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President's Letter

As I write my final letter I am aware of how honored I am to have had to opportunity to serve as your president for the past four years. It has been my tremendous privilege to have had the opportunity to work with a fantastic board, phenomenally dedicated committee members and exceptionally talented presenters and play therapists. Thank you all for your passion and dedication!

Annual Conference:
The 13th Annual NYAPT conference is fast approaching! This year's conference will be March 9-10, 2012 at the Poughkeepsie Grand Hotel in Poughkeepsie, NY. This year's conference will feature Paris Goodyear-Brown's two day presentation entitled ***Helping the Wild Child: Creative Play Therapy Interventions for Problems of Dysregulation***. A copy of the brochure is available on the NYAPT website at: http://www.newyorkapt.info/wp-content/uploads/2012/01/2012-NYAPT-Conference.pdf
Don't miss this excellent training opportunity. We hope to see you there!

Conference Scholarships:
We are pleased to announce that NYAPT was again able to provide two student scholarships and two professional member scholarships this year. These scholarships have been awarded and will cover or reimburse the cost of registration for two students and two members. Congratulations to the recipients!

Conference Raffle:
We would like to continue to offer (and potentially expand) scholarship opportunities. This year we will again be raffling off various themed baskets towards this goal. Tickets will be available at the registration desk. Please join us!

Election:
It is hard to believe how quickly this year has gone by! It is election time once again. This year's ballot is enclosed in this newsletter. Please take a moment and vote. We want this election to be reflective of your wishes!

Newsletter:
As I previously noted, Chris Foreacre and David Crenshaw have worked very hard for many years to put this newsletter together. The May 2012 edition of this newsletter will be the final edition that Chris and David will co-edit. Their efforts and dedication are very much appreciated!! In order to facilitate as smooth a transition process as possible we would like to begin to coordinate this transition. If you are interested in assisting please contact me at maassini2000@yahoo.com. Thank you in advance!

Student Representative:
NYAPT is in need of a Student Representative. This is an honorary position on the NYAPT board. The responsibilities of the Student Representative include taking an active part in encouraging affiliate members to become full or professional members. The Student Representative's function is to attend board meetings in order to understand the workings of the NYAPT board (in order to eventually take on a more active role within the organization).

We are looking for someone who is motivated and creative; someone who can envision and put into action ways to reach out to students and mobilize their involvement. Interested student members can contact me at maassini2000@yahoo.com for more information.

Hope to see you in Poughkeepsie!

Again, thank you for four wonderful years! Hope to see you in Poughkeepsie!
Mary Anne

New NYAPT Members

Congratulations to the following people who became members of NYAPT in the last three months (November 2011- January 2012): David Becera, Kathryn Clark, Sarah Devorah Goldman, Stephanie Grover, Renee Jungreis, Barbara Landau, Nicole Metazas-Monogiousis, Natalie Selim, Christine Walawander, Katherine White. Welcome!

News of Members

Lois Carey has recently announced her retirement due to her and her husband's current health issues.

Laurie Zelinger is happy to announce the release of her latest book published by ***American Girl***. It is about self-esteem: **A Smart Girl's Guide to Liking Herself- even on the bad days**
the secrets to trusting yourself, being your best & never letting the bad days bring you down
In addition, Laurie has given interviews in the past three months to Parents Magazine, The National (Dubai), Healthy Way, Red Book, Newsday, Tech News Daily and Dr. Oz' website.

ACAIT Professional Insurance

Professional malpractice insurance is available at very competitive rates to APT member psychologists, counselors, therapists and social workers via the ACA Insurance Trust program. Inquiries should be directed to: Paul Nelson, 800-347-6647 x 342 or pnelson.acait@counseling.org.

Grist for the Mill of the Play Therapist

David A. Crenshaw, Ph.D., ABPP, RPT-S

I am going to devote my column this issue to honor one of my most dear, respected, and valued long-time colleagues Lois Carey who recently announced her retirement due to health reasons. Not only has Lois made monumental contributions to NYAPT from its inception but she is internationally acclaimed as a Jungian sand tray therapist as well as play therapist. When Athena Drewes founded NYAPT 16

years ago, Lois was one of the people who served on the original Board of Directors and became after Athena our second President, capably serving for 4 years and providing strong leadership during the terror event that redefined many of our lives on 9/11. Lois has always been willing to help out in any way possible over the years. I well remember her willingness to volunteer her time as she and I took a cab several years ago from Grand Central to E. 16th Street in Manhattan to do a free regional training for NYAPT. When she took over as President, she sent out a call for Newsletter editors and Chris Foreacre and I decided to take it on some 12 years ago out of respect for this gracious and wonderful lady. Through all these years she never fails to tell us what she likes about each issue, and that support has kept us going through thick and thin. In her beautiful and touching memoir, *A Salty Lake of Tears: A Soul Journey*, Lois states on page 42, "My struggles have been intense, but now in my later years, I realize how important they were to my eventual development and how these very struggles helped form me into the person and therapist I am today." I would add a person and therapist that many of us cherish, admire, and love. Lois you will always occupy a special place in the hearts of all of us who were privileged to learn from you and continue to be inspired by your heartfelt dedication and love of helping countless children.

Inexpensive Play Therapy Techniques

Edited by Jillian Kelly, LMSW, Institute for Family Health

Mental health clinicians at the Institute for Family Health in New York City have compiled some of their favorite youth-friendly interventions to share with members of NYAPT. These interventions are inexpensive, can be implemented within a 30 minute therapy session, and rated as 5 star interventions by the youth we work with!

Intervention: Therapeutic Jenga/Jumbling Towers
Age Range: 5+
Materials Needed: Jenga/Jumbling Towers/even sized rectangular blocks
How To: I have the patient (and any family) build up the tower (3 blocks in a square, with each layer alternating directions). Players take turns removing a block carefully from the tower and putting it on the top of the tower. Block removed cannot be from top 3 rows of tower. When tower falls over, everyone yells "Jenga". Goal is to keep tower standing. For the therapeutic component, every round, a different question is posed to patient/family members. Sample questions can relate to patient's self-identifications (non-intrusive questions such as favorite activity, school subject, etc.), to family relationships (something you like about your family and something you wish you could change), to triggers, affect, behavior, and cognitions (name a time when someone would feel X, what is something that makes you feel X, how do you respond when feeling X, what do you wish you did differently when feeling X), to coping skills (name something that helps you feel better when feeling X, name things you can do to relax), to desires (if you had 3 wishes, what would you wish for), etc. At times I will share opportunity to ask questions to patient and family, allowing learning about what patient and family are curious about from each other, assessing interpersonal communication patterns, etc.
Clinician: Amy Greenberg, LMSW

Intervention: What do I feel?
Age Range: 10-17
Materials Needed: Paper, markers/colored pencils/crayons
How To: Pick an event to focus on (one's I've used it for include a child whose parents were divorcing, and a child felt very guilty about being hit by father). Ask the child to list all the different emotions that they feel about the event, write them on the side of a piece of paper and have the child assign a color to each feeling. Ask child to draw an outline of themselves/a person on a sheet of paper. Then ask the child to choose the emotion they feel most strongly and color in the amount of themselves that feels that emotion. Then go through the other emotions doing the same thing. Process the coloring/choices afterwards. Depending on the stage of treatment and the amount of thought/feeling work that we've done, I sometimes ask the child to write the thoughts that go with each feeling around the picture. At the end I usually ask the child what they would like to title the picture and if they want to take it home.
Clinician: Sarah Pole, LMSW

Intervention: Trouble with … (insert problem like “Managing Anger”, etc.)
Age Range: 5+ (I have even used with adults)
Materials Needed: Trouble the pop-o-matic bubble game, 2 blank Post-its

How To: The game is played as instructed with the exception of when certain numbers are popped. Choose a problem the patient is working on such as anger management, or building self esteem. Then ask the patient to choose 1 or 2 numbers from 1- 5. Then write each number on a Post-it (usually doing no more than 2 numbers). Under the each of the Post-its write something the child should say or do related to the problem chosen. For example if the patient chose #2 and then on the #2 Post-it it says that the patient should name at least 1 trigger to the patient’s anger, then every time the patient pops a 2, in addition to moving the patient’s game piece, they have to also name a trigger to their anger. Depending on the time of the session the clinician also plays by those rules to model for the patient as well. You can come up with many types of Post-its for any number of problems – some common ones I have used are:
Name a negative consequence of your anger
Rephrase something negative you have said about yourself
Name a trigger to your anger
Name something positive about your personality
Name one way people know you are focusing
Give an example of a time in which I could have handled my anger better
Discuss a negative emotion you had recently and explain what triggered it
Named p positive ways you can control your behavior
Say something positive about your actions
Clinician: Laura Leone, LMSW

Intervention: My Safety Poster
Age Range: 5+
Materials Needed: I suggest larger paper, but even computer paper will work.
How To: The purpose of this activity is to use art and writing to create a poster which highlights a client's protective factors. It can be used in addition to or to enhance a safety plan. And you can work on it over several sessions. Be sure to explain the purpose each time and feel free to modify the items as needed. Fold a piece of paper in half once, then again, so there are four squares when you open the paper back up. Each square is used for a different item. Each square should list the title to identify what is described in that square. The client can draw or write, but s/he should be encouraged to put effort and care into either. As the clinician, provide assistance as necessary. When finished, encourage the client to share the poster in a collateral session and to hang the poster somewhere s/he and other family members can see it.

My Supports
all the people who support me
people I can trust
people I can turn to for help

My Strengths
things I am good at - my talents, abilities
things people like about me/I like about myself
qualities that

My Coping Skills
Things, activities I do to feel better
Ways that I calm down
What I can do to stay safe

Positive Thoughts and Statements
Words I can say to myself to stay focused
Reminders I need when I am feeling upset
Images I can visualize to calm me
Clinician: Michelle Kohut, LCSW

Intervention: Poetry
Age Range: 13-18

Materials Needed: Computer paper
How To: I write a title of a poem (about something I know that applied to the youth, something they're struggling with) and ask them to fill the rest of the paper with a poem applicable to that title. I explain that poems do not have to rhyme, and can be thoughts/feelings/sentences/lists/experiences/memories. If the patient would like, they can also write a title for me and I will write a poem as well (also catered to the patient's treatment).
Clinician: Marissa Block, LMSW

Intervention: Psychoeducation/Empowerment within Medication Management
Age Range: 13-18
Materials Needed: Workbook: http://www.kpchr.org/research/public/acwd/acwd.html
How to: Use the STEADY teen workbook for teens on an SSRI. It is also a good workbook for CBT materials.
Clinician: Talia Halperin, LMSW

Intervention: The Squiggle Story
Age Range: 5-10
Materials Needed: Paper ("Draw and Write" paper by Crayola is best), markers/colored pencils/crayons
How to: Ask the child draw a squiggle on a piece of paper. Then the clinician adds to that squiggle. Continue to take turns until the child decides the picture is complete. Ask the child to talk as much or as little about the picture. When the child is finished describing what the picture symbolizes to him/her, take turns writing a sentence about the picture until it develops into a story (the clinician can be either directive or non-directive with giving this a coherent theme throughout). This picture and story can be added to throughout multiple sessions, and the child can also choose to invite caretakers to partake. This has helped strengthen the therapeutic alliance, promote creativity, enhance self-efficacy, and unfold some of the stories the child carries with him/her. This can also be extended as a metaphor (for higher functioning children) by showing the child how seemingly meaningless/"lonely" (as one child described to me) squiggles on a page can take on vibrant personas and join other squiggles to create something masterful.
Clinician: Jillian Kelly, LMSW

School-based Clinics vs Community Clinics: Key Contrasts in Mental Health Treatment for Youth

by Michelle Kohut, LCSW, Institute for Family Health

Introduction

After four years supervising an Article 31 (Behavioral Health) school-based clinic serving middle school youth in Washington Heights, I became the Program Director of an Article 31 community clinic in the Bronx serving both youth and adults. Both types of clinics are important resources for youth and families and each has unique strengths in the provisions of services. These experiences afforded me the opportunity to compare and contrast school-based and free-standing community clinics. The purpose of this article is to highlight key contrasts and strengths observed in the areas of attendance, presenting problem/diagnosis, referral source and process, collateral involvement, modality for treatment and collaboration between school and clinic. By understanding more about the dynamics of both settings, treatment providers can utilize the strengths and minimize the barriers of each.

Definitions

A school-based clinic is housed within the walls of a school and may or not be connected to a health clinic. Its location within the school community allows for clinic services to be integrated into the fabric of a child's daily school life. A school-based clinic is viewed as a part of the school itself and not a separate entity. It is an important resource for not only students, but also for teachers and administrators. Providers of services have direct relationships with school personnel and can observe children in the context of their peer group and daily school life. To a child, a school-based clinic is where "counseling" happens and there may be almost no differentiation by the child between a "school counselor" and a mental health provider.

A community clinic is located in the community and may or may not specialize in the mental health treatment of youth. Community clinics are set up like "the doctor's office" and may be viewed by both children and their parents as "more formal". Community clinics provide services to a diverse group of individuals who may or may not live in the same community. To a child, attending treatment at the community clinic is "going to therapy" and requires a time commitment by the family not required in the school-based clinic.

Key Contrasts

Attendance
In a school-based clinic, youth may show higher rates of attendance at treatment sessions. Treatment attendance is most impacted by attendance at school. In other words, if a child is in school, s/he will attend treatment that day. If a student is absent on Wednesday, the clinician can re-schedule the session that week for Thursday or Friday and it may only require that the clinician seek out the student during lunch or another non-academic period for the "make-up" session. As such, truant youth are not generally well-served by school-based clinics as they are not in school to access the services. Show rates in a community clinic are much lower and clinicians must book themselves at a rate almost double than school-based clinicians in order to meet productivity requirements. Non-attendance at a community clinic is often related to a barrier the parent is experiencing, as generally youth attend sessions accompanied by their parent. Thus, in a school-based clinic, youth are not as frequently impacted by the parent's barriers or limitations.

Ability to Serve Multiple Family Members
In a community clinic that serves children and adults, all members of a family may receive treatment if necessary. Thus, if it is recommended during the course of a child's treatment that the parent also engage in his/her own treatment, there are fewer barriers for the parent in receiving those services. In a community clinic, child and parent can both attend sessions at the same time and their treatment providers can collaborate directly and easily. In contrast, a school-based clinic provides treatment to students of the school only, and not to their siblings (unless they also go to the school) or to their parents, aside from collateral participation in their child's treatment.

Perception of Services and Stigma
In a school-based clinic, mental health services may be less stigmatized. Because the services are part of the school and occur during the school day, they become normalized. Even students that do not receive treatment get a sense of "what goes on in there?" At the elementary, middle and high school levels, when students with high social status receive services at the clinic, other students are curious and want to participate as well. Commonly, the school-based clinician is asked by the classmates of her/his clients, "when are you going to come pick *me* up?" and becomes an expert at polite refusals or re-directions.

At the same time, there are always students who feel more stigmatized when receiving services at school, as members their peer group may be aware of treatment being utilized/provided. When a student is "picked-up" for treatment by a clinician, it is virtually impossible to maintain complete confidentiality. While the content of the treatment may be confidential, the fact that a student is receiving treatment is not. Thus, some youth are better served in a community clinic and may show higher rates of attendance and engagement when their treatment is "off-site" from the school.

Lastly, treatment in a community clinic may be viewed as "more formal" or "more serious" as it is not provided in the "known" environment of school. Parents and youth may take more seriously a referral to a community clinic as it requires an "appointment" and is perceived more like "going to the doctor" as opposed to "going to the counselor". This dynamic may serve an important benefit to families as it may allow for "the problem" and "the treatment" to be defined and differentiated more effectively. Additionally, the community clinic may serve as an "oasis" for youth whose experience of school is highly negative. Furthermore, clinicians who are not part of the school community may have more influence as "outsiders" when advocating on behalf of students, and can be more effective in holding the school accountable for providing an appropriate education to youth with mental illness. School-based clinicians must maintain positive relationships with school administrators which

can make it more difficult for them to “make waves” and push for change. Clinicians from community clinics do not have to worry about this “loyalty conflict” and can put pressure on school personnel without repercussions.

Presenting Problem/Diagnosis

To qualify for Article 31 services, young people must meet criteria for an Axis I diagnosis. Thus, while youth in both school-based and community clinic settings carry Axis I diagnoses, there is an observable difference between the severities of symptoms between the two groups. In a community clinic, youth are often referred from psychiatric in-patient programs, juvenile justice programs and child welfare agencies. They are typically “in crisis” at the time of referral and the referral itself is generally “a last resort“. With the presence of a school-based clinic, there is more opportunity to intervene with youth in the early stages of difficulty and provide services in a preventative manner to avoid crisis. In addition, each school community has its own dynamics that contribute to the health or illness of its youth. As such, in a school-based clinic, services can be designed using the strengths of the setting and to meet specific, unique needs of the student population. For example, school communities with a high proportion of immigrant youth can provide services that assist their students in making the adjustment to a new culture, a new home, a new school and a new life so that they do not develop symptoms of an adjustment disorder.

Many school-based clinics operate with an Article 28 (medical clinic) license. In these clinics, treatment is viewed as “short-term”. Typically, students with serious mental health diagnoses and high risk cases are recommended for referral to Article 31 services so that longer-term treatment integrated with psychiatric services can be provided.

The Referral Source

One sharp contrast between school-based and community clinics is the area of referral source. In a community clinic, one almost never sees a child who is “self-referred” for treatment. Rather, youth are often referred from psychiatric in-patient programs, juvenile justice programs and child welfare agencies. In school-based clinics, especially at the middle and high school levels, self-referrals are significantly higher due to the direct visibility of treatment providers, the positive experiences that students report to their classmates about receiving services and the tendency for school-based services to be less stigmatized. In addition, it is not uncommon for students to refer or recommend one another for services. These “referrals” may sound something like this, “My friend wants to come too. She’s got a lot of problems and needs counseling.” In these instances, students provide the bridge for their classmates to engage in services.

The difference in self-referral rates plays out most directly in the level of engagement and the amount of ownership and responsibility a young person has toward her/his treatment. Most obviously, when a child is “mandated” for treatment by the school or by the family, s/he will likely be more resistant to treatment than her/his peer that is self-referred. Of course, within schools, many children are still “mandated” for treatment. In these cases, because clinicians are on-site, there are a number of ways to outreach to and engage students in treatment that is not possible in a community clinic. For example, the clinician can meet the child directly with or without the involvement of the parent. The clinician can meet the referred student in any part of the school-building or at any time of the school day (with administrative approval) to provide outreach directly. In a community clinic, a parent must be present at the time of intake and typically at each session, at the very least to bring the child to the appointment.

The Referral Process

In a school-based clinic, the referral process can be formal or informal. It can occur in planned way or in a crisis. Formal referrals follow the standard “fill out a form” procedure whereas informal referrals may happen through collaboration between clinician and school staff in a less standard but no less frequent “I’d really like for you to meet this student, could you come by today at lunch?” Referrals can be generated in a planned way, for example, by the school-based support team following a review of a child’s IEP, or in contrast, in a moment of crisis in which a clinician must provide crisis-intervention service which then generates an automatic referral for treatment.

Collateral Involvement
One noted difference in collateral involvement is in the area of parent participation. In a school-based clinic, services are provided between the hours of 8 a.m. and 4 p.m. which limits the involvement of working parents. In contrast, at a community clinic, young people attend sessions in the evenings or on weekends, so as not to interfere with the school day. A parent is typically required to transport the child to sessions (except for in the case of some teen-agers) which allows the clinician to almost always have direct access to the parent during session time. Thus, family sessions happen more regularly and parent participation in treatment planning is typically more direct and frequent.

In a community clinic, the involvement of school collaterals can be quite challenging. Clinicians must reach out to teachers and school personnel at school, when and where they are rarely available to answer phone calls. When teachers are done with their work day, the school is generally no longer accepting phone calls. If and when teachers do return calls, it generally occurs in the evenings when clinicians are busy seeing patients. In the end, collateral involvement with teachers typically follows a long game of phone tag which begins again following each contact.

In a community clinic, all communication with non-family collaterals is preceded by the completion of HIPAA release forms. In a school-based clinic, while the clinician still needs a HIPAA release to share information about the child's treatment, information flowing from school personnel to the clinician is on-going and can be obtained immediately and directly. One example may be a teacher in the faculty lounge who states publicly to a clinician "you really gotta talk to him today; his behavior is "off-the-hook!"

Modalities
In a school-based clinic, there are modalities that can be utilized that are not very possible in the community clinic. For example, "conflict resolution" between students is a primary intervention of a school-based clinician. In a community clinic, clinicians do not have access to a client's classmates who may be primary influences in a child's wellness or difficulties. The collateral involvement of peers for young people in middle school and high school can be a primary intervention for a variety of mental health presentations for youth, as this age group tends to prioritize peer relationships. Peer collateral involvement is possible in a community clinic, but a lot less likely, as it would require special arrangements for the client's peer collateral to attend a session.

Group treatment in schools is especially effective and easy to facilitate during the school day. In addition, group members are peers and can utilize knowledge and practice skills directly with one another in and out of session time. Lastly, a variety of other interventions and modalities are more likely in a school community such as parent workshops, student workshops, teacher trainings, participation on school-based intervention teams, classroom observations, clinical consultations prior to referral, and school assemblies and "campaigns" to raise awareness and educate students and faculty. In general, school-based clinics are able to de-stigmatize mental services more effectively by integrating mental health services into the school day and through the vehicle of "education".

Level of "access" to a child's life
In a community clinic, the clinician most frequently observes and interacts with a child/adolescent client for a total of 30 - 60 minutes per week within the context of an individual or family therapy session. There is little to no direct "access" to the child's social or vocational context. In a community clinic, clinicians can assess and explore these areas of a child's life but must rely on the perspective of the client and collaterals providing the information to formulate appropriate treatment needs and goals. Thus, in a school-based clinic, treatment may be more effective in addressing the needs of "the whole child" as the clinician can make direct observations at any point during the school day, such as during academic classes, during lunch/recess, during transitions, during testing, etc.

Continuity of Treatment

In a school-based clinic, treatment is viewed as coinciding with the school year. As a result, participation in treatment during school vacations and summertime plummets. In a community clinic, treatment occurs year-round with fewer gaps in continuity.

Table 1: Strengths of Clinic Settings

School Based Clinic	Community Clinic
1. Higher attendance rates	**1. Capacity to treat more serious diagnoses, presenting problem**
2. Increased collaboration with school personnel	**2. Increased collaboration with parents**
3. Ability to reduce stigma associated with treatment	**3. Services viewed as more "formal"**
4. More self-referrals, more peer referrals	**4. Different level of confidentiality**
5. Capacity to provide "preventative" services	**5. Ability to provide treatment to all members of a family**
6. Ability to view the child in their social and vocational context	**6. Continuity of treatment throughout year**
7. Use of additional modalities not possible in community clinic	**7. Clinicians may have more influence as "outsiders" and may be more effective in holding the school accountable**

Conclusion

Both school-based and community clinics are important resources for youth, their parents and school personnel. However, each setting has unique strengths in the mental health treatment for children and teens. By understanding the strengths and limitations of each setting, schools, parents and treatment providers can work to maximize the benefits and minimize the barriers of each treatment environment. This article serves as a jumping-off point for further research in this area as continued comparisons and contrasts of each setting can contribute to professional knowledge, service design and social policy.

Loose Parts in the Playroom

by Deborah B. Vilas, MS, CCLS, LMSW

I learned about an intriguing and wonderful concept several years ago at a week- long seminar on Play at the Sarah Lawrence College in Westchester. It is the idea of "loose parts" as essential play materials for children of all ages. "Loose parts is a wonderful term coined by architect Simon Nicholson, who carefully considered landscapes and environments that form connections. Nicholson believed that we are all creative and that "loose parts" in an environment will empower our creativity." (Better Kid Care, retrieved January 11, 2012 from http://betterkidcare.psu.edu/TIPS/tips1107.pdf). Nicholson thought of loose parts in a natural sense, water, dirt, fire, wood…. etc. In my practice, I have broadened this concept to open-ended manmade materials as well, anything from masking tape to string, as long as it can be used to create something else.

My next big aha was in thinking about how to apply this concept to the work of my Child Life graduate students in hospital settings. I did not have to think far. Child life specialists are regularly called upon to prepare children for any number of medical procedures. We know that a child's understanding of concepts is deepened when they can roll up their sleeves and interact in exploratory and creative ways with materials. I think about it this way. Telling a child about what to expect is a one-dimensional (auditory) way of the child accessing information. Showing the child a photograph is two- dimensional, as it addresses the visual aspects of the information. Showing the child on a doll what will happen to the child's body is a three-dimensional approach. Having the child interact with the doll and medical materials would be a four-dimensional approach. But the deepest and most meaning-making approach would be the fifth dimension, where the child and specialist create something together that represents the child's experience.

And so, I began to assign “loose parts” projects to my students in my therapeutic play course at the Bank Street College of Education. I just finished my third round and the results have been amazing. I am including a photograph or two representing their work. They have come up with interactive materials that demonstrate everything from kidney dialysis to burn wound care, and include 5-D demonstrations of diagnoses, such as Crohn’s Disease , asthma and cancer. Of course the best stories are those coming from my alumni out in the field, who send me photos or video footage of their co-creations with children. There is no doubt that the act of co-creating 5-D representations of a child’s medical experience provides incredible opportunities for mastery, expression of feelings, and clarification of misunderstandings about their bodies and medical situations.

My guess is that play therapists could easily use loose parts in their practice to help children explore their chronic or acute medical experiences. The therapist would be learning along side the child, which would build trust and attachment in the therapeutic relationship as well. I challenge you all to include more loose parts in your playroom, whether they are there to address medical issues or just typical development. As we all know, kids naturally strive towards creativity and healing when given the space, materials and support.


A student uses Gatorade, a plastic takeout container, aluminum foil, a leggo figure and gauze to depict burn wound care.


A student uses a cloth doll, gauze, Elmer’s glue, lanyard and duplos to depict a VEEG test.

Suggested Loose Parts:

Masking tape
Aluminum foil
Plastic takeout containers
String
Gauze
Straws
Tongue depressors
Cardboard boxes of all size

Grin and Share It

A humor column based on true experience
by Dr. Laurie Zelinger

In a session with 5-year-old Gabby, I asked, “How do you think you’re behaving in school lately?” (no response) then, “What would your mother say about how you’re behaving?”
Gabby: “You should ask my mother. She is very smart! She knows everything! Even when I’m lying!”
Me: “How can she tell?”
Gabby: “Well, take a look at me! Do you see it? My mom can! If you look closely you can see that my nose has been growing!”

In a session while playing *store* with a young child/cashier, I asked, “How much does that cost?”
Her: “Oh, it’s free! It’s no money.”
Me: “Oh thank you, but how do you stay in business?”
As I’m ready to leave, she says, “That will be eight dollars please.”
Me: “But you said it was free!”
Her: “Yes it is free. But there’s eight dollars tax on everything that’s free.”

In December at lunch, I heard two girls arguing about whether Santa exists.
L: “Can’t you tell that he’s not real? He always has a different handwriting when he writes letters to kids.”
J: “Oh yes he is real! Because I went on his website, and he is real because he texted me back!”

A young boy was at recess outside on a cold day. He asked one monitor, “When are we going in?” to which she replied, “ In a few minutes”. He asked another monitor the same question and was told, “Soon”. Cold and impatient, this youngster then went up to the school principal and then asked, “Which is shorter? A few minutes or soon?”

Are schools going to be closed on King Martin Junior day?

Adolescents and Adults with Fetal Alcohol Syndrome Disorders (FASD):
Living a Life Sentence with New Hope
The Play Therapist’s Role
By Catherine E. Cwiakala, LMSW

Upcoming Conference: FASD: It's a Matter of Justice
5 National Biennial Conference on Adolescents and Adults with FASD
April 18-21, 2012, Vancouver, DC. Updates: interprofessional.ubc.ca
http://www.moappp.org/Documents/events/2007/FASDConferenceBrochure.pdf

The Role of Play Therapists:
With the proper knowledge, understand and skills, play therapists are able to be key members of the teams to Diagnose Fetal Alcohol Spectrum Disorders (FASD) and to participate in creating and carrying out Treatment Plans for Adolescents/Adults with FASD. This article contains the updated information on the FASD Diagnostic Process and creating and providing Individualized FASD Treatment Plans for Adolescent/Adults. Play therapists' observation in the play room and intake interviews with parents, teachers, medical doctors and other mental health providers provide key information for the diagnosis of possible FASD in a client.

Four previous NYAPT Newsletter Articles addressed the diagnosis, creating and providing Individualized Treatment Plans for infants (including before birth) and children.

Assessment Resources for play therapists to assess whether a client may need to be tested for a FASD diagnosis are:

"The Fetal Alcohol Spectrum Disorders: Competency-Based Curriculum Development Guide for Medical and Allied Health Education and Practice" especially:

- Competency V—**Screening, Diagnosis, and Assessment of FAS Framework for FAS**
- Diagnosis and services FAS diagnostic criteria
- Considerations for a referral for an FAS diagnostic evaluation
- Evaluation of fetal alcohol spectrum disorders

National Center on Birth Defects and Developmental Disabilities Centers for Disease Control and Prevention Department of Health and Human Services,

http://www.cdc.gov/ncbddd/fasd/curriculum/fasdguide_web.pdf

- **Overlapping Behavioral Characteristics & Related Mental Health Diagnoses in Children:** Chart prepared by Cathy Bruer-Thompson, 3/23/10 (Created with sources including the NAMI: National Alliance on Mental Illness and Mayo Clinic)
  http://www.samaritanbehavioralhealth.com/files/Overlapping-characterisitics-chart.pdf

- **How Fetal Alcohol Spectrum Disorders Co-Occur with Mental Illness: What You Need to Know; http://store.samhsa.gov/shin/content//SMA06-4237/SMA06-4237.pdf**

FASD and DSM V: National Organization on Fetal Alcohol Syndrome (NOFAS)
NOFAS, the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS), and over 40 other FASD-focused organizations are advocating for the inclusion of FASD in DSM-V. http://www. nofas.org

The MOFAS Position on FASD and the DSM:

- **http://www.mofas.org/2011/09/dsm/**

Diagnosing FASD:

(Hoyme et al 2005) explain that it a team effort to obtain a correct FASD Diagnosis. For adolescents and adults it requires a team of an adolescent doctor and/or internist, psychiatrist and mental health personnel working together to determine the individual FASD diagnosis and degree of damage to determine what specific brain, organ, and/or sensory damage has occurred and how the FASD and their environment has affected the teen and/or adult.
A surge of research has and continues to occur to effectively diagnose FASD. The four main ones include:

- Washington Criteria: 4 Digit (Astley)
- Center of Disease Control (CDC) Guidelines, (For FAS only)
- Revised Institute of Medicine (IOM) Criteria (Hoyme et al, 2005)
- Canadian Guidelines (Chudley, et al, 2006)

Hoyme et al, 2005 state their Conclusions:

- FASD should be a diagnosis of exclusion.
- A multidisciplinary approach, utilizing medical, dysmorphology, educational/psychological and neuropsychological assessments is suggested.
- Advances in molecular biology, molecular genetics and neuroimaging have added significantly to the body of knowledge about the pathogenesis of FASD giving rise to sound treatment and prevention strategies.
- Studies of FASD through the current international consortium should further advance knowledge regarding this preventable spectrum of disability.

Syndrome-specific Neurocognitive Profile:
(Kodituwakku, 2009, 2011) notes research continues to identify a syndrome-specific Neurocognitive profile to aid in diagnosing prenatally exposed children with cognitive deficits who do not exhibit clinically discernable physical anomalies. “We recommend the study of developmental trajectories of both

elementary and high-order functions in future research on FASD to elucidate the development of this cognitive profile."

Choose the Best Combination of Treatments:
The next crucial step is to determine and provide the best combination of treatments to help clients diagnosed with FASD reach their full potential. The combination of treatments may include: medication, nutrition and/or vitamin therapy, mental and emotional health supports, physical therapy, occupational therapy, sensory therapy, special education, individual, parent and family counseling and support groups, play therapy, financial, legal rights and ethics counsel and be carried out by a team personnel of above professions .*

Excellent Resources to Choose Treatments Include:

- "The Fetal Alcohol Spectrum Disorders: Competency-Based Curriculum Development Guide for Medical and Allied Health Education and Practice"
  - Competency VI—Treatment Across the Lifespan for Persons with FASDs
  - Concerns across the life span
  - Providers and approaches to treatment for FASDs
  - Family support services and resources
  - http://www.cdc.gov/ncbddd/fasd/curriculum/fasdguide_web.pdf

- Medication: For a review of "Medications for Children and Adults with FASD" by Sumner, Dubovsky, and O'Malley (1997) Iceberg Newsletter 7(4) updated January 8, 2009 go to http://www.come-over.to/FAS/meds.htm

This team needs to address the mental, emotional, educational, financial, legal, and support of the adolescent/adult with FASD and their family.

Single-Case Design

Jennifer Baggerly, Ph.D., LPC, RPT-S shares my concern for play therapy for FASD clients as she has an adopted daughter from Russia, with FASD. Dr. Baggerly said she would consider being a keynote speaker on FASD to our NYAPT Chapter and also suggested play therapist conduct Single Case Design Research on their clients with FASD. She referenced the "Single-Case Design: A Primer for Play Therapist", by Dee C. Ray and April A. Schottelkorb, International Journal of Play Therapy, 2010, Vol. 19, No. 1, 39-53. P. 40 'Single-case designs allow play therapists to investigate the effectiveness of their interventions with the individual clients they treat."… P. 52 "When single-case designs are conducted with rigor established by the evidence-based movement, play therapists can offer the field of play therapy a much needed base of evidence from which to promote the effectiveness of play therapy."

Recommendations for Treatment of FASD Clients Adapted for Play Therapists:
(Based on the article, "Training Needs of Healthcare Providers Related to Centers for Disease Control and Prevention Core Competencies for Fetal Alcohol Spectrum Disorders" Brems and al, 2010 p. e405-e417)

- FASD-specific interventions to provide effective diagnostic and treatment services that lead to improved long-term outcomes by reducing the occurrence of secondary disabilities.

- Understand the distinction between FAS and FASDs

- Understand the adolescent and adult with FASD Clients' needs and determine the supportive care for them and their families across the lifespan.

- P 409 Meet the challenges of FASD treatment services, especially psychiatric and mental health treatment for all ages, as well as treatment in general for adults.
- Develop effective clinical treatment skills for FASDs especially with children and adolescents displaying inattention, hyperactivity, impulsivity, emotion dysregulation, or maladaptive behavior associated with attention-deficit/hyperactivity disorder, bipolar disorder, oppositional defiant disorder, or conduct disorder.
- There is a need for experiential education and training for those working with Adolescents and Adults with FASD.
- Increase intra- and interdisciplinary communication in a team approach to meet the needs of individuals with FASD
- Families need to be part of defining what treatment success means for the individual
- Help clients qualify for DD Services.
- Develop Practical education and skills on how to provide play therapy with an adolescent and/or adult with FASD
- Adapt the play therapy treatment for the individual client
- Support interventions to develop role models and mentors
- Address the ethical, legal, and policy issues with Adolescent/Adult with FASD Clients and their families.
- Be sure treatment is culturally and age transitioning sensitive

In choosing play therapy for adolescents and adults with FASD, I suggest:

- Study the teen/adult's full individual diagnosis, treatment needs, and both the adolescent/adult and family's desires.
- Study multidimensional and collaborate approaches with other members of their treatment team.
- Learn the specific group treatment strategies (i.e. medical, educational, occupational therapy, …) that have been effective with the individual needs of your client.
- Check to see if your treatment plan has culturally specific prevention and intervention strategies.
- Be sure the chosen strategies are transitional sensitive with adolescents and adults.
- Provide play therapy techniques to protect from and/or provide remediation for secondary disabilities associate with FASD

I suggest exploring the following play therapy techniques:

- Sand Tray
- Art Therapy
- Theraplay

- Quilt Therapy encouraging the client to design and create a quilt for themselves with squares/pictures of their hopes, wishes and dreams, their heritage, pictures of them growing up, if possible surrounded by those who loved them, their best memories, their capabilities, a picture of their FASD, etc. The client would choose the fabric (texture, colors, size) this quilt would be used to comfort and encourage them. This could also be a collage.
- Cooperative games
- Making things – woodworking, sewing, pottery, cooking, etc which also develop a skill.
- Serenity Prayer Adaption for adolescents and adult with FASD and other appropriate prayers based on their Spiritual Beliefs.
- Support Groups with Friendship Training Materials using (Handbooks, movies, presentations, …) to both explain FASD, tailored to their specific individual diagnosis and help them process what their FASD Diagnosis and Treatment means to them. This would also give them socialization in protective, safe environments.
- Help case manage so they obtain their needed treatments
- Mentors and Sponsors
- Parental and Family Education and Support Groups with Respite Services
- Access learning settings, group homes, camps, day treatment centers that appropriately and effectively support people living with FASD
- Drama and puppet therapy to act out and practice how to handle difficult situations
- Biblio-therapy – There is a growing list of books
- Soft lights –not florescent lighting
- Music therapy to assist in memory retention, focusing, motor skills, and socialization. Explore neurologic music therapy (NMT) and creative music therapy. *Peter Meyer, MT-BC, Supervising Music Therapist*
- Less things in the play room and the same order each session
- Animal therapy with specially trained animals
- Goal Setting – Life Plans

FASD Treatments:

Additional key information in the medical, educational, and mental health areas on FASD: Identification, Assessment, and Treatment:

- Types of Treatments: Medical Care, Medication, Behavior and Education Therapy (Friendship training, specialized tutoring, executive functioning training, parent-child interaction therapy, parenting and behavior management training) and alternative approaches (including art therapy, animal-assisted therapy, vitamin and other therapies)
  http://www.skfasnetwork.ca/pdf%20files/LivingwithFASD_Fall2010.pdf

- **"Context driven assessment and treatment of a developmentally and psychiatrically complex patient with FASD" -** PowerPoint/Slides with Notes, by Dr. Paul Lockhart . Description: Dr. Lockhart provides an overview of the patients with FASD seen at Kennedy Krieger Institute in Baltimore. Many of the patients can achieve stability over time. The more impaired individuals have problems with cognition, environmental conditions, behavioral and emotional reactivity, and genetic disposition for

psychiatric disorder. Power Point Presentation
http://www.fasdcenter.samhsa.gov/documents/BFSS2006_Paula_Lockhart_Presentation.ppt

School and Community Resources:

- **Teaching Students with Fetal Alcohol Syndrome/Effects: A Resource Guide for Teachers**, especially note: "Common Misinterpretations of Normal Responses in Students with FAS/E, http://www.bced.gov.bc.ca/specialed/fas

- **FASD: Strategies not Solutions,** a strategies booklet to educate caregivers and the community in managing the behaviors associated with FASD.
http://www.betterendings.org/strategies_not_solutions.pdf

- **So You Have Been Diagnosed with FASD…Now What?** The goal of this handbook is to help young people, like you, learn more about Fetal Alcohol Spectrum Disorder (FASD). It also offers strategies that you can use to better understand yourself, improve your relationships, manage your feelings, do better in school and live a healthy life. 2007 Boyle Street Education Centre & Agnieszka Olszewska, **http://www.bsec.ab.ca/pdf/So_You_Have_Been_Diagnosed_With_FASD_Now_What_Education_Resource.pdf**

- **Re: Defining Success: A Team Approach to Supporting Students with FASD: A Strategy Guide for Mentors and Coaches Working in Schools (Grade 1-12)**
http://education.alberta.ca/media/932737/redefining_final.pdf

- **Canada School Information for the treatment of children with FASD:**
http://www.lrc.education.gov.ab.ca/pro/default.html

Parent Resources:

- **The Mayo Clinic** has an excellent article for parents of children with FASD:
"Fetal alcohol syndrome" which includes: When to see a doctor; Preparing for your appointment, Test and diagnosis; and Coping and support.
http://www.mayoclinic.com/health/fetal-alcohol-syndrome/DS00184

- **Fetal Alcohol Syndrome: A Parents' Guide to Caring for a Child Diagnosed with FAS**, 2004 Wake Forest University Health Sciences: School of Medicine, NC
http://Fetal_Alcohol_Syndrome_Parents_Guide[1].pdf

- **"HaysKids: Pathways to Understanding Raising Kids with Fetal Alcohol Spectrum Disorder: a Seminar with John Hays"** CD HaysKids: pathways to understanding, 2005 Follow Productions

- Effective methods of raising children with FASD through adolescents and into productive adulthood. **Go to http://www.mofas.org/ and search for Hayskids.** There are excellent topics such as: *Parenting Techniques, Brain Development; Fetal Alcohol Workbook; Assisted Living Center.*

- Seven Secrets to Savvy Sex Ed: For Families Facing Fears of the Future with FAS/E, by Eva Carner, http://www/come-over.to/FAS/SexEd.htm

- "FAS and Sexual Acting Out" by Teresa Kellerman, http://come-over.to/FAS/sexuality.htm

- **12 Parent Goals, by John Hays, 2009, http://www.hayskids.org/?page-id 385**

Adults with FASD Resources:

- **Treatments for Women with FASD:** "Thus, from the perspective of FASD prevention, women with FASD need to be viewed as a group warranting particular attention." page 5

- **Voices of Women with FASD: Promising Approaches in Substance Use Treatment and Care for Women with FASD,** prepared by Deborah Rutman
  January 2011. Research Initiatives for Social Change Unit School of Social Work
  University of Victoria, Victoria, BC Canada,
  http://socialwork.uvic.ca/docs/research/Substance%20Using%20Women%20with%20FASD%20-%20Voices%20of%20Women%20Report-web.pdf

- **Resources for families of Adults with FASD - http:/www.mofas.org/families**

  Misdiagnosis and Screening in Adults and links to other helpful sites:
  http:/www.mofas.org/adults-living-with- fasd/

  - **Resources to prevent FASD created by ACOG:**
  - Pregnant? Think: Don't Drink! FASD Preventing Handbook
    http://mail.ny.acog.org/webside/ThinkDontDrink.pdf
  - Pregnant? Think: Don't Drink! FASD Preventing Poster
    http://mail.ny.acog.org/webside/FASDPoster.pdf

- **Voices of Women with FASD: Promising Approaches in Substance Use Treatment and Care for Women with FASD,** prepared by Deborah Rutman
  January 2011. Research Initiatives for Social Change Unit School of Social Work
  University of Victoria, Victoria, BC Canada,
  http://socialwork.uvic.ca/docs/research/Substance%20Using%20Women%20with%20FASD%20-%20Voices%20of%20Women%20Report-web.pdf

Adolescents with FASD Resources:

- **Adolescent FASD Prevention Videos with Teachers' Resource Books:**
  Human Relations Media, Mount Kisco, NY
- **Understanding Fetal Alcohol Syndrome**, DVD Version: IBSN 13-978-1-555548-7645 (2009)
- **No Safe Amount: Women, Alcohol and Fetal Alcohol Syndrome**, DVD Version: ISBN 13-978-1-55548-433-0 (2008)

- "Transitions: Pathways to Success: A Fetal Alcohol Workbook: For an individual with Fetal Alcohol: To Help them plan for their future and then live it." By: HaysKids, 2009
  http://www.hayskids.org/?page-id

- **I'm the VISIBLE TEEN with the Invisible Disability, by Teresa Kellerman, 1999-2002, Frasstar Enterprises, www.fasstar.com**

- **Booklets for Teens – Alcohol and Drug Prevention:** http://store.samhsa.gov/list/series?name=Tips-for-Teens&sortBy=3&ascending=false

- **Go to http://www.mofas.org/ and search for Hayskids.** There are excellent topics such as:;*Fetal Alcohol Workbook; Transitions: Pathways To Success, Assisted Living Center.*

- **Adolescent FASD Prevention Videos with Teachers' Resource Books:** Human Relations Media, Mount Kisco, NY
- **Understanding Fetal Alcohol Syndrome**, DVD Version: IBSN 13-978-1-555548-7645 (2009)
- **No Safe Amount: Women, Alcohol and Fetal Alcohol Syndrome**, DVD Version: ISBN 13-978-1-55548-433-0 (2008)

FASD and Art Therapy:

- **Monsters, Monkeys, & Mandalas: Art Therapy with Children Experiencing the Effects of Trauma and Fetal Alcohol Spectrum Disorder (FASD)**, June Gerteisen, Anchorage, Viewpoint: Canadian Research Projects: http://www.fasdmanitoba.com/researchprojects.html

- **Art Therapy and Children with FASD: A Unique Connection?** By D. Beaudmont, Art Therapist, FASD Support Network of Saskatchewan Inc. Living with FASD Fall 2010 http://www.skfasnetwork.ca/pdf%20files/LivingwithFASD_Fall2010.pdf

Theraplay and Fetal Alcohol Syndrome:

- **Theraplay and Fetal Alcohol Syndrome, by Dafna Lender, LCSW, Training Director of the Theraplay Institute; http://www.theraplay.org/articles/Lender_09.pdf**

FASD Legal Issues and Support:

"The Fetal Alcohol Spectrum Disorders: Competency-Based Curriculum Development Guide for Medical and Allied Health Education and Practice"

- Competency VII—**Ethical, Legal, and Policy Issues**

National Center on Birth Defects and Developmental Disabilities Centers for Disease Control and Prevention Department of Health and Human Services, http://www.cdc.gov/ncbddd/fasd/curriculum/fasdguide_web.pdf

- **Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System: Facilitator's Manual: Volume 1 -** U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention Power Point Presentation - http://store.samhsa.gov/product/SMA07-4291

- **Fetal Alcohol Spectrum Disorders (FASD): When Your Child Faces the Juvenile Justice System:** What you Need to Know; 4/2007; Fact Sheet for Parents & Caregivers
  Series: Fetal Alcohol Spectrum Disorders: What You Need to Know
  http://store.samhsa.gov/product/Fetal-Alcohol-Spectrum-Disorders-FASD-When-Your-Child-Faces-the-Juvenile-Justice-System/SMA06-4241
- **Fetal Alcohol Spectrum Disorders (FASD) and the Criminal Justice System:** What you Need to Know; 4/2007; Fact Sheet for Family & Advocates, Law Enforcement, Legal Community, Prevention Professionals, Women as Audience
  Series: Fetal Alcohol Spectrum Disorders: What You Need to Know
  http://store.samhsa.gov/product/Fetal-Alcohol-Spectrum-Disorders-FASD-and-the-Criminal-Justice-System/SMA06-4238

- ***RESEARCH BRIEF:*** **Is There Justice in the Juvenile Justice System? Examining the Role of Fetal Alcohol Spectrum Disorders* Sharon J. Williams**
  http://www.cjcj.org/files/is_there.pdf

"When professionals are trained, the system is then poised to adapt communication styles and legal strategies to accommodate the limitations that result from FASD. Successful efforts at systemic change will be marked by replacing punishment with treatment, the path toward further criminality with a safe environment that fosters appropriate interventions for FASD, and human indignity with human compassion."

http://www.americanbar.org/groups/child_law/projects_initiatives/child_and_adolescent_health/fasd_dealingwithpolice.htmlIntroduction; Cards to Give to the Police; How to Use; Guidance for Police Interaction; Text of Card

Organizations for Help:

- National Organization for Fetal Alcohol Syndrome (NOFAS); http://www. nofas.org
- U.S. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention www.samhsa.gov
- **WebMD** http:www.webmd.com
- **The National Organization on Fetal Alcohol Syndrome (NOFAS) provides a list of the State Resources for New York** (including: Community Resources and Family Support Groups, Diagnosis of FAS, Prevention Programs, including Treatment for Women, Treatment Services for Affected Individuals and Statewide Services):
  http://www.nofas.org/resource/results.aspx?ST=32&Name=New%20York
- **Northeast Regional FAS Education and Training Center**
  The Northeastern RTC, located in the University of Medicine and Dentistry of New Jersey (UMDNJ), has provided FASD-related education in multiple training and practice environments…. Visit their website to learn more about the Northeastern RTC and find training materials and resources.

I implore my fellow NYAPT and International APT Members to join together to educate ourselves in how to help adolescents and adults with FASD.

Please share your knowledge and expertise!
Please send your information to Catherine Cwiakala, at ccwiakala.lmsw@yahoo.com or 118 Edgehill Drive, Wappingers Falls, NY 12590. I will compile the information sent to me and put it in our next NYAPT Newsletter. Thank you!

The next FASD International Awareness Day will be September 9, 2012.

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REMINDER

Coming Soon - NYAPT's 13th Annual Conference

March 9-10, 2012

Poughkeepsie Grand Hotel in Poughkeepsie, NY

Two informative days with Paris Goodyear-Brown, LCSW, RPT-S

Plus networking opportunities, raffles, an ice cream social, shopping

Don't Forget - Register soon!

Keep reading - Important Ballot on next 2 pages

VERY IMPORTANT - Ballot for
ELECTION OF OFFICERS
RETURN BY March 1, 2012

TO: All Members of the New York Association for Play Therapy
FROM: Chair of Nominations Committee
RE: Election
DATE: February 2, 2012

It is election time for officers of your Board. We ask that you complete the following ballot and return it to me as soon as possible. **PLEASE VOTE** – we want this to be a reflection of your wishes. Please be aware, in order for your vote to count, ***you must provide your signature on the envelope when you return the ballot; otherwise the ballot cannot be counted.*** Thank you for your prompt response. Installation of new officers will be held during the Membership meeting at the conclusion of our annual conference. The nominees follow – please vote for each position:

President

Candidate Athena Drewes _____

Dr. Athena A. Drewes is a licensed child psychologist and Registered Play Therapist and Supervisor. She is Director of Clinical Training and APA-Accredited Doctoral Internship at Astor Services for Children and Families, a large multi-service nonprofit mental health agency in New York. She has over 30 years clinical experience in working with sexually abused and traumatized children and adolescents in school, outpatient, inpatient and foster care settings. She has been a clinical supervisor for over 20 years. She is a former Board of Director of the Association for Play Therapy (6 years), Founder and Past President of the New York Association for Play Therapy and currently NYAPT Vice President. She is on several journal editorial boards, adjunct professor at Marist College and Sage Colleges and has written extensively and been an invited guest lecturer throughout the US and internationally on play therapy. Her books include *School-based Play Therapy; Cultural Issues in Play Therapy; Supervision Can be Playful: Techniques for Child and Play Therapy Supervisors; Blending Play Therapy with Cognitive Behavioral Therapy: Evidence-Based and other Effective Treatments and Techniques, School-based Play Therapy: Second Edition* and *Integrative Play Therapy.* She is also Chair of the American Psychological Association's Trauma Division 56 Child and Adolescent Special Interest Group.

Vice President

Candidate Stephen Demanchick _____

Stephen P. Demanchick is an Assistant Professor for the Creative Arts Department at Nazareth College and Director of the Nazareth College Play Therapy Center for Children and Families. He earned his Ph.D. from University of Rochester in 2007. Stephen is a Licensed Mental Health Counselor, a Registered Play Therapist, Nationally Certified Counselor, and NIRE certified child-centered play therapist. Stephen has completed the APT leadership academy training. Stephen serves on the editorial board for the *International Journal of Play Therapy*, is a member of the APT director nominations committee, and is the former Chair of the APT University Education Committee. As chair of our university education committee, he clinically supervised the development and content of two initiatives, *Play Therapy Works* and *History Speaks*. His interests include play therapy process work, filial therapy, CCPT with individuals with developmental disabilities, and clinical supervision. In 2011, Stephen won the APT Service Award.

Recording Secretary

Candidate Kim Berkery _____

Kim Berkery is a Licensed Mental Health Counselor and a Registered Play Therapist-Supervisor. She earned her Masters degree in Counseling Psychology from Marymount University and is a Licensed Professional

Counselor in the state of Virginia as well. She has served on the NYAPT board for the past two years as the Recording Secretary. She is an active member of the chapter and continued commitment to the advancement of play therapy. Ms. Berkery is currently the Clinical Supervisor at YES Community Counseling Center, a non-profit community agency in Massapequa, New York. Ms Berkery provides therapeutic services to children, adolescents and families as well as supervision of staff and interns. She also has a private practice in Rockville Centre, New York where she utilizes play therapy and a family systems approach. She has received advanced training in sexual abuse and trauma, suicide prevention and intervention, critical incident debriefing, and sand therapy. Ms. Berkery demonstrates over 15 years of experience in various settings with children, adolescents, and families. She worked in a residential treatment center for sexually and physically abused adolescents in Fairfax County, Virginia. In addition, she was the Program Manager for Inova Kellar Center (Fairfax Virginia) in the Adolescent Day Treatment Program, Intensive Outpatient Programs (Mental Health and Substance Abuse) and Coordinator for the Children's Day Treatment Program.

Director (Please cast one vote)

Candidate Annie Monaco _____

Annie J. Monaco, LCSW-R. Annie has been a certified social worker since 1995. She has extensive training in play therapy, family therapy, offender work, and trauma therapy. She specializes in working with parents, teenagers, children, and foster care kids. In addition to her private practice, Annie is an independent affiliate of Child Trauma Institute and she trains therapists nationally and internationally about trauma, working with children and teenagers. Annie is also an EMDR trainer and consultant and provides consultation to many therapists around the country on integrating EMDR and play therapy.

Candidate Wendy Ludlow _____

As a registered play therapist-supervisor Ms. Ludlow has received over 20 years of post-graduate supervision and training by the National Association of Play Therapy. Ms. Ludlow's accomplishments include: presenting on play therapy at both national and international conferences, training teachers in a village in India, serving as an expert witness for children in foster care and in custody challenges, the development of an intensive family therapy program, supervision of graduate interns from Columbia and Fordham University, and the development of a play therapy program in both a special needs pre-school and an elementary school. Ms. Ludlow co-authored a chapter on group therapy for children experiencing divorce published in the revised edition of "Short Term Play Therapy", Edited by Dr. Heidi Kaduson and Dr. Charles Schafer. Ms Ludlow is Past President of The New Jersey Association for Play Therapy and has served as editor for both the New Jersey and the New York Associations for Play therapy newsletters. She is currently co-authoring a book on Energy Systems Therapy, release date TBA. Ms. Ludlow has earned three degrees from: Austin College in Sherman, Texas (BA in Psychology); McGill University in Montreal Quebec, Canada (Special BSW); and The University of Texas at Arlington (MSSW) and is a provider for continuing education credits for The Association For Play Therapy. She is a mother of two children, and lives with her family in The Bronx, NY although she travels frequently to Phonecia in the CatSkill Mountains.

The names of those receiving the highest number of votes will be installed as your new officers on March 09, 2012.

Please return this form no later than March 1, 2012 - (YOUR SIGNATURE MUST BE ON ENVELOPE) to:

Rebekah Crofford, PhD, LCSWR, RPTS
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Associate Professor
Division of Social Work
Roberts Wesleyan College
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Crofford_rebekah@roberts.edu