# SPRING NEWSLETTER

**NYAPT Board Members**

Athena Drewes
President

Mary Anne Assini
Past President

Stephen Demanchick
Vice President

Rebekah Crofford
Corresponding Secretary

Kim Berkery
Recording Secretary

Sheila Doherty
Outgoing Treasurer

Gabriel Lomas
Treasurer

Laurie Zelinger
Outgoing Director

Annie Monaco
Director

Joan Bender
Director

Jillian Kelly
Director

President's Message
Athena A. Drewes, PsyD, RPT-S

Happy Spring to everyone! Hopefully the warmer weather will soon be here along with bulbs and trees blooming. It feels like it has been a long winter, but now we will have lots to celebrate and look forward to!!

First and foremost **CONGRATULATIONS** to our newly elected Board members. Thank you for your willingness to serve:
Rebekah Crofford, (returning) Corresponding Secretary; Gabriel (Gabe) Lomas, Treasurer; Jillian Kelly and Joan Bender (returning) as Board Members. Welcome aboard! We look forward to your enthusiasm and new ideas to help NYAPT continue on its path forward towards becoming an even more vibrant and active organization. A special ***thank you*** goes to outgoing Board officers Sheila Doherty, for her long and untiring service as Treasurer, and to Laurie Zelinger, for her years of service as Director. You both have helped NYAPT grow and thrive! Thank you for your unwavering support and service. Although "retired", we look forward to your continued involvement with NYAPT.

Next, let's all celebrate achieving the status of **GOLD BRANCH**!!! We met APT's requirements of holding even in membership (we held even to 2012 at 197), as well, as met and exceeded the necessary requirements for outreach trainings to the community, outreach communications to our members, as well as achieving above the required training hours available to membership and the public. We get to use the Gold Branch logo (see above) for as long as we maintain APT's requirements. So everyone, pat yourself on the back, for without your membership, and bringing in new members and RPT/S we would not have achieved this goal! Thank you!

**Congratulations to our new NYAPT/APT members!** Welcome:
Martha Oakley; Jennifer Johnson; Diana Cummings; Danielle Kudela; Julie Mulero; Evelyn Page; Andrea Florez Marino; Kristin Redell; Lia Fegley; Jennifer Bardo; Sara Kranzler; Krystin Wessner; Jean Gargala and Lydia Moore.

Also **Congratulations** to Michelle Conelli and Cecilia Rembert for achieving **RPT** status; and to Ann Beckley-Forest for moving up into **RPT-S** status!!! Well done!!!

And another thing to celebrate is our upcoming NYAPT Annual Conference April 19-20th with Scott Riviere. Our Buffalo Conference Committee has done an excellent job getting everything ready (Annie Monaco with committee members Mary Carol Dearing, Ann Beckley-Forest, Elizabeth Davis and Brenda Bierdeman), with lots of registrations coming in and special baskets to raffle to raise money for next year's NYAPT conference scholarships (we were able to give out three student scholarships to this year's conference)! This year we will also have a sign language interpreter for some attendees. DeeDee and Harry from The Self Esteem Shop will be returning with lots of great puppets, play therapy toys and materials, and the latest and favorite play therapy books. A great place to do your play therapy shopping! Please be sure you have registered to attend. And be sure to download your handouts off the NYAPT website to bring with you! I look forward to personally welcoming each of you soon!

Finally, additional news includes an article on the new **New York State Safe Act** which you should be sure to read. It impacts all play therapists, whether you are working in a school, clinic, residence or privately with respect to additional reporting requirements of suicidal or homicidal ideation and intent.

As we bloom and blossom into Spring 2013, we have lots to look forward to: several upcoming Free NYAPT co-sponsored trainings where you can network and obtain CEs, continued regular e-blasts to keep us updated (thanks Jillian for your great work!!) and emerging new training sites! Stay tuned! The best is yet to come!

In Service,
Athena

**IMPORTANT INFORMATION FOR ALL PLAY THERAPISTS!!!**

## NYS SAFE ACT

From Athena A. Drewes, PsyD, RPT-S

All New York State Play Therapists need to be aware of the new law that went into effect on Saturday, March 16, 2013, the ***New York State Safe Act***. MHL9.46 requires "mental health professionals" to report to the county DCS (Director of Community Services) or designee when, in their reasonable professional judgment, one of the persons for whom they are currently providing mental health treatment service is "likely to engage in conduct that would result in serious harm to self or others." This includes "threats of, or attempts at, suicide/serious bodily harm to self, or homicidal/violent behavior towards others."

Whether or not the person becomes hospitalized, you may need to report the suicidal ideation or intent to the DCS through the required form. If the DCS agrees that the person is likely to engage in such conduct, the NYS Division of Criminal Justice Services (DCJS) would be notified to determine if that person (or possibly family) has registered for or owns a weapon. This would set in motion the revoking of the person's license and removal of guns from the home.

The professionals defined as "mental health professionals" at this time are: Physicians, Psychologists (licensed and those not licensed), Registered Nurses and Licensed Clinical Social Workers. It is currently unclear what this means for Licensed Mental Health Counselors and MSWs. This law applies to those clinicians in private practice as well as those working within agencies of any kind.

While various professional organizations (such as NYS Psychological Association, NYS Psychiatric Association, and the Veteran's Administration) are objecting to some of the pieces of legislation and trying to get the mental health reporting piece delayed, it IS IN EFFECT. And we ARE to follow the procedures as of March 16th.

It is important that you become aware of this new law and reporting requirement. You can obtain the complete Powerpoint as well as listen to the presentation by going to: http://www.omh.ny.gov/omhweb/safe_act/. There is **NO** fee for the training, and the 23 minute training can be viewed at your convenience at any hour or day.

## Chapter Updates

**Training News:** Check your e-blasts for ongoing training news! And, our website has lots of great information on trainings/supervisors in the NY area. In the meantime, here are some goodies coming up…

What?: FREE NYAPT Sponsored Training Integrative Counseling Services, PLLC with Dr. Jodi Mullen, PhD LMHC NCC RPT-S & June Rickli, MS LMHC CCPT-S RPT
Where?: 5 W. Cayuga Street, Oswego, NY
When?: Monday, May 13, 2013; 12:00am-2:00pm
*Attached flyer

And… you can learn from home!
The Association for Play Therapy (APT) has numerous opportunities for distance CE via:

**Audio courses**

**Book tests**

**Journal tests**


Visit the webpage below and explore the options:
http://www.a4pt.org/ps.training.cfm?ID=1638

**Student Voices:** Remember to contact Courtney Dolan (Dolan_Courtney@roberts.edu), Student Representative, with ideas to help grow our Student Affiliates membership.

**NYAPT in the News:** Please share your fame, successes, or just good ole fun anecdotes with us! Send us your news. We can't wait to applaud you!

## Meet Your Newly Elected Officers!

**Rebekah Crofford – Corresponding Secretary**

Rebekah Crofford, PhD, LCSWR, RPTS has been in the field of social work for close to 20 years. Throughout her career she has worked predominately with children and families where there are multiple risk factors. She enjoys working primarily in strengthening the parent child relationship through play therapy. Her passion for children and families is evidenced by her current position as graduate faculty in the Division of Social Work at Roberts Wesleyan College where she teaches courses on Play Therapy, assessment and interventions with children and families. In addition, Dr. Crofford provides play therapy supervision to mental health professionals has a small private practice and provides trainings in play therapy in the Rochester, NY community. When not working she serves on the Board for the New York Association for Play Therapy and at Christian Central Academy and volunteers in her church community. She has a husband of 18 years and 3 children whom she takes great delight in.

**Gabriel Lomas – Treasurer**

Dr. Gabriel (Gabe) Lomas, RPT-S resides in Putnam Valley, NY and is an associate professor of counseling at Western Connecticut State University in Danbury, CT. Gabe recently moved to the area from Texas, where he was born and raised. While in Texas, he taught at the University of Houston – Clear Lake, and maintained a private practice which served several populations, especially deaf and hard of hearing clients. Gabe has significant experience in both counseling and forensic testing of both victims and offenders involved in child protection cases in Texas. Recently, he served on an Independent Mental Health Examination team to investigate child abuse in Hawaii. He has numerous scholarly contributions to the field including journal articles, book chapters, and other professional offerings. He is married to New York native Jennifer Freundel-Lomas, and they have two kids, Becca and Jake, and a cat, Adler, together.

**Joan Bender – Board Member**

Joan Bender is a Licensed Mental Health Counselor in New York. She earned her Master's degree in Community Psychology from Sage Graduate School, and is currently enrolled in the Institute for Integrative Nutrition's Certified Health Coach program. Between 2003 and 2012, Joan was the Director of Training and Professional Development at St. Catherine's Center for Children, a multi-service, human service agency in Albany, where she coordinated, conducted and created training workshops to meet the needs of the direct care, clinical and administrative staff. Joan is currently enrolled in the Association for Play Therapy's Leadership Academy and is a 2007 Capital District *40 Under 40* business leadership award winner. Joan's clinical experience includes using a variety of individual, group, family and play therapy modalities with at risk children and families, separated families, and the assessment and treatment of children with fetal alcohol spectrum disorders. Joan's areas of interest include nutrition and mental health, sensory integration, healing from trauma, sand tray therapy, therapist self care and play as a tool for organizational change.

**Jillian Kelly – Board Member**

Jillian Kelly, LMSW is a Mental Health Clinician and Youth Coordinator at Institute for Family Health in Bronx, NY. Utilizing the powers of play, while meeting the demands of an outpatient community mental health setting, Jillian is actively pursuing her RPT credential as well as her Trauma Focused CBT certification. Jillian earned her MSW at Columbia University, where she was a student in the schools of Social Work and Public Health. Jillian's interest in play therapy was cultivated while interning with the Child Life/Play Specialist departments in Dublin, Ireland. It was there that Jillian marveled at the therapeutic powers of play in aiding children's ability to cope with, heal, and smile during incredibly challenging life experience. Jillian is a proud member of the Association for Play Therapy, National Association of Social Workers, Play Therapy International, and Gold Award recipient of Girl Scouts of America. Within her agency, Jillian is part of the School Based Mental Health Committee, Trauma Initiative, and Psychosocial Clinical Management Team. Here's a sweet fact: in her free time, Jillian is a gluten-free/sugar-free/vegan/organic baker for NYC based cafés… an avid "health nut", she is constantly seeking out learning opportunities for integration of nutrition, holistic and mental health treatments.

**Member Submissions**

## WHAT TO DO IN THERAPY WHEN CHILDREN CLAM UP

David A. Crenshaw, Ph.D., ABPP, RPT-S
dcrenshaw@childrenshome.us
www.childtherapytechniques.com

Children for a variety of reasons often "hit a wall" when asked to verbalize their feelings and concerns in therapy whether individual, group, or family therapy. At that point the child becomes anxious and the therapist is challenged to shift gears and find "face saving" and productive ways for them to participate in a meaningful way in the therapy process. Some children may not be able to verbalize due to developmental limitations, others may "shut-down" due to anxiety, anger, fear, resentment, a few may not be able to verbalize due to trauma events or trauma that occurred in the preverbal period. When this wall is hit it is helpful for the child if the therapist has a repertoire of strategies that are not language-dependent such as symbolic play either directive or non-directive, drawing, storytelling, or therapeutic work with symbols.

Children with rare exceptions don't choose to come to therapy, rather they are "brought" or 'sent" by parents who in turn are sometimes pressured to do so by extended family, schools, or courts. The child's experience upon arrival at the therapist's office is often akin to being sent to the "principal's office." Creative methods of engagement are driven by necessity because good therapy doesn't usually take place in the principal's office. The therapist must think out-of-the box for ways to transform the experience for the child and make the context a safe, comfortable, and playful context that gradually allows for trust to build and for the child to unburden. When children reach the outer limits of their ability to express their psychic pain in verbal language as they often do, they are uncanny in their ability to articulately express from the depths of their soul the pain beyond words in the language of play, artistic images or symbols. Just as the poet is said to be able to "create harmony out of chaos", the child becomes the poet who uses not words but creative modes of expression to create harmony out of inner chaos or to make sense of a shattered relational world. The child can do this with a precision that would be the envy of even a Keats, Byron, or a Shelly. Drawing on the work of Allan Schore, play, artistic depiction, and use of symbols is the language of the right hemisphere that is dominant in the first 3 years of life while the left hemisphere doesn't even come on line until about 15 months. Play, drawing, and use of symbols thus permit access to trauma occurring in the preverbal period. Although the writer is best known for his work in developing directive child therapy interventions involving the use of art work, symbolic play, and therapeutic use of symbols, the three case illustrations in this workshop depict the spontaneous use by children of drawings, play, and symbols. A developmentally sequenced approach to child trauma will be the unifying framework for the three clinical case examples. Examples of therapy tools developed by the author are offered on the following pages that engage the child in an active and interactive therapy process when verbal expression reaches a natural limit. I wish to emphasize that these are tools that can be integrated in a wide range of therapy approaches and theoretical models, but they are not the therapy itself, rather they are simply tools.

# THREE DOORS

**©David A. Crenshaw, Ph.D., ABPP**

**Theme:** Therapeutic Exploration of key issues of loss, disappointment, and hopes and dreams for the future

**Recommended Age Range:** Nine to Seventeen

**Treatment Modality:** Individual, Group, and Family Therapy

**Goals:**

1) To offer older children and teens structure that facilitates communication about important losses and disappointments;
2) To facilitate therapeutic communication about what is valuable and worth holding onto from their past;
3) To further therapeutic exchange regarding hopes and dreams for the future;
4) To highlight strengths and resilience.

**Materials**

Paper, Pencil, Markers, Colored Pencils, Crayons

**Description**

The child is asked to imagine what is on the other side of the three doors. The first door is the door to their past that opens to whatever disappointments, losses, or setbacks that they've experienced. These are experiences they may wish to put behind them. The second door opens to the things they want to hold on to from their past. These could be happy memories, relationships, skills, or lessons learned that they value and wish to keep. The third door opens to their hopes and dreams for their future. The child can either describe to the therapist what is behind each door, or write, or draw or to use miniatures to symbolize what is to be found on the other side of each door. The therapeutic value of this activity will rest largely on the ability of the therapist to take what the child or teen expresses and expand on it to create meaningful and heartfelt exchange around issues central to the child's emotional life.

**Discussion**

This therapeutic activity like many others previously described (Crenshaw, 2006; Crenshaw, 2008a; Crenshaw & Mordock, 2005) give children and teens the tools to discuss matters in therapy that are emotionally significant that they may wish to talk about but can't easily initiate the therapeutic conversation. The therapist can, however, structure the therapeutic session by using such activities to enable them to more easily share their inner feelings and in this instance some of their regrets, disappointments, as well as valuable lessons learned from their past, ways that their past hurtful experiences may have strengthened them and their hopes and dreams for the future.

This activity is intended to honor the strengths-based approach and the view that children can gain strength and hardiness from weathering some of the disappointments and setbacks in their past and challenges them to seek out what they would want to hold onto and carry forward from their past. This focus draws on the Solution-Focused approach to therapy as pioneered by Insoo Kim Berg and her colleagues. This activity is informed by the strengths-based, competency approach to therapy (Brooks & Goldstein, 2001; Brooks & Goldstein, 2004; Brooks & Goldstein, 2007; Waters & Lawrence, 1993). Garbarino (2008) observed, "All of us have some capacity to deal with adversity, but some of us have more than others and thus more resilient, whereas others are more vulnerable in difficult times" (p.7). In pursuing the door to the past it is important for clinicians to balance the recognition of and honoring of strengths without in any way minimizing the genuine suffering caused by harsh experiences in life or painful losses (Crenshaw, 2010).

Likewise, clinical sensitivity is required in pursuing the open door that leads to the child's hopes and dreams (Crenshaw, 2008a; Crenshaw, 2008b). Some children because of the adversities they've faced in life keep their expectations low, a way of coping known as the "survival orientation" (Hardy & Laszloffy, 2005). They can't afford "the luxury of hope" (Crenshaw, 2008a; 2008b). While hopes and dreams are vital forces in the lives of children, it can in some cases fortify them for facing tough challenges but is some cases may be regarded as dangerous to their psychological well-being if their hopes and dreams have been crushed too many times. Thus the third door offers insight into a given's child reliance on hope and dreams to sustain them in their quest for a better life or whether they are afraid to entertain hopes and dreams because they can bear further disappointments.

One of the advantages of this strategy is the wide range of choices offered to children and teens from direct verbal expression to drawing, therapeutic writing or even the use of symbols to communicate their inner life.

**References**

Brooks, R. & Goldstein, S. (2001). *Raising resilient children.* New York: McGraw- Hill.

Brooks, R. & Goldstein, S. (2004). *The power of resilience: Achieving balance, confidence, and personal strength in your life.* New York: McGraw-Hill.

Brooks, R. & Goldstein, S. (2007). *Raising a self-disciplined child.* New York: McGraw-Hill.

Crenshaw, D. A. (2008a). *Therapeutic engagement of children and adolescents.* Lanham, MD: Jason Aronson, an imprint of Rowman & Littlefield Publishers.

Crenshaw, D.A. (Ed.). (2008b). *Child and adolescent psychotherapy: Wounded spirits and healing paths.* Lanham, MD: Lexington Books.

Crenshaw, D. A. (ed.) (2010). *Reverence in healing: Honoring strengths without trivializing suffering.* Lanham, MD: Jason Aronson/Rowman & Littlefield.

Garbarino, J. (2008). *Children and the dark side of human experience: Confronting global realities and rethinking child development.* New York: Springer.

Hardy, K. V., & Laszloffy, T. (2005). *Teens who hurt: Clinical interventions to break the cycle of adolescent violence*. New York: Guilford Press.

Waters, D. & Lawrence, E. (1993). *Competence, courage & change: An approach to family therapy.* New York: Norton.



**Heartfelt Feelings Coloring Cards Strategies**
**© David A. Crenshaw**

**Theme:** Feelings Expression
**Recommended Age Range:** Six to twelve for the expressive domain; Nine to twelve for the relational domain
**Treatment Modalities:** Individual, Group, Family
**Goals**

- Teach feelings and vocabulary for identification and expression
- Increase awareness and expression of heartfelt feelings in relation to the key attachment figures in the child's life
- Explore sensitive issues and heartfelt matters with children in a way that is non-threatening and leads to greater disclosure and gradual exposure to the avoided painful material

**Materials**

- The Heartfelt Feelings Coloring Card Strategies (HFCCS) Kit that includes a Clinical Manual and 20 *expressive* and 20 *relational* cards. The kit can be ordered from the Children's Foundation of Astor (http://www.astorservices.org/heartfelt-feelings-manual.php) All proceeds from their sale go to the Children's Foundation. Additional sets of cards can be ordered as needed.
- Crayons, markers, or colored pencils for the child to color the heart, and pencils or pens for the child to write in the card

**Description**

The Heartfelt Feelings Coloring Card Strategies (HFCCS) Kit is a series of strategies that use the potent symbol of the heart shape in therapeutic activities. The strategies are inviting and natural to children (coloring and writing in greeting cards) and can be used in play therapy, child therapy, family therapy, group therapy, and art therapy to facilitate the expression and sharing of heartfelt emotions (Crenshaw, 2007, 2008).

The greeting cards were developed in collaboration with the Coloring Card Company, which makes greeting cards for children created by child artists. The HFCCS has the unique feature of emphasizing two core domains: the *expressive* and the *relational*. In the *Expressive domain* the child is instructed to pick a feeling from a group of 40 emotions in the Clinical Manual. The feelings are arranged from simple such as "sad" to more complex such as "perplexed" — the latter would be appropriate for children at the upper limit of the age range.

The child is then directed to pick a color to go with the feeling. If the child picks blue for sad, for example, she/he will then be asked to color in the heart on the front of the greeting card with the color blue. When finished, the child is instructed to write about a time when her/his heart was filled with sadness on the inside of the card on the lines provided. This gives the child an opportunity to express the heartfelt feeling in the context that produced the feeling. If the child is too young to write, she/he can dictate the response and the practitioner can write it on the inside of the card.

In the *relational* domain the clinical manual contains specific directives for the child that allows for exploration of their social world, for example, "Draw in the heart on the front of the card a person who once was in your heart but no longer is." The *relational* component consists of systematic exploration of the heartfelt feelings in connection with key attachment figures and with important persons in the child's interpersonal world. The *relational* cards have the heart shape on the front of the card but the instructions on the inside of the card are different from the *expressive* cards. Using the example above, the child would be asked on the inside panel of the card to write or dictate a note to the person who was once in their heart but no longer is.

**Discussion**

Many practitioners have used some variation of the heart shape in child, play, art therapy and other creative arts therapies. The *expressive* domain offers structured therapeutic practice in identifying, labeling, and expressing feelings. These are key skills in affect regulation and for developing social competence. Allan Schore (2003a; 2003b), in his groundbreaking work on affect regulation, has demonstrated that affect dysregulation is central to almost all forms of psychopathology. Therapeutic interventions that address this crucial deficit will have wide application across the psychodiagnostic spectrum.

The *relational* domain emphasizes that our most heartfelt emotions do not develop in a vacuum. They develop in an interpersonal context. The social context is critical. Some children get angry at school but not at home. The main value of this therapeutic activity is that it creates an entry point for the child to further explore her/his heartfelt feelings and the interpersonal context that elicits them.

The Clinical Manual also contains a number of variations of the HFCCS for use in bereavement work, supervision, examining countertransference feelings, and highlighting strengths in the child, group, or family therapy.

**References**

Crenshaw, D.A. (2007). *The Heartfelt Feelings Coloring Card Strategies (HFCCS).* Rhinebeck, NY: Children's Foundation of Astor.

Crenshaw, D.A. (2008). *Therapeutic engagement of children and adolescents: Play, symbol, drawing, and storytelling strategies.* Lanham, MD: Jason Aronson.

Schore, A.N. (2003a). *Affect dysregulation and disorders of the self.* New York: Norton.

Schore, A.N. (2003b). *Affect regulation and the repair of the self.* New York: Norton.

# HEART SYMBOL STRATEGIES

**©David A. Crenshaw**

**Theme:** Feelings Expression
**Recommended Age Range**: 6 to 17
**Treatment Modality:** Individual, Group or Family
**Goals**

- To create and expand on a potentially healing therapeutic dialogue about important losses and disappointments in the child's life
- To identify and highlight important interpersonal resources that are critical to a child at a time of emotional crisis

**Materials**

A collection of hearts of a wide variety of shape and colors and materials can be easily obtained at novelty shops. The collection can include plastic, felt, glass and gem stone materials. Children are fascinated by the beauty and variety of the hearts in the collection. The hearts can be placed in a leather-bound and velvet lined jewelry box that adds further mystique and value to the collection as perceived by the children.

**Description**

**The "Velvet-Lined Box of Hearts"**

The child is asked to pick from a collection of hearts in a leather bound and velvet-lined jewelry box a heart that symbolizes someone important whom they miss—someone they don't see at all (a person who died or someone who moved away) or someone they don't see as often as they wish. They can pick more than one heart to represent each of the persons they are missing. On inquiry, the child is asked to tell why they picked that particular heart for each of the persons they are missing, and to talk about that important person who is presently missing from their life.

**The "Circle of Hearts"**

The child is instructed to pick a heart from the velvet-lined box of hearts to represent the self. Then the children are asked to pick a heart for every person that loves them. These hearts are arranged in a circle around the heart they have picked for self. If children are unable to make a full circle of people who love them, they then should be directed to place also in the surrounding circle a heart representing friends, peers or adults who care about them or support them. If they are still unable to complete the circle the children can be asked to pick a heart to represent people who they would like to be able to turn to for love and support.

**Discussion**

The heart symbol has been a potent symbol in cultures around the world throughout the ages. For many, the heart symbolizes love, for others passion, or the emotional center of the person. Among the strategies previously described are the Heartfelt Feelings Strategies (Goodyear-Brown, 2002; Riviere, 2005; Crenshaw, 2008) and the Heartfelt Feelings Coloring Card Strategies (Crenshaw, 2007). The strategies above build on the previous ones by using the heart shape in symbol therapy work.

As with all strategies that are evocative of emotion, sometimes quite powerful emotions, only the clinician working with the child or family or group of children can decide if such a strategy would be appropriate for a given client(s) at a particular time. Obviously, timing and pacing are critical factors in clinical decision making, as well as a thorough understanding of the child's level of functioning at any one point in time, including the ability to tolerate anxiety and emotional distress. The level of external stress in the child's life at the given point of time also needs to be considered. It is impossible to overemphasize the factor that repeatedly has been demonstrated empirically to have the most bearing on psychotherapy outcome, the quality and strength of the therapeutic alliance. The ultimate goal is to expand emotionally meaningful and heart-centered dialogue with the child, family, or group that contributes to the healing process.

**References**
Brown Goodyear, P. (2002). *Digging for buried treasure.* Antioch, TN: Paris Goodyear Brown.
Crenshaw, D.A. (2007). *The Heartfelt Feelings Coloring Card Strategies (HFCCS).* Rhinebeck, NY: Rhinebeck Child & Family Publications
Crenshaw, D. A. (2008). *Therapeutic engagement of children and adolescents: Play, symbol, drawing, and storytelling strategies*. Lanham, MD: Jason Aronson/ Rowman & Littlefield Publishers.
Riviere, S. (2005). Play therapy to engage adolescents. In L. Gallo-Lopez and C. E. Schaefer, (Eds.), *Play therapy with adolescents*, 2nd ed. (pp.121-142). Lanham, MD: Jason Aronson/Rowman & Littlefield.

## The Magic Key
**©David A. Crenshaw**

Therapeutic Engagement of Children and Adolescents: Play, Symbol, Drawing, and Storytelling Strategies (2008) Jason Aronson Publishing
**Theme:** Therapeutic Exploration of Losses
**Recommended Age Range:** Nine to Fourteen
**Treatment Modality:** Individual, Group, and Family Therapy

**Goals:**
1) Verbally identify key issues to address in therapy
2) Increase awareness of losses, particularly unacknowledged or disenfranchised grief
3) Verbally express denied or disconnected feelings about prior losses
4) To expand therapeutic dialogue about the issues that matter most to the child

**Materials**
Paper
Markers
Pencil or Colored Pencils
Crayons

**Description**
Read the following instructions to the child:
Imagine that you have been given a magic key that opens one room in a huge castle. There are four floors in the castle and since the castle is huge there are many rooms on each floor, but your magic key only opens one of the many, many rooms in the castle. Pretend you go from room to room, and from floor to floor, trying your magic key in each door until you finally come to the door that your key opens. You turn the key and the lock opens. Because you have been given a magic key that only opens this door, what you see is the one thing that money can't buy that you always thought would make you happy. Pretend that you are looking into the room. What is it that you see? What is that one thing that has been missing that money can't buy that you always thought would make you happy? When you have a clear picture, please draw it as best you can.

**Discussion**
Projective drawing and storytelling strategies along with therapeutic play and the use of symbols are central to tools used in therapy with children and adolescents (Crenshaw, 2004; 2006; 2008). *The Magic Key* (Crenshaw, 2004, Crenshaw & Mordock, 2005; Crenshaw, 2008), is a projective drawing strategy that was developed to evoke themes of loss, longing, and missing in the lives of children.

In early versions of this strategy, the caveat "that money can't buy" was not included in the directions. It is not surprising in this highly consumer-oriented culture that many children drew a big screen television or the latest video game console. Some children, however, drew a missing or deceased parent, a safe home they never experienced, or a family where the parents don't argue. They drew a home they always longed for, one that sadly was missing in their lives. By adding the qualifier "that money can't buy" the strategy focuses the child on essential emotional needs that have not been met or important losses that the child has suffered rather than the latest electronic gadget or toy.

This projective drawing strategy is especially useful with children whose lives are replete with loss. Many severely aggressive children have suffered profound, multiple losses (Crenshaw & Garbarino, 2007; Crenshaw & Hardy, 2005; Crenshaw & Mordock, 2005). This strategy is one of the ways to access these feelings when children are disconnected from their emotions or have great difficulty verbalizing their painful affect. Issues of timing and pacing, including the readiness of both the child and therapist to undertake emotionally focused work, are critical. Before using this tool readers should review the Play Therapy Decision Grid (Crenshaw and Mordock, 2005) and determine whether the child is appropriate for the Coping or Invitational Track of therapy. This technique should only be used with children judged to be ready for the Invitational Track. Children appropriately assigned to the Invitational Track will be judged to have adequate ego strengths, mature defenses, ability to manage anxiety and the ability to tolerate and contain strong emotion without becoming overwhelmed. The child in the Invitational Track will not show signs of "spillover" from therapy sessions resulting in disruptive anxiety and behavior during or immediately following the session. The name of the Invitational Track is meant to imply that the child is invited to go as far as he or she can at any one point in time in approaching the painful affect or events that need to be faced and resolved.

Tools, such as the *Magic Key,* are meant to expand and enrich the therapeutic dialogue between therapist and child and do not constitute the therapy itself. The therapy process entails much more than the application of tools such as this but they can facilitate meaningful exchange and therapeutic dialogue which can aid the healing process. Whatever drawing the child produces in response to the directions to the *Magic Key* serves as a springboard to elicit more of the child's feelings, wishes, fears, dreams, hopes, and serves to create a portal of entry to the child's inner life.

**References**

Crenshaw, D. A. (2004). *Engaging resistant children in therapy: Projective drawing and storytelling strategies.* Rhinebeck: NY: Rhinebeck Child and Family Center Publications.

Crenshaw, D. A. (2006). *Evocative strategies in child and adolescent psychotherapy*. New York: Jason Aronson (An imprint of Rowland & Littlefield Publishing Co).

Crenshaw, D. A. (2008). *Therapeutic engagement of children and adolescents: Play, symbol, drawing, and storytelling strategies*. New York: Jason Aronson (An imprint of Rowland & Littlefield Publishing Co).

Crenshaw, D. A. & J.B. Mordock (2005). *Handbook of play therapy with aggressive children.* New York: Jason Aronson (An imprint of Rowland & Littlefield Publishing Co).

Crenshaw, D. A. & Garbarino, J. (2007). The hidden dimensions: Profound sorrow and buried human potential in violent youth. *Journal of Humanistic Psychology, 47, 160-174.*

Crenshaw, D.A. & Hardy, K.V. (2005). Understanding and treating the aggression of traumatized children in out-of-home care. In N. Boyd-Webb (Ed.), *Working with traumatized youth in child welfare*, (pp. 171-195). New York: Guilford.

## *The Art of Using Art in Therapy*

**Part 2 (check out our Winter Newsletter for Part 1!)**

By: Jessica Tappan, LMSW

**Intervention:** Rotating Mural
**Age Range:** 11 to 12 +
**Type:** Group
**Materials Needed:** Crayons or Markers and either individual pieces of paper or one extra large sheet
**How To:** Ask everyone in the group to draw on the paper in front of him or her. Next (if using individual pieces of paper) ask the adolescents to rotate the individual pieces of paper to the left OR (if using one large sheet of paper) ask the youth to rotate their seat to the seat to the left. Next have the adolescents add to the drawing that is now in front of them. Continue rotating until the adolescents have added to every person's drawing and are back in front of their original (first) drawing. Start a group discussion about the process.
**Purpose:** This group project allows for discussion around working together to create an image as well as giving up control over the outcome. It is a fun and interactive activity that can help build group cohesion.

**Intervention:** Squiggle Drawing – Projective Drawing
**Age Range:** 7+
**Therapy Type:** Individual
**Materials Needed:** Markers or Crayons or Colored Pencils and Paper
**How To:** Ask child or adolescent to close their eyes or look away while drawing with their non-dominant hand. Use one color for this part of the activity. Have the patient allow the marker, crayon, or pencil to wander aimlessly around the paper creating a squiggle or doodle. Next, ask the child or adolescent to open his or her eyes and to find images within the doodle. Once they find images in the doodle, ask them to use a different color to develop these images (ie: if a child sees what could be a face, ask them to outline the face and add to it). View the doodle from different angles if the child or adolescent struggles to find images within the drawing.
**Purpose:** This projective drawing technique is helpful to use when children or adolescents are silent and do not know what to talk about during the session. This also helps children and adolescents to break away from impersonal drawings and stereotyped forms (butterflies, smiley faces, hearts).

**Intervention:** Strengths Collage
**Age Range:** 10 +
**Type:** Individual
**Materials Needed:** Magazine, Paper, and Glue
**How To:** Have the adolescent choose three positive qualities about him or herself. Ask the child or adolescent to cut out images from a magazine that represents these qualities and to paste them on paper. Begin a conversation about strengths chosen.
**Purpose:** This activity is used to boost self-esteem and explore self-expression. Instead of naming his or her strengths, some adolescents find it easier to identify positive aspects of themselves through photographs found in magazines.

**Intervention:** Guided Imagery
**Age Range:** 7 to 8+
**Type:** Individual
**Materials Needed:** Crayons, Markers or Paint and Paper
**How To:** First, use a series of directives (guided imagery) to help the patient mentally imagine a relaxing and safe place. Next, ask the child or adolescent to draw or create a picture based upon the guided imagery. The child or adolescent can take this picture with him or her to look at when stressed.
**Purpose:** Guided imagery helps induce relaxation and reduce stress. It can help children and adolescents tap into their own internal resources, and teach them a technique to calm themselves when they are stressed.

**Intervention:** Mandala Drawing
**Age Range:** 6 +
**Type:** Individual
**Materials Needed:** Crayons or Markers and Paper with a large circle pre-drawn on it
**How To:** Hand the child or adolescent the paper with a large circle drawn on it. Ask the child or adolescent to fill in the circle with anything he or she wants.
**Purpose:** Mandala drawings allow the child or adolescent to work within a confined space with clear boundaries, which can be both calming and centering. If the patient finds this relaxing, suggest using it as a calming method at home or in class when he or she becomes frustrated.

**Intervention:** Music and Art
**Age Range:** 7 to 8 +
**Type:** Individual or Group
**Materials Needed:** Oil Pastels or Paint, Pre-Cut squares of paper, and an array of music (jazz, classical, pop, rap, country, upbeat, slow tunes etc…)
**How To:** Ask the child or adolescent to create a piece of artwork on each square of paper for each segment of music played. Play a type of music, such as rap, and have the child or adolescent draw or paint colors, images, and line qualities that embody and match the emotional quality of the music you are playing. Repeat with all of the different music types. Discuss each square, making sure to ask about the colors, lines, shapes, images, and feelings each song/type of music elicited. Sometimes it helps to print out artwork off of the Internet first and ask the child or adolescent to match the art to the music you are playing. Once the patient gets the hang of it, ask the patient to create the art by him or herself.
**Purpose:** This gestalt therapy technique helps children and adolescents develop self-expression and emotional expression. It is also a great teaching tool to use with patient's who choose to include "listening to music" on their safety plane. Teach the patient's through their artwork how some songs can help to motivate them, increase energy, or put them in a good mood, while other forms of music can decrease energy and mood. Make sure they are including only upbeat songs in their safety plans.

**Intervention:** Masks (Inside/Outside)
**Age Range:** 12 to 13 +
**Type of therapy:** Individual
**Materials Needed:** Option of Crayons, Markers, or Paint, and a Popsicle Stick, and Poster board
**How To:** Prepare a poster board of a cut out face with the eyes cut out. Glue matching poster board face pieces together, and glue a popsicle stick on the bottom, which will allow the teen to hold up the mask. Give the teen this pre-made mask, and explain that we all have invisible masks that we put on every day. First ask the teen to draw on the outside of the mask, what he or she shows to the world. Next, ask the teen to draw what he or she keeps private from the world on the inside of the mask. Open up dialogue about when it is beneficial to wear this protective mask, and when it is harmful to wear this mask.
**Purpose:** This activity allows adolescents to explore qualities they choose to show others and qualities they hide from the world.

**Intervention:** Past, Present, Future
**Age Range:** 7 to 8+
**Type:** Individual
**Materials Needed:** Crayons, Markers, Colored Pencils, or Magazine and Paper
**How To:** First, ask the child or adolescent to draw three lines vertically down a large piece of paper. Next, have the child or adolescent draw or use magazine cut outs to depict his or her past in the first column, present in the middle column, and future in the last column.
**Purpose:** Use this activity to build hopes and dreams for the future, as well as to help the patient identify changes he or she has made or hopes to make.

**Intervention:** Anger Key
**Age Range:** 7 +
**Type:** Individual
**Materials Needed:** Crayons or Markers and Paper
**How To:** Ask the child or adolescent to draw an outline of a person on a piece of paper. Next, provide psycho-education about the physiological responses to threat (fight, flight, or freeze). Create a "feelings key" and ask the child or adolescent to use colors, line quality, and images to depict where in the body she feels physical "warning signs" that alert her that her anger is increasing. Mark these "warning signs" in the key (ie: A patient may experience shaking hands, and draws jagged red lines on the hands of the person. Under "Key" draw a red jagged line and write = shaky hands).
**Purpose:** This activity helps the patient to connect physiological "warning signs" to anger. Learning his or her body's "warning signs" can help the child or adolescent to identify building anger before the child or adolescent reaches a point where he or she has trouble calming down.

**Intervention:** Circle of Trust
**Age Range:** 7+
**Type:** Individual
**Materials Needed:** Markers or Colored Pencils and Paper
**Purpose:** This activity allows the therapist and the child or adolescent to view a tangible representation of the people who he feels comfortable opening up to and trusting. Some clients include too many people in the inner circle, while others do not place anyone within the circle. Therapists should allow this to guide their future work (especially with trauma survivors) to help the patient set boundaries, prevent over sharing or flooding, or to increase trust in others. Create a second version of the "circle of trust" at the end of treatment and compare the differences between the two.

**References**

Furth, G. and Kubler-Ross, E. (1988). *The Secret World of Drawings: A Jungian Approach to Healing Through Art*. Toronto, Canada: Inner City Books.
Lowenfeld, V. and Brittain, W. (1987). *Creative and Mental Growth (8th Edition)*. New York: MacMillan Publishing Company.
Malcchiodi, C. (2007). The Art Therapy Sourcebook.
Naumburg, M. (1955). Art as symbolic speech. *The Journal of Aesthetics and Art Criticism*, 13(4), 435-450.
Riley, S. (2001). Art therapy with adolescents. *Western Journal of Medicine*, 175(1), 54-57.
Rhyne. J. (1973). *The Gestalt Art Experience*. Belmont, CA: Wadsworth Publishing Company, Inc.
Seiden, D. (20001). *Mind over Matter: The Uses of Materials in Art Education and Therapy*. Chicago: Magnolia Street Publishers.

***What Every Play Therapist Should Know about FASD/ND-PAE***
**Part 2 (check out our Winter Newsletter for Part 1!)**
(Advanced Professional Responses to Prevent, Diagnosis, and Treat Fetal Alcohol Syndrome Disorders (FASD) and Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE)
By: Catherine E. Cwiakala, LMSW, Private practice for parenting counseling and play therapy

**Legislative and Legal Developments:**

S. 2262: Advancing FASD Research, Prevention, and Services Act; 112th Congress, 2011–2012. Text as of Mar 29, 2012 (Introduced).
Advancing FASD Research, Prevention, and Services Act - Amends the Public Health Service Act to revise and extend the Fetal Alcohol Spectrum Disorders (FASD) programs (as renamed under this Act, previously the Fetal Alcohol Syndrome and Fetal Alcohol Effect programs).[37]

American Bar Association
Defending Liberty, Pursuing Justice

**House of Delegates Unanimously Passed The Resolution on FASD - AUGUST 7, 2012**

**RESOLUTION**
RESOLVED, That the American Bar Association urges attorneys and judges, state, local, and specialty bar associations, and law school clinical programs to help identify and respond effectively to Fetal Alcohol Spectrum Disorders (FASD) in children and adults, through training to enhance awareness of FASD and its impact on individuals in the child welfare, juvenile justice, and adult criminal justice systems and the value of collaboration with medical, mental health, and disability experts.

FURTHER RESOLVED, That the American Bar Association urges the passage of laws, and adoption of policies at all levels of government, that acknowledge and treat the effects of prenatal alcohol exposure and better assist individuals with FASD. [38]

**International FASD Awareness Day**, on September 9th of each year.[39]

Play therapists need to collaborate our knowledge, research, and teaching experience of what has helped both those we know have FASD/ND-PAE and those we suspect may have FASD/ND-PAE. There is a crucial need to implement play therapy specifically designed for these children, adolescents and adults.

Together we can give babies and children with FASD/ND-PAE and their families (birth, adoptive and/or foster) the education, protection, resources, services, education, and play therapy they need. Then we will be able to help these precious children, adolescents and adults reach their full potential to have productive and satisfying lives.

Please share your knowledge and expertise! Please send your information to:
Catherine Cwiakala, at ccwiakala@yahoo.com or 118 Edgehill Drive, Wappingers Falls, NY 12590. Thank you!

Due to space limitations the extensive list of all references will not be printed. The reference list is available upon request, by contacting Jillian Kelly at JKelly@Institute2000.org.

***Combining exercise with therapy: an integrated approach to treat both physical and emotional illness***

By: Julia Roth, LMSW

Every day we hear about the epidemic of obesity, especially among children and adolescents. There are numerous articles explaining the consequences of obesity. Physical consequences such as type II diabetes as well as emotional consequences such as depression, low self-esteem, and anxiety are some examples. I'm a social worker for Institute for Family Health, currently placed at a school based health center in East Harlem. Instead of telling kids what they need to do, I have decided instead of just talking about it, to do something about it. There are many studies that state that the intensity of the exercise is not as important as the consistency of the exercise especially for kids that have not been as active. Although we all hear and may know that exercise is good for us, there are specific reasons it helps our mental health. According to the Mayo Clinic, "releasing feel-good brain chemicals that may ease depression (neurotransmitters and endorphins), reducing immune system chemicals that can worsen depression, increasing body temperature, which may have calming effects" (http://www.mayoclinic.com/health/depression-and-exercise/MH00043). For kids and adolescents it can have the added bonus of gaining confidence, relax them if they are feeling anxious or stressed about school, increase social interaction and making friends, and develop positive coping skills. People may understand these benefits, however I have seen that it is a challenge to make exercise a part of daily lifestyle instead of seeing it as a hassle or conflict with other commitments.

Since I see many children that suffer from anxiety, depression, difficulty concentrating on their academics, on top of being overweight or obese, I have decided to use our therapy time to tackle both physical and emotional issues. I have started this intervention with two clients. Both are female, 9 years old, and have a medical diagnosis of obesity. Both students come from a lower socio-economic community and attend the same school. Although I see the students for different reasons, both have had difficulty focusing, have difficulty in academics, and are diagnosed of adjustment disorder with anxiety. I see both students once a week for 30-40 minutes. Interventions I have used so far include play therapy, collaboration with family and teachers, cognitive behavioral therapy, motivational interviewing, and problem solving therapy. I have seen progress - evidenced by both students expressing their feelings in a developmentally appropriate manner, developing positive coping skills, as well as identifying goals and objectives for behavior, expressing feelings and academic goals. However there continues to be one issue that I have yet to see major progress in -- their weight and medical health. Starting about one month ago, I initiated my therapeutic sessions with both of these clients by walking laps inside (due to weather) in the school. I challenged each student to add 1 additional lap each week. I have expressed the possibility of walking outside when the weather becomes more accommodating. A quality improvement project I will shortly be starting correlates decrease in anxiety and depression as evident by a depression or anxiety screening (i.e. CES-DC for depression and SCARED for anxiety) or by using a Likert scale (i.e. asking them on a scale of 1-5 or 1-10 how they are feeling), with their medical diagnosis. If possible, I would like to have the client evaluated by the medical provider every month to see if their physical health has improved as well. Collaboration with the client's family is an important factor in this intervention, since I will be able to walk with these clients once a week, however to make a true difference, this needs to become part of their lifestyle and not only during therapy.

What I hope to show is that exercise can be easy, fun and a little increase weekly can make a big improvement both with physical health and emotional well-being. As a society we talk about obesity and health and although improvements have been made. Let's focus on one child at a time, and hopefully small steps can make a huge difference.

## Communications Corner

NYAPT Communications works on connections to members, social networking, the newsletter, soliciting discussions and interactions, and sharing information with members. If you are interested in partaking in these activities, contact Jillian Kelly at JKelly@Institute2000.org.

Check out our website at: http://www.newyorkapt.info/
Check out the Association for Play Therapy at: http://www.a4pt.org/

Like us on Facebook: New York Association for Play Therapy (NYAPT)
Or link to: http://www.facebook.com/pages/New-York-Association-for-Play-Therapy-NYAPT/188037501208101

Follow us on Twitter: @NYA4PT
Or link to: http://twitter.com/#!/NYA4PT

Connect to us on Linked In: NY APT
Or link to: http://www.linkedin.com/pub/ny-apt/2a/14b/520

*…and remember that April is Child Abuse prevention month!*