives.

Disappearing Crayons

The therapist tells the child that they will make crayons in a crayon box disappear, then reappear. The therapist tells a story that describes the metaphor of feelings as colors. "If feelings were colors, what would yellow be?" The therapist points to the yellow crayon, accepts the child's response, and continues with more colors. Then, the therapist says, "Let's pretend all feelings disappeared" and makes the crayons disappear, explaining that "Without feelings, life would be boring and empty, like this empty box." By turning a crayon box of crayons backwards, then forwards, the crayons disappear, then reappear. The secret is that half of each crayon has been cut off and removed. By gently squeezing the box on the bottom or top, the therapist controls the movement of the crayons from top to bottom, making the crayons disappear, then reappear.

This prop (Youthlight, 2003) can be combined with the *Magic Coloring Book of Feelings* (http://www.youthlight.com/connect/magic-counseling/) for added effect. By flipping through the pages with the thumb at different positions on the outside edges, the pages seem to change dramatically from uncolored to colored, then to completely blank, then back to colored. This trick has application for anger management, grief and loss, and adjustment to change.

Magic Cauldron

Shapiro (1994) described how "...with a drop of my magic elixir and a pinch of my magic powder... I can turn it into a powerful potion to scare all the evil witches and bad monsters away" (p. 75). He explained how adding baking soda and a drop of blue food coloring to a glass half full of white vinegar makes bubbles and overflows. This trick is a metaphor for "things are not always what they seem" or for a volcano.

The therapist relates feelings to volcanoes, noting that when they are kept inside, they can build up and erupt like a volcano (e.g., Stern, 2002). Whitehouse and Pudney (1996) provided a volcano activity sheet. A volcano lamp inside a see-through water container can also enhance learning (https://www.adaptivetechsolutions.com/tower-volcano-lamp/). When a switch is pressed, red lava balls erupt through a volcano into red-lighted water, then back down outside the volcano. These activities also have applications for anger management, sensory issues, and relaxation.

Moving Straw

The therapist tells the child that they will move a straw without touching it (Osborne & Boyce, 2013). A cotton ball or feather will also work. They place a straw horizontally on a table in front of them. The therapist rubs their hands together and says, "I'll create a magnetic current with my mind." The therapist leans over the straw, moves a finger slowly in circles around the straw, then gradually stops, placing one finger over and in front of the straw. The therapist then moves the finger away from the straw while secretly and gently blowing on the straw, which will move by itself toward the therapist's finger, as though following it.

To divert attention away from the fact that the therapist is blowing on the straw, the therapist tells a story about using the power of their mind or brain. In a more directive approach, the therapist can explain that play therapy sessions can help to "make your brain stronger, so you can pay more attention, have better listening ears, use your words when you are mad [or some other relevant therapeutic goal]. You can be the boss of your brain." A small squeeze ball in the shape of a brain can be given to the child, or as an optional item in a prize box at the end of the session to reinforce learning.

Magnet Tricks

Some tricks available on YouTube use magnets to demonstrate how they attract or repel other magnets or objects. Stern (2002) described an activity using a magnet metaphor, explaining that a people magnet is someone who attracts people. Lists are made on how to pull people toward you (e.g., share toys) or to push people away (e.g., be bossy). The Wonderboard® *Make A Face* includes magnetized, interchangeable facial features on a playboard, which teaches children how feelings are revealed through facial expressions.

Changing Spots

The therapist holds a six-sided die between the thumb and index finger. With a secret twist of the fingers and rotating the hand back and forth, the die makes an extra turn, revealing a different side. This trick is a metaphor for changing feelings, especially when combined with *mood dice,* which have a different face on each of the six sides. A mood die can be strategically used while playing board games, such as alternating a throw of a standard, dotted die with a mood die. When a mood die is thrown, the therapist can say: "What feeling does that face show? Talk about a time you felt that."

Case Example

Alex (pseudonym) was a an upper-elementary school-aged boy with a history of disruptive behavior, including physical aggression toward siblings, vandalism, defiance toward adults, low impulse control, low self-esteem, and poor grades. The first session, he appeared angry, sat in a swivel chair, turned around to face the wall and said defiantly, "I'm not talking. You can't make me." I replied, "You don't have to… I don't force children to talk. I'll just practice a magic trick."

I took a 35-inch long piece of rope and tied a knot in it using only one hand. He slowly turned around and with widened eyes watched me. He said, "How did you do that? I can do that." He grabbed the rope, attempted to perform the trick, without success, and threw the rope down on the floor next to a magic wand. I picked up the wand (a transparent plastic tube filled with water and glitter that moved when shaken) and said, "Let's pretend this is a magic wishing wand. I'll make a deal with you. When you tell me three wishes, I'll show you how the trick is done. You can write them down on this doodle board or just tell me."

He quickly picked up the doodle board and wrote, "Not be here, no school, no brothers or sisters." I explained play therapy and that I was not a third parent, which seemed to ease his anxiety. Alex learned the trick after a few attempts, agreed not to tell anyone the secret to the trick (to preserve its uniqueness, his authority and self-esteem, and the professional Magician's Code), then he chose a small magic trick from the prize box at the end of the session.

In subsequent sessions, his skill with visual-spatial tasks – Legos and puzzles – became evident. I used an integrative approach, including more magic tricks and storytelling, often during our outdoor walking sessions. I told him the story of Matthias Buchinger. Despite being born without hands or legs and being only 29 inches tall, Matthias Buchinger became an expert magician, musician, bowler, and made ships inside bottles, a compelling metaphor for turning weakness into strength. Another helpful self-esteem-building story for children is *EllRay Jakes is magic,* by Susan Warner (2014).

Alex's grades improved and his disruptive behavior decreased. Occasionally, he showed me a trick he learned. Over the years, he became proficient at magic tricks, performed for community organizations, participated in summer magic camps, graduated from college, and began a successful career in the entertainment field.

Conclusion

Magic tricks are beneficial, developmentally appropriate, metaphoric tools for play therapy that promote lasting and meaningful change. It provides opportunities to problem solve, develop perseverance, and gain mastery over the mysterious. The multisensory aspects performing magic can help children channel their energy and concentration into a socially engaging interaction with others. Finally, play therapists can use tricks to help children change perspectives like the colors on their magic silk scarf.

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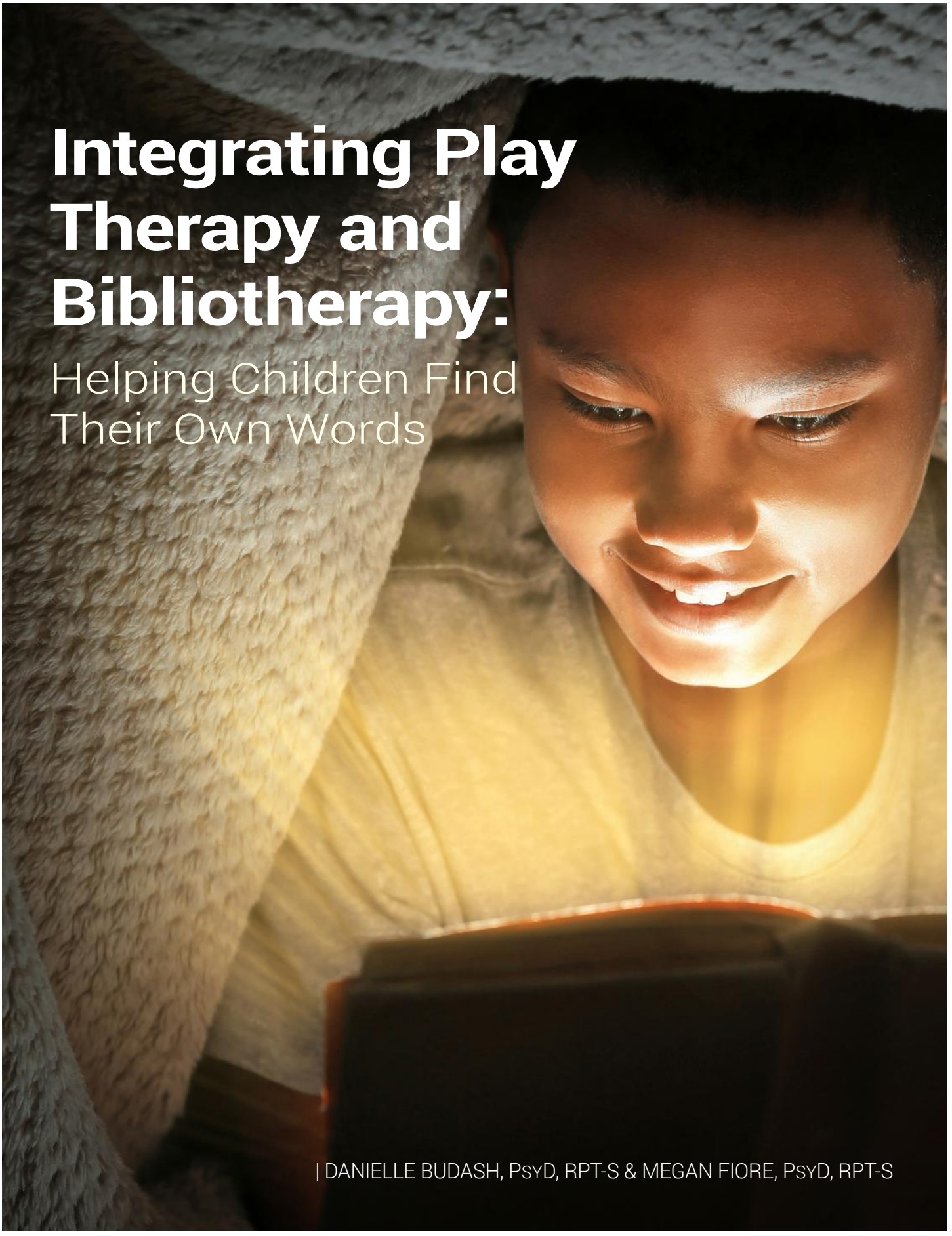

Integrating Play Therapy and Bibliotherapy:

Helping Children Find Their Own Words

| DANIELLE BUDASH, PsyD, RPT-S & MEGAN FIORE, PsyD, RPT-S

CLINICAL EDITOR'S COMMENTS:

Combining play therapy and bibliotherapy can bring powerful metaphors to life.

Take a moment and think about your favorite childhood book. Why is this book important or influential? Was it the setting, the situation, the storyline, or maybe the characters? Was it the act of reading or being read to? How did it impact you? Could you relate to the book in some meaningful way? Books are powerful agents with relatable characters and relevant stories that can have a profound impression on our lives. This is why books are appealing, and more importantly, therapeutic, as Ava (pseudonym) helps us understand through the following case example.

Ava, an adolescent female, is the oldest of several siblings being raised by her grandparents. She was referred for therapeutic services due to a history of abuse and neglect. Ava reported experiencing a repetitive nightmare nearly every night. Despite initially not disclosing the details of the nightmare, we tracked the occurrence of the nightmare while practicing coping strategies to help her become the director of the dream and manage the associated feelings. Ava eventually shared that the nightmare was related to a traumatic event in her life concerning the murder of family pets in which a parent involved her. Ava reported that she would wake up seeing the images fresh from the nightmare. She felt extreme guilt and sadness. The first author took a book off of the shelf, *Dog Heaven*, by Cynthia Rylant (1995), and asked Ava if it would be okay to read her a book. Ava cried as the book was read. After finishing the book, therapist and client side-by-side in silence, Ava said, "Thank you," as large tears rolled down her cheeks. Ava did not report having the nightmare again during her time in therapy. This was the moment the first author recognized the therapeutic power of a book and the significance of bibliotherapy.

The Healing Power of Books

Bibliotherapy is a therapeutic technique that uses the healing power of books to help children navigate, learn from, and cope with a variety of life circumstances and a range of social, emotional, behavioral, and developmental concerns. Bibliotherapy can be used as an approach to facilitate a corrective experience or to aid children with emotional and behavioral difficulties or disorders. The goal is to broaden and deepen the understanding of a child's particular concern or problem (Akinola, 2014) by relying on the analogy of the story to convey acceptance, meaning, or similarity.

Bibliotherapy can be used during different stages of the therapeutic process, including building rapport and a therapeutic alliance; assessment, intervention, and treatment; and termination. It provides the client with a degree of separation from the issue at hand that normalizes similar difficulties, encourages identification with the characters, offers coping skills and solutions to problems, and creates a sense of safety. Moreover, bibliotherapy can be utilized in individual, family, or group therapy and in a variety of therapeutic settings. In other words, it can be a universally effective treatment approach across a wide variety of client populations, settings, presenting problems, and throughout all stages of treatment.

There are four steps involved in bibliotherapy that contribute to the therapeutic process. The first three steps were developed from a psychodynamic premise (Shrodes, 1955) and include identification, catharsis, and insight. The goal in identification is to help the child identify with the information, storyline, and/or character(s) in the book. In step two, catharsis, the goal is for the child to become emotionally involved in the story and experience emotional release. Within the third step, insight, the client understands their own processes, and sees that they can experience positive change and growth based on the progress depicted in the story. Afolayan (1992) added universalization as a fourth step to this theoretical ladder, which occurs when the child realizes that they are not alone in their experience and can view their situation and future with a new lens of understanding and hope.

Combining Approaches

Bibliotherapy can be used in conjunction with play therapy to provide children with a nonthreatening and fun therapeutic experience. Hasty (2010) believed the combination of these two therapeutic processes to be the dynamic duo of effective treatment modalities. Integrating books into play therapy capitalizes on a child's language skills and social-emotional literacy to enhance the therapeutic process. Pehrsson (2006) considered the integration of bibliotherapy and play therapy a perfect companion set with the emphasis from bibliotherapy on reception and from play therapy on expression.

Tailoring the approach to the specific client or group makes bibliotherapy in the context of the play therapy relationship incredibly powerful. The combination of books and play adds value to the therapeutic process and aids in the progression of treatment by encouraging the expression of emotions, making meaning of life events, relationships and self, and, ultimately, fostering growth and healing.

Clinical Practice Examples

When working in a residential facility many years ago, the second author led a social skills group to a classroom of six 8-to-10-year-old children. These children loved to be read to, and the play therapist later discovered that the simple act of reading a story to a child was applicable to most children. It did not matter if the story was an imperfect fit for their age or their life circumstances; there was something in every book for each child to connect with and enjoy. One book shared was a personal favorite, *Ish,* by Peter H. Reynolds (2004). This book was about shifting the mindset and, not only accepting, but embracing imperfections, which was a powerful choice to share with this group of children. It allowed each child to see parts of themselves in the characters of the book and use those parts and similarities to draw their own conclusions about how to be kinder to themselves and to one another.

The play therapist asked the children to create *Ish* drawings, which involved: drawing a picture of their choosing with the freedom to make it "imperfect." Oohing and ahhing in prosody upon seeing others' works, each of them felt confident and excited to share their art in alignment with the book's message. They even adapted this *Ish* language in their play throughout the school year: using this suffix to further define feelings (e.g., mad-ish, sad-ish) and play expression (e.g., describing what family-ish means to them, playing something they named "Simon Says-ish"). This example illustrates that groups or families can experience the power of bibliotherapy through participating in play therapy exercises directly tied to the message of the chosen book.

Bibliotherapy also can help a child feel empowered to tell their own story. In the past, the present authors have worked with children who read several therapeutic books to gain insight into how book authors tell the story of the characters. These play therapists then used that information as a starting point to help children create their own story, including trauma narratives to address loss, abuse, neglect, or family transitions. It can also help a child progress to a place of feeling hope and resiliency in their own experiences.

One clinical example of this involved the second author's work with a nine-year-old boy who was coping with the sudden loss of his father. We discussed how trauma narratives can be helpful in processing grief and loss. That child felt stuck about how to get started and used bibliotherapy as a starting point. The play therapist and child read every book that was available related to grief, loss, death, and dying, and the child created a ranking system to notate what he enjoyed and disliked about each book. The child's highest-ranking book was *The Fall of Freddie the Leaf: A Story of Life for All Ages,* by Leo Buscaglia (1982). Inspired by this book, the child created his own trauma narrative.

Another client, a six-year-old girl, could not find a book about a rare genetic disease that fully captured her own symptoms and experience of the illness. That child's favorite book is entitled *It's Okay to be Different,* by Todd Parr (2009). She seemed drawn to it because of the simple, playful messaging about how people can be unique in a myriad of ways. Play therapy sessions were used to create a personalized book about her illness that incorporated her drawings, sandtrays, pictures of puppet shows, and a staged playhouse scene. According to the child, her book depicted a true account of her personal experiences with this illness. With both of these clients, bibliotherapy served as a starting point to help them process their own life experiences.

Selecting Bibliotherapy Material

Like toys in the playroom, books used in bibliotherapy should also be carefully selected, and not just collected. The best title with which to start your booming bibliotherapy bookshelf may be the one that was your own childhood favorite. From there, best practice would be to continue finding and selecting high-quality, well-written stories that would add value to the bibliotherapy collection. The present authors' shelves are stocked with personal favorites and they continue to build with titles that fit their client populations. The authors' collections have grown over the years, giving them a curated selection to fit most presenting problems and developmental stages. When building a catalogue of books, it is important to have titles that would be helpful to specific diagnostic categories and a range of topics, such as feelings identification, self-image, family issues, abuse/maltreatment, social issues, empathy, diversity/acceptance, and trauma. As evidenced in the above case examples, selected books were integrated with play therapy techniques (e.g., creative arts, sandtray, games, fantasy/puppet play, role-playing, and relaxation/mindfulness activities). By doing so, the authors combined knowledge and experience of the benefits of bibliotherapy with their deep belief in the healing power of play.

In play therapy, it is believed that "play is a child's language and toys are a child's words" (Landreth, 2012, p. 16). Although words may come from toys in the playroom, they also may be found in the pages of a book. When integrating bibliotherapy and play therapy, the authors believe that play is a child's language and books can help children find their own words.

Top 5 Favorite Books

Danielle:
Thotso by Rachel Robb Avery
Moody Cow Meditates by Kerry Lee MacLean
Have You Filled a Bucket Today? by Carol McCloud
Frederick by Leo Lionni
Kona and His Hard Shell by Crissy Miyake

Megan:
Ish by Peter H. Reynolds
The OK Book by Amy Krouse Rosenthal
Invisible String by Patrice Karst
Sometimes I'm Bombaloo by Rachel Vail
Double Dip Feelings by Barbara S. Cain

Clinical Editor (added with permission from the authors):
Beautiful Oops by Barney Saltzberg
Brave as Can Be: A Book of Courage by Jo Wittek
I'm Gonna' Like Me: Letting Off a Little Self-Esteem by Jamie Lee Curtis
Tear Soup by Pat Schweibert and Chuck DeKlyen
You've Got Dragons by Kathryn Cave and Nick Maland

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- CALENDAR -

MAR. 15	Awards of Excellence Nominations Due
MAR. 31	Board of Director Candidate Questionnaires Due
MAY. 5	Registration opens for 2020 Annual Conference
MAY 5 - JUN. 25	Poster proposal accepted for 2020 Annual Conference
JUN. 20	Conference volunteer applications due
OCT. 6-11	37TH ANNUAL ASSOCIATION FOR PLAY THERAPY INTERNATIONAL CONFERENCE

APT Mailing Changes & Your Member Profile Settings

Effective March 1, 2020, APT correspondence will be mailed to the address selected as the "Preferred Contact" in your APT Member Profile. This will help ensure delivery of all APT publications and mail. Your "Preferred Contact" address will ALSO appear as your contact information on APT's Find a Play Therapist Directory. To change your "Preferred Contact" address (and manage your privacy settings), log in to the APT website (www.a4pt.org), click the Manage Profile link at the top of the home page, then click Edit Bio. Contact APT for assistance at info@a4pt.org or call (559) 298-3400.

Staff Update

As APT membership continues to grow, so does the APT Staff! Meet **Jaqueline Rosales** and **Michelle Horwege**, the newest members to join the team.

Jaqueline Rosales

Jaqueline graduated from Universidad De La Salle Bajio, Mexico, with a BA in Modern Languages and Intercultural Relations. She is a part-time tutor with a passion for teaching English and Spanish as foreign languages. She moved to Fresno aspiring to enter Fresno State's Multilingual & Multicultural Education Master's Program. Her goal is to teach linguistically and culturally diverse students in demographically changing schools. As the new Coordinator of Education & Training, you'll find Jaqueline reviewing Approved Provider and Approved Center applications as well as adding to APT's E-Learning Center library.

Michelle Horwege

Michelle graduated from Cal State Monterey Bay with a BS in Kinesiology, concentrating in Health and Wellness. She earned her MS in Healthcare Administration from Cal State East Bay. Her experience varies from working in a call center for residential mental health treatment centers, to provider recruitment and credentialing at an employee assistance program, to being the clinical services administrator for a large organization of health care centers. Michelle recently relocated to Fresno from the Bay Area with her husband, 4-year-old daughter, and 6-month-old son. As the newest Coordinator of Credentialing Services she will be assisting the Credentialing Department with applications and much more!

After years of service, APT said goodbye to Continuing Education & Credentialing Administrator, **Alex Jarrell**, and Coordinator, Credentialing Services, **Megan Dawes.** Both were an integral part of the APT staff family and will be greatly missed. Although we were sad to see them go, we are thrilled that they will continue their professional journeys, Alex with her alma mater, Fresno State, and Megan as a clinical counselor.

Member Survey Results

The results are in! The Annual Membership Survey provides APT the opportunity to gather valuable member feedback to keep improving resources, programs, and benefits. With the addition of APT's Instagram page in 2019 and the ever-growing presence of technology, this year's survey focused on our social media platforms (Facebook, Twitter, & Instagram). Survey questions assessed member satisfaction on current content/posts, engagement with platforms, and the type of content they would want to see. Here are some of the results:

Members indicated they were actively engaged in:

- **Facebook: 73.12%**
- **Instagram: 41.94%**
- **Twitter: 9.68%**

Members indicated they would like to see APT post more about:

- **Research on play therapy and child related topics**
- **Conferences and opportunities for play therapy training**
- **Member accomplishments and recognition**
- **News from state branches**
- **Volunteer opportunities**

Thank you to everyone who participated! APT appreciates your feedback and continued support.

Welcome Approved Centers

Center Director Lucinda T. Grapenthin, PhD, NCSP, RPT-S, Brenau University Play Therapy Training Institute

Richmont Center for Play Therapy

Congratulations to APT's two newest Approved Centers, **Brenau University Play Therapy Training Institute** and **Richmont Center for Play Therapy!** With 40 Approved Centers, APT remains committed to supporting the inclusion in graduate mental health programs. APT Approved Centers provide play therapy graduate courses and supervised experiences, research and publications, playroom(s), continuing education workshops, and/or certificate programs.

2019 Growth Summary

	2013	2014	2015	2016	2017	2018	**2019**
Members	5,869	6,076	6,166	6,259	6,550	6,815	**7,518**
RPT/S & SB-RPT's	2,362	2,543	2,868	3,089	3,411	3,553	**4,381**
Approved Providers	239	264	284	307	326	349	**345**
Approved Centers	21	23	29	29	32	30	**31**
Facebook Followers	5,581	8,398	11,225	15,240	18,148	20,880	**23,526**
E-Learning Center Credit Hours	524	535	637	690	749	862	**994.5**

Congratulations New RPT, RPT-S & SB-RPTs!

Congratulations Registrants! Join us in celebrating the following licensed professionals in their attainment of our Registered Play Therapist (RPT), Registered Play Therapist-Supervisor (RPT-S), and School Based-Registered Play Therapist (SB-RPT) credentials during the months of November through January!

NEW REGISTERED PLAY THERAPISTS

Roberta Abdo, MA, LPC, El Paso, TX
Sh'Niqua Alford, MSW, LCSW, Arlington, TX
Nicole Allen, MS, LPC, Flower Mound, TX
Elizabeth Andersen, MS, LPC, Nashville, TN
Chrissy Anderson, MEd, LPC, Round Rock, TX
Heidi Anderson, MSW, LCSW, Shalimar, FL
Renee Arcement, MSW, LICSW, Poulsbo, WA
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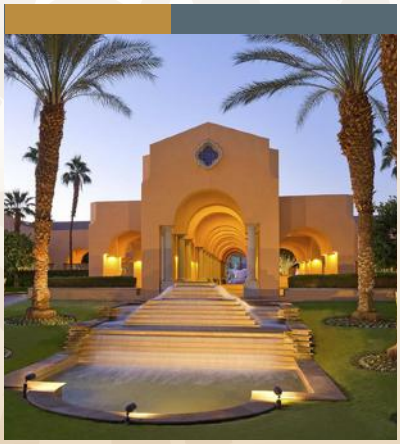

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