A publication of the Canadian Association for Play Therapy (CAPT)

Playground

Fall/Winter 2021

Trauma-Informed Virtual Reality Play

Integrating Neuro-experiential Interventions with Sandtray for Trauma Treatment

Trauma Literature Review

Recognizing, Assessing and Working with Dissociation in Children and Youth

CAPT Foundation Play Therapy Training 2022

Training will be presented on-line in one or two-day trainings with individual instructors over a period of six weeks. Each day offers 6 educational units toward the 180 educational units required for Foundation Play Therapy Training for Certification as a Play Therapist.

Live On-line Instructor Lead Individual Full Days of Training for 2022

May 9 – 20, 2022

- Introduction to Play Therapy
- Play Therapy History, Models and Process (2 days)
- Ethical Practice in a Play Therapy Setting
- Assessment & Treatment Planning in a Play Therapy Context
- Attachment Theory and Therapy in a Play Therapy Setting
- Non-Directive Play Therapy and Filial Therapy (2 days)
- Theraplay as a Play Therapy Model
- Family Play Therapy

June 13 – 24, 2022

- Sandtray Therapy (2 days)
- Brain Research and Child Development in a Play Therapy Setting
- Understanding Traumatized Children and Applying Play Therapy Tools in the Treatment of Trauma in Children (2 days)
- Treating Disruptive Behaviour Problems in a Play Therapy Setting (2 days)
- Creating an Inclusive and Culturally Competent Play Therapy Practice
- Storytelling in a Play Therapy Session
- Understanding and Treating Anxious Children

August 1 – 12, 2022

- Play Therapy with Abused Children (2 days)
  Day 1: Physical and Emotional Abuse
  Day 2: Sexual Abuse
- Puppetry in a Play Therapy Setting
- Play Therapy with Adults
- Group Therapy
- Play Therapy for Children and Families Coping with Loss (2 days)
- Case Application
- Art Therapy in a Play Therapy Setting
- Vicarious Trauma and Self Care in a Play Therapy Environment

Please Note: All classes will be held weekdays, Monday to Friday.

For Details on Dates, Registration, Training Outlines and Learning Outcomes go to:
https://cacpt.com/foundation-play-therapy-training

For further information on becoming certified as a Play Therapist, please visit our Education webpage under **Education and Certification** at: **www.canadianplaytherapy.com** or call **905-686-3372**

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Playground

Canadian Association for Play Therapy

Contents

Thanks to the Playground committee for this edition of our magazine.

A special thanks goes to Katie Bauer for her keen editorial skills.

Message from the President

Dear Members,

This edition of Playground magazine is focussed on trauma and trauma treatment. With the support of Elizabeth and Kip Sharpe, Tracy Blyth and your volunteer and hardworking Board of Directors we have weathered another difficult year during a world pandemic. As a healing community we acknowledge the presence of intergenerational trauma with the formation of our Diversity and Inclusion Committee. We have attempted to provide inclusive training that will support the learning of therapists in all corners of Canada.

We acknowledge (with the presence of racism against BIPOC citizens/ therapists and the national acknowledgement of unmarked, undocumented burial sites of Indigenous children at residential schools), that our country has a long way to work towards healing. Consequently, your Playground committee wanted to create a Playground issue that is focussed not only on trauma but the resiliency approaches that mark our commitment to survival and healing. In this spirit, I have permission to share the following written by the Wisdom of Trauma.com team in a companion document (2021) that accompanied Gabor Mate's recently released movie: the Wisdom of Trauma.

The Canadian Association for Play Therapy also believes that we should work together towards a more inclusive world and a trauma-informed society where:

- We recognize the prevalence of trauma among all of us
- We learn to notice and feel the trauma symptoms in ourselves
- We acknowledge that whenever there is a reaction, there is an old wound
- We understand the imprint of trauma on our behaviors and its impact on our relationships
- We recognize the pain in others and understand how that pain might be driving their behavior
- We see the real person underneath the behavior and the trauma
- We support connection and compassion as the foundations of safety
- We know that the experience of safety is the beginning of healing
- We understand that all trauma is intergenerational

We invite all CAPT members to stand with us to create societal changes beginning in our playrooms, homes, and communities. We can be the change we want to see (Mahatma Gandhi).

With love

Theresa Fraser
President of the Canadian Association for Play Therapy

Update from your Executive Director

Fall 2021,

Members across Canada have gone above and beyond to support the mental health needs of children and families over the past months. We have witnessed ultimate sacrifice and commitment to the Mission and Vision of CAPT and I am so proud of my connection with such professionalism.

We are all aware that this next phase of opening our communities after COVID will bring many more unexpected challenges. CAPT is committed to continuing its support to members in timely training, upgraded services, advocacy, and communications for CAPT.

Internally, upgrades to our learning management systems will enhance your ability to work on-line more quickly and efficiently. There are changes being made to registration services to support this that will be explained over the next few months. In the immediate future and into 2022, all training will be offered on-line. Kip Sharpe will continue to support this system change and training support over the upcoming year.

In September, your Board of Directors will meet for a full day, facilitated, strategic planning session to examine the current state of CAPT. From there the Board will determine its expectations and outcomes for the next five years of operations of the association. The 2021 Strategic Plan will be posted on-line for you to review when this exercise has been completed in late fall.

As I move to my last few months in the role of your Executive Director, I am grateful for your support, kindness, and encouragement over the past fifteen years. On December 15th I will pass the baton to Tracy Blyth, CAE to move CAPT forward. Tracy has worked over the past year as our Operations Manager and is well prepared for her next role in providing leadership and advocacy support for play therapy and play therapists across Canada.

I will stay in touch over the next few months as we engage our new strategy.

Wishing you the very best in your work and good health for you and your families.

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

Recognizing, Assessing and Working with Dissociation in Children and Youth

Billie-Jo Bennett MSW RSW, CPT, Certified EMDR therapist and Consultant

Interest in trauma focused and informed care in clinical professions has grown since 2000 (Marich, 2021). Despite the fact that complexly traumatized individuals make up high percentages of caseloads in child welfare settings as well as clinical mental-health settings, professional training lacks much needed attention to understanding and working with post-traumatic responses including dissociation (Courtois, Ford, & Briere, 2015; Marich, 2021).

Additionally, many training programs only briefly touch on symptoms of dissociation even when teaching about the Diagnostic and Statistical Manual of Mental Disorders (DSM), and suggest that dissociative disorders including dissociative identity disorder (DID) are extremely rare (Marich, 2021). Among clinicians trained in recognizing and treating dissociation and dissociative disorders, it is recognized that the percentage of persons with dissociative symptomatology and dissociative disorders is much higher than is published in mainstream textbooks.

For reasons including those identified above, the concept of dissociative disorders in children and adolescents is unfamiliar, even for some working with complexly traumatized populations, despite the fact that dissociative disorders typically develop in childhood. Children who experience dissociation and develop dissociative disorders often have peculiar and difficult behaviors that can be easily misdiagnosed. Currently there is no specific DSM IV diagnostic classification for dissociative disorders in children and adolescents, just as there is no specific diagnosis for childhood trauma (European Society for Trauma and Dissociation, UK Network, n.d.). Accurate screening, assessment and recognition of dissociation and dissociative disorders in children allows for thorough treatment planning, symptom reduction and healing, rather than exacerbation of symptoms and increasingly difficult behavior worsening over time as happens when dissociation goes unrecognized. Indeed, dissociation and dissociative disorders is a hidden epidemic (Steinberg and Schnall, 2001).

Dissociation is an adaptive trauma response

Dissociation is a learned defense (Gil, 2017), and a standard response to trauma (Steinberg et al., 2001). Mild to moderate experiences of dissociation are as common as anxiety and depression (Steinberg et al., 2001). After the danger has passed, dissociation may continue to be used in maladaptive ways, leaving the person disconnected in situations of ordinary life, and

under extreme and repetitive situations including severe chronic trauma such as physical, sexual and or neglect, a dissociative disorder may develop (Marich, 2021). The formation of complex trauma and dissociation in the human psyche can develop at different times in the lifespan. However, it is very often a result of exposure to severe stressors that occur at developmentally sensitive times in the victim's life where the trauma exposure is repetitive, prolonged, and involves harm, betrayal, abandonment by caregivers or adults responsible for care (Courtois, Ford, van der Kolk & Herman 2009).

Although the pathways to dissociation are not entirely understood, there is consensus in the literature that attachment insecurity and disorganization are precursors to the development of dissociation. Liotti (2006) proposed a model of dissociation based on decades of research and attachment theory, and concluded that infant attachment disorganization is in itself a dissociative process, and pathological dissociation begins in infancy with disorganized attachment as a precursor. Liotti (2006) identified the emergence of dissociative symptoms resulting from the collapse of early defensive strategies when the attachment system is activated.

Dissociative symptomology is on a continuum

Dissociation comes from a Latin root word meaning to separate or sever (Definition of Dissociation | Dictionary. Com, 2021). As human beings we have the inherent capacity and tendency to separate oneself from the present moment as an adaptive capacity to protect ourselves. Many theories recognize a dissociative continuum. PTSD and mild symptoms of dissociation are on one end of the continuum. Typical and normal dissociation may include zoning out, escaping into television, video games or other fantasy constructs. Complex PTSD and Dissociative Disorder Not Otherwise Specified (DDNOS) is in the mid range, and Dissociative Identity Disorder (DID), formerly known as multiple personality disorder, is on the far end of the dissociative disorders. The further along the continuum, the greater the likelihood that aspects or parts of self may be separated or severed (Marich, 2021). All humans have different parts or aspects of themselves (Marich, 2021); however, with clinically significant dissociation these separations are more pronounced and can include amnesia and lack of co-consciousness between parts (Waters, 2016).

Dissociative responses warrant serious clinical attention

Dissociative responses in children and youth are expected and common trauma symptomatology, and warrant significant clinical attention and understanding (Silberg, 2021). Dissociative experiences can be extremely frightening to those who experience them. Dissociative symptoms can include things like not having control over your body, not being able to hear or see things, and hearing voices, to name a few. Without discussion or screening, clients don't typically report such symptoms. This is especially true for children who may think that everyone has these experiences.

Children and youth with pathological dissociation have convoluted presentations which can easily be misdiagnosed for more widely popular and well known diagnoses such as ADHD, bipolar, psychoses, conduct disorder, and oppositional defiant disorder (Waters,). Dissociative symptoms are often overlooked and misunderstood due to the fact they can suddenly appear and then disappear quickly, or may only appear when triggered or activated (Waters, 2016).

Core dissociative symptoms in children and adolescents

In addition to the daydreaming or staring off and glazed look that comes with dissociation, the following symptoms are typical in varying degrees in complex trauma and moderate to severe dissociative disorders:

1. Amnesia

Traumatized children often have significant memory problems. They may be amnesiac for events or people. They may remember fragments or spotty sensory distortions such as tunnel vision or only hearing parts of a traumatic event. Inconsistent memory and amnesia for disruptive behavior often results in children with dissociation being called liars or manipulative (Putnam, 1997, Waters, 2016).

2. Trance states

Children who are chronically abused can develop habitual patterns of trance behavior and altered states of consciousness with mild stressors. In more severe forms of dissociation, there is the presence of self-states, sometimes identified as imaginary friends, distinguished from the normal experience of imaginary friends that some children have. Children with self-states may express intense affect and conflict that are quite distressing to the child, and may present as auditory and visual hallucinations (Putnam, 1997, Waters, 2016).

3. Extreme mood and behavior switches (Identity confusion)

Rapid switching of self-states presents externally as rapid and extreme fluctuations in mood and behavior, and can easily be misdiagnosed as oppositional or bipolar. These switches can be seemingly unprovoked and go

from calm to aggressive or displaying infantile regressed behavior (European Society for Trauma and Dissociation, UK Network, n.d.). Self-states can demonstrate discrepant and varying food preferences, dress, toys, activities, and confusing sudden somatic complaints such as headaches, stomachaches, and painful extremities (Putnam, 1997, Waters, 2016). Additionally, children may exhibit inconsistent performance of abilities such as being able to do math one day and not being able to do it the next (European Society for Trauma and Dissociation, UK Network, n.d.), may speak in different voices, and act like different people from moment to moment (Lyons, 2020).

4. Auditory and visual hallucinations

Children with dissociative disorders frequently experience the presence of voices coming from within that can be antagonistic, helpful, friendly, or destructive. They will typically only report this if asked (Waters, 2016). Sometimes children report these as voices that tell them to do things (Waters, 2016). Children with dissociative disorders also frequently experience images of floating objects, figures, faces or shadows (Waters, 2016). An important part of treatment is to demystify these hallucinations and help children recognize that these parts hold feelings the child could not handle at the time of the trauma (Waters, 2016).

5. Depersonalization and de-realization

De-realization is a sense of unreality or unfamiliarity with the environment, and can include distortions of space and time (Steinberg et al., 2001), feeling like everything is unreal or dreamlike, and feeling as if others are like robots or not real (Lyons, 2020). Depersonalization is the phenomenon of detachment of consciousness, affect and the body, and feelings of unfamiliarity with the self (Steinberg et al., 2001), and may feel like the person is floating away, like their body belongs to someone else, and having out of body experiences.

Assessing Dissociation

The International Society for the Study of Trauma and Dissociation provides guidelines for assessing for dissociative symptomatology in children and youth (Silberg, 2000), which includes screening and clinical interviews. Dissociation screening tools are available online for free along with scoring guides. It is recommended the clinician seek appropriate consultation as needed. The Child Dissociative Checklist (CDC) (Putnam, 1997) is an observer rated screen with both reliability and validity, and is given to parents of children aged 5-12 early in treatment. The Children's Dissociative Experiences scale (CDES) for ages 7-12, and the Adolescent Dissociative Experiences scale (ADES) for ages 13-17, was adapted from the Dissociative Experiences Scale designed for adults by Bernstein & Putnam (1986). These screens are self-report measures, designed to obtain information about the child or adolescent's own internal experiences of dissociation and provide a plethora of information. Structured diagnostic interviews that inquire about dissociative experiences allow for clients to articulate experiences they may have had trouble putting into words (Putnam, 1997). Screening for dissociation gives a broad clinical picture of the child and supports a thorough case conceptualization and treatment plan. It also gives voice to the internal experiences the child may have as a result of their trauma. Psycho education about dissociation normalizes the experiences, and supports healing for the client as they can then learn to recognize when and why the adaptive defense of dissociation is showing up. We are then able to treat the symptoms of dissociation, a prerequisite for trauma work.

Helping professionals, teachers, play therapists, and clinicians working with trauma have an ethical responsibility to recognize and work with all post-traumatic symptomatology including dissociation. Children are vulnerable and rely on adults and systems to protect them. If helpers and systems are not trauma informed or aware of the common symptoms of dissociation and dissociative disorders, it makes it incredibly difficult for those victims to be heard. Children speak through their actions and behavior. Anyone working with complex trauma needs to learn to listen to the language of dissociation, and bring a voice to the symptoms so that children and youth can heal.

Tips for working with Dissociation in the Play Room

Dissociation may show up spontaneously in play therapy sessions as a symptom of post-traumatic play. Gil (2017) recommends tracking where the episodes occur in the play, how long they last, and how the dissociative episode is broken. In addition to using screening tools and psychoeducation for client, Lyons (2020) identifies the following tips for working with dissociation:

1) Use eye contact and a calm low slow voice.
2) Call their name and remind them they are safe and of where they are.
3) Use simple grounding questions like asking them what they can see hear and smell.
4) Use a potent smell or turn on some music.
5) Give them something to eat or drink.
6) Get them to move their body by standing up, tossing a cushion back and forth.

About the author

Billie-Jo Bennett, MSW RSW, CPT is a social worker, certified play therapist, qualifying CAPT supervisor, EMDR clinician and EMDRIA Approved Consultant in private practice in Cambridge Ontario. She specializes in the integration of play therapy and EMDR for simple and complex trauma as well as dissociative disorders. billie@healingwingstherapy.ca 226-475-1224

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ANNOUNCING

CAPT Research Award for Active Research in Play Therapy

PURPOSE: The mission of CAPT is to promote the value of play, play therapy and Certified Play Therapists in Canada.

CAPT will award one research grant of $1,000 to a project involving current research in the area of play and play therapy for 2022. The Award is approved by an Ethics Board. Applications must be received by CAPT no later than November 19, 2021 and the study or a report of the study is to be completed and submitted by September 1, 2022. A decision regarding grant applications will be made by the Research Committee by December 30, 2021.

For information and an Application Form please contact:
Elizabeth A. Sharpe, Executive Director
elizabeth@cacpt.com.

Submit inquiries to:
Dr. Nancy Riedel Bowers CPT-S
Chair of the CAPT Research Committee
nrbowers@aol.com

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Upcoming Workshops

Courageous Conversations in Play Therapy

This is a two-day course that introduces understanding the importance of diversity and equity within clinical practice with children and adults in play therapy.

The course examines the impact of race, gender, and sex identity upon children and adults, and how those experiences can influence their emotional-social development and needs.

Through awareness of the agents of socialization, participants will explore bias, microaggressions, and cognitive discourse that influence those individuals with multiple identities.

The course will close with providing clinical implications and recommendations for work with clients.

September 24 & 25, 2021
9:00 – 3:30 EST

Mobile Play Therapy: Techniques for Providing Play Therapy in Alternative Settings

This one-day course will teach Play Therapy practitioners how to provide Play Therapy in various settings, including schools, homes, and other locations outside the traditional office space. Considerations such as coordinating with professionals in different settings, ethical issues, adapting Play Therapy techniques to different settings, how to select toys and prepare your own mobile toy kit will be discussed.

October 23, 2021
9:00 – 3:30 EST

For more information and to register for any workshop please go to: https://cacpt.com/workshops/

Playing with Gender in the Play Therapy Space or Supporting Gender Inquiry in Play Therapy

This two-day certificate will engage participants in a journey of self-reflection investigating how their play therapy practice supports gender inquiry and curiosity for children, youth and families.

Participants will engage in a bias survey, hear from a trans adult about their service experiences, review their forms and spaces from the lens of inclusion and engage in play experiences that support gender discovery and identity. World Association for Trans Health standards will be reviewed and discussed in relation to applicability to the field of Play Therapy.

November 13 & 14, 2021
9:00 – 3:30 EST

CONTEST

Win a Sand Tray!

With each workshop registration you will receive one ballot for a draw to win a sand tray from Sand Trays Etc.

The winner will be announced in our newsletter after the final workshop in November.

Integrating Neuro-experiential Interventions with Sandtray for Trauma Treatment

By Theresa Fraser CYC-P, CPT-S, RP, MA, RCT

Sandtray is a well-known form of play therapy that utilizes miniatures, sand, water, and a container known as a sandtray. The placement of miniatures in the sand was first published by Dr. Margaret Lowenfeld who described her method as the World Technique and was later adapted by Dr. Dora Kalff who called her method Sandplay Therapy. Others, such as Dr. Gisela De Domenico, adapted the approach and named it Sandtray-Worldplay(c).

The commonality of these approaches include the tools used and the invitation to the builder to create a world using any of the tools that are provided. Builders are often instructed that if there is something that they need and can't locate, to let the therapist or witness know so the item can be found or created with materials such as fabric or play dough.

Sandtray is utilized with children, teens, adults, couples, groups, and families. Recent publications also identify its effectiveness with older adults (Fraser, 2021, Suri, 2012, Siampani, 2013). Sandtray is utilized as a form of communication where words are not necessary to access implicit memories since miniatures become symbols of experiences. Sandtray can be helpful in creating the safe distance and physical boundaries often needed in the face of emotional pain. At times the trauma experience is challenging in that the builder cannot use words to share (Webber et al., 2008). Therapists who train in this method often pair training with supervised practice from an external supervisor who has long-standing expertise in this method. Currently, there is no certification program for Sandtray Therapy except for individual theoretical certifications (WASTP, 2021).

There is growing awareness of the efficacy of EMDR (Rapid eye movement and desensitization) therapy in trauma treatment created by Dr. Francine Shapiro in 1987. Using this approach, the therapist follows an eight-phase protocol that supports the client to process the symptoms that occur because of trauma experiences and other negative or challenging experiences that have overwhelmed the brain's natural ability to heal. The healing process is addressed using bilateral stimulation (Riddle, 2021). Training is protocoled and pre-approved by EMDRIA; a certified EMDR therapist is also required to obtain well documented supervision (twenty hours) from an EMDR consultant. This supervision is paired with a minimum of fifty clinical sessions where the protocol has been practiced. To maintain the credential, EMDR Certified Therapists must complete twelve hours of continuing education in EMDR every two years (EMDRIA, 2021).

Brainspotting was discovered by Dr. David Grand in 2003. Using a wand, the therapist "locates points in the client's visual field that help to access unprocessed trauma in the subcortical brain" (Brainspotting, 2021).

Therapists can begin using this approach after attending a minimum of three days of training but can seek support for certification with six hours of consultation from a certified Brainspotting consultant and documented fifty hours of clinical practice as well as completion of Level II (Brainspotting, 2021).

Both EMDR (Menon et al., 2010) and Brainspotting have an immediate effect on decreasing post traumatic symptoms (Grand, 2013, Corrigan et al., 2015). Little has been written of the integration of sandtray with Brainspotting whereas much more has been published about EMDR being integrated with play therapy approaches (McGuinness, 2011, Beckley-Forest, 2016, Banbury, 2016, Gomez, 2012, Sullivan & Thompson, 2016,). Brainspotting is based on the belief that "where you look affects how you feel" (Grand, 2021). The Brainspotting therapist is

> *"attuning to the client's neurobiology by noticing at which eye positions the client manifests increased, sustained reflective activity (outside window), locating with the client eye positions where the client feels it the most (inside window) and noticing where the client spontaneously identifies where they gaze, when talking about their emotional material (gazespotting)" (Corrigan, Grand, 2013, p. 760).*

Gazespotting is a specific technique utilized in Brainspotting. It is easily integrated with the Sandtray-Worldplay. The eight phases of Sandtray-Worldplay include:

1. Introduction to the medium
2. Free and spontaneous playing/building
3. Builder experiencing phase
4. Client-therapist joint experiencing phase
5. Reflecting
6. Photographing
7. Sacred Undoing (De Domenico, 2002, p. 152)
8. Therapist reflective, recovery phase (De Domenico, 2002, p. 152)

After the builder experiencing phase, where the builder creates their world and has had the opportunity to share the story of what has shown up, the witness (therapist) is then able to ask specific questions about the world. This is the client-therapist joint experiencing phase. At this time, the builder can be invited to gaze at a part of the world using a Brainspotting technique. For example, by staring at a spot near or behind the therapist and/or the world, this can assist the builder to connect the current experience felt in their body with a previous experience. The therapist can then inquire what thoughts or feelings may be coming up now that the builder has focussed on this material in a different or new way. They also could ask the builder what their subjective units of distress level also known as SUDS is (Wolpe, 1969).

Dennise Rathbone who is an UKCP accredited psychotherapist & Certified Brainspotting Practitioner reports that she uses both sandtray and Brainspotting, sometimes integratively and sometimes following each other in subsequent sessions. She has shared:,

> *"one interesting thing I've found is that when a client uses a phrase or word and perhaps says "That's not a phrase I'd usually use", it's almost as though something has slipped out from under the radar of their usual protective mechanism. I'm always very curious about this, as though something of them has slipped out and wants to be known, to tell you it's story" (personal communication, D. Rathbone, 2021).*

Interestingly, the same dynamic often happens in sandtray. The world that shows up can be something that wants to be known and a story is shared (perhaps only in the moment). This can be an example of implicit memory becoming explicit.

For example, Paulina experienced a robbery in her home when she and her family were out for dinner. She subsequently experienced nightmares, panic attacks and had difficulty sleeping. She contracted to have a security company install a full security system but identified that she was starting to feel that she didn't want to leave the house. After engaging in Brainspotting, Paulina was able to connect that the robbery precipitated feelings of powerlessness. These same feelings were first felt as a child when Paulina's family became homeless after a fire. After Brainspotting, she was able to build a sandtray where the child had a home, food, a telephone, and caring adults who could take care of the children.

Pauline's next brainspotting experience included utilizing a resource spot (Grand, 2021).

This spot was found by Pauline after looking around the office and finding a spot that was reassuring to her. After processing the feelings that came up, she subsequently created a world with the identified resiliency factors that she noted has previously helped her manage events that she could affirm were outside of her control.

Gabor Maté defines trauma as:

> *"a psychic wound that hardens you psychologically and then interferes with your ability to grow and develop. It pains you and now you are acting out of pain. It induces fear and now you are acting out of fear. Trauma isn't what happened to you, it is what happens inside of you as a result of what happens to you. Trauma is that scarring that makes you less flexible, more rigid, less feeling and more defended" (thewisdomoftrauma.com.pg. 1).*

Trauma interventions address this scarring and are successful when the therapist (within the attunement of the relationship) can assist the person to be in the present instead of perpetuating old survival patterns of the past. The integration of somatic intervention as described, can empower the individual to release the traumatic material that renders therapy more effective than cognitive therapy alone (Wisdom of trauma, 2021). The combination of touching the sand and harnessing the power of the brain is a combination that warrants further research to support clinical efficacy in the treatment of trauma.

About the author

Theresa is Canadian Play Therapy supervisor located in Nova Scotia Canada. In addition to her play therapy certification, she has specialized training in sandtray, EMDR and Brain spotting. In 2009 the National Institute for Trauma and Loss named her Trauma Clinician of the Year.

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Trauma-Informed Virtual Reality Play Therapy

By Jessica Stone Ph.D., RPT-S

Therapeutic Virtual Reality (tVR) (Lamb & Etopio, 2019) has become a personal passion over the last decade. Beyond the "cool" and "wow" factors of virtual reality lies an immersive, customizable tool with an ever-growing assortment of available options. By definition, virtual reality encompasses the senses, the body, and the mind. The user's mind and body perceives a reality of existence in the environment. If we sit with that for a moment, the impact and implications are innumerous.

As clinicians we can choose and/or create environments which support and propel treatment goals forward, based on case conceptualization. As clients, tVR allows for interaction, creation, exploration, and expression of different roles, environments, approaches, coping skills and styles, and so much more. tVR can be used with a wide variety of populations; this includes different age ranges, cultures, presenting concerns, environments, and diagnoses.

One of the most complex therapeutic presentations for a play therapist includes a person or family system who has experienced trauma (Goodyear Brown, 2019; Gil, 2010; Mellenthin, 2019). Although there are some commonalities for people who have experienced trauma, it becomes more complex as we investigate the impacts on the person, the family, the systems, intergenerational histories, culture, race, developmental levels of everyone involved, whether or not there have been multiple traumas, or even multiple layers to single trauma, and so much more. The client typically presents in pain and is exhibiting a plethora of ensuing symptoms, subtle and/or overt. The play therapist works to create a safe space, a solid rapport, mechanisms for abreaction and catharsis, and ultimately healing which allows the client to move from a place of pain to one of meaningful growth, whatever that might mean for the client/family/system.

This article describes the integration of these two powerful concepts: trauma-informed play therapy with therapeutic virtual reality. A proposed acronym of TIVRPT will be used throughout for ease of communication. With virtually endless possibilities and options, using TIVRPT with clients who have experienced trauma can be a powerful way for the play therapist to provide the environment, connection, and creativity needed to move through the play therapy work. The Digital Play Therapist TM has the power of highly motivating therapeutic creation and immersion in their hands (Stone, 2020).

Trauma

Trauma; vulnerability, fear, pain, loss, grief, injustice. There are many types, many experiences, and many repercussions of traumatic experiences. These experiences can be singular (an awful event), a series of traumas which become exponential, and/or intergenerational trauma with fears, beliefs, and messages passed down through generations with the intention of keeping one safe.

> *Psychological trauma is an affiliation of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning.*
>
> *Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life. Unlike commonplace misfortunes, traumatic events generally involve threats to life or bodily integrity, or a close personal encounter with violence and death. They confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe. (Herman, 1992, p. 33)*

In a chapter within the Handbook of Play Therapy, 2nd edition, author Charles Edwin Myers reminds us that children are relational beings who learn about themselves and the world around them through significant relationships. The connections we make, break, and lose drastically affect future connections. Myers continues to relay that "One of the most serious aspects of interpersonal trauma is the damage it can do to children's and adolescents' desire to form and maintain such relationships. Furthermore, interpersonal trauma can have a pervasive and long-lasting impact on children's neurological development because their brains are still developing." (Myers, 2016, p. 418; van der Kolk, 2005). This only emphasizes the importance of providing environments in which trauma can be processed, one of which is TIVRPT.

Trauma-Informed

A trauma-informed therapist conceptualizes the client, client history, information from within the session, information from collateral contacts, and familial history with a lens that realizes, recognizes, and responds to the need to "address the consequences of trauma and to facilitate healing" (McGregor, 2015, para. 3). Six principles have been identified within a trauma-informed approach:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues (para. 4).

The Trauma-Informed Play Therapist

As play therapists, we are in positions of great importance. We work to provide an environment in which we can enter a client's world and sit with the trauma: hear it – or not, feel it- or not, witness their experience – or not. The client has had experiences which create a ripple effect throughout their existence, their perception of themselves in the world, their worth, how relationships function, and so much more. The play therapist respects the client's process.

Play therapy trauma-specific interventions should include the following components:

1. Respect and connection regarding the client, their needs, their timeline, and their process. In play therapy, this includes the activation of numerous Therapeutic Powers of Play core agents of change (Schaefer & Drewes, 2014).
2. A recognition of the relationship between the trauma and any ensuing manifestations of behavior which will most likely appear both in session and in their day-to-day existence.
3. A highly motivating play activity which speaks the client's language (Stone, 2020).
4. Recognition and inclusion of the systems involved in the trauma and/or recovery process, whether that be conceptual inclusion (understanding the impacts of and on the system) and/or actual inclusion (family therapy, or some other configuration of participants as deemed appropriate).
5. Meets the needs of the client for experiences of respect, connection, creativity, abreaction, catharsis, empowerment/mastery, safety, control, tools to regulate and re-regulate, and a solid foundation from which to move forward.

Virtual Reality

Virtual reality (VR) includes a 360-degree view of video footage with real-world content, computer generated content, or a combination of both to create and provide fully immersive experiences (Stone, 2021; Irvine, 2017). Computers and headset hardware are used to "eliminate the traditional separation between user and machine, providing more direct and intuitive interaction with information" (Bricken & Byrne, 1993, p. 200; Stone, 2021). Built-in sensors "track the body, head, and hand movements in ways that reflect natural movements, allowing for a sense of immersion and congruency" (Stone, 2020; 2021, p. 97; Maples-Keller, et al., 2017).

The use of tVR opens a new world of wonder and possibilities. The client can now either choose or create an environment desired for healing in any of the stages listed above. One of the complicating components of therapeutic communication is the depiction of that which is imagined. Some people have phenomenal abilities to convey and create that which they picture in their mind or have experienced, but most do not. Communication typically involves the process of relaying information from one person's mind, to the other's (Bar-Zeev, 2017). This has been an age-old therapeutic process; the client speaks, shows, creates, relays, acts-out, etc., the information to be communicated. The therapist pictures, observes, imagines, etc., the content being communicated. The therapist and client may or may not be experiencing the same depiction. They may or may not be accurate; may or may not be what is needed therapeutically. It is what we have had for centuries; the proverbial game of telephone (the story is altered as it is passed from listener to listener).

With the advent and advancements of virtual reality (and other digital tools), the translation of this information has a "much higher bandwidth conduit than any existing language" (Bar-Zeev, 2017, para. 25). Meaning, the feedback loop between the participants is greatly enhanced. Adapted from Bar-Zeev's steps, the feedback loop when using VR includes the following :

1. A person imagines or thinks of something,
2. They express the something using some type of medium/program/environment,
3. The computer renders, or shows, the creation which the therapist and client observe and/or interact with,
4. This world or scene, etc., is depicted in ways the other person can directly perceive and a more precise interaction can ensue.

Communication via TIVRPT is a way of translating the client's experience, imaginings, etc., into a more precise (to the client's intentions) depiction of emotions, experiences, dynamics, and more.

Clinicians in the forefront of tVR have researched and demonstrated powerful results with concerns such as: PTSD, phobias, anxiety, depression, and depression (Rizzo & Shilling, 2017; McMahon, 2019; Maples-Keller, et al., 2017). Approaches have included a variety of envisioning exercises, role-playing, and cathartic and abreactive experiences. Many programs used in TIVRPT are "off-the-shelf" or readily available for the consumer. Programs such as the Virtual Sandtray®© App – Virtual Reality are created for use within therapeutic sessions.

Case Example

Marissa is a 13 year old who presented with symptoms of interpersonal trauma. Much work was done to identify what safe felt and looked like for her. Traditional play therapy methods were not fruitful, so TIVRPT was employed. Through the program NatureTreks, Marissa was able to identify an area within a meadow that she recognized as safe. She used the available orbs to place rocks, trees, and flowers around the spot where she stood. She then laid on the floor and fell asleep. This client was an extremely hypervigilant young person who created a space within tVR where she felt safe enough to fall asleep. This was incredible. It really spoke to the power of the immersion and the environment she could identify and create. After waking her, she and the therapist identified the components of the safe area: colors, sensations, sounds, etc., and worked to identify how she could recreate this environment in her home. She was able to do so and sent photos to the therapist. TIVRPT provided the environment, control, creativity, and connection she needed to feel safe and identify what that meant to her.

Conclusion

The well-rounded play therapist is one who incorporates the client's needs into the case conceptualization, treatment goals, and interventions. Allowing the client to move through the stages needed to process their trauma(s) in ways that are motivating and speak their language, will result in powerful therapeutic transformations. TIVRPT is one remarkable way to include these aspects within your play therapy practice.

*It is important to note that the use of any new tool introduced or utilized within a play therapy session should be used by a clinician who has worked toward achieving the 5 Cs of Digital Play Therapy: comfort, competence, culture, congruence, and capability (Stone, in press).

These are achieved through education, experience, and supervision. Ethically, the play therapist must be familiar enough with the modality and/or interventions, that the therapeutic components can be recognized and utilized. Each program used should be vetted by the therapist first (if introduced by the therapist) or explored further with the therapeutic powers of play in mind after a client introduces a program. All of the ethical guidelines for one's country, province, and licensing and regulatory boards should be researched and adhered to.

About the Author

Dr. Jessica Stone is a speaker, supervisor, psychologist, and registered play therapist. A stalwart advocate for the use of digital technology in the field of psychology, Dr. Stone strives to be an innovator and ambassador of play.

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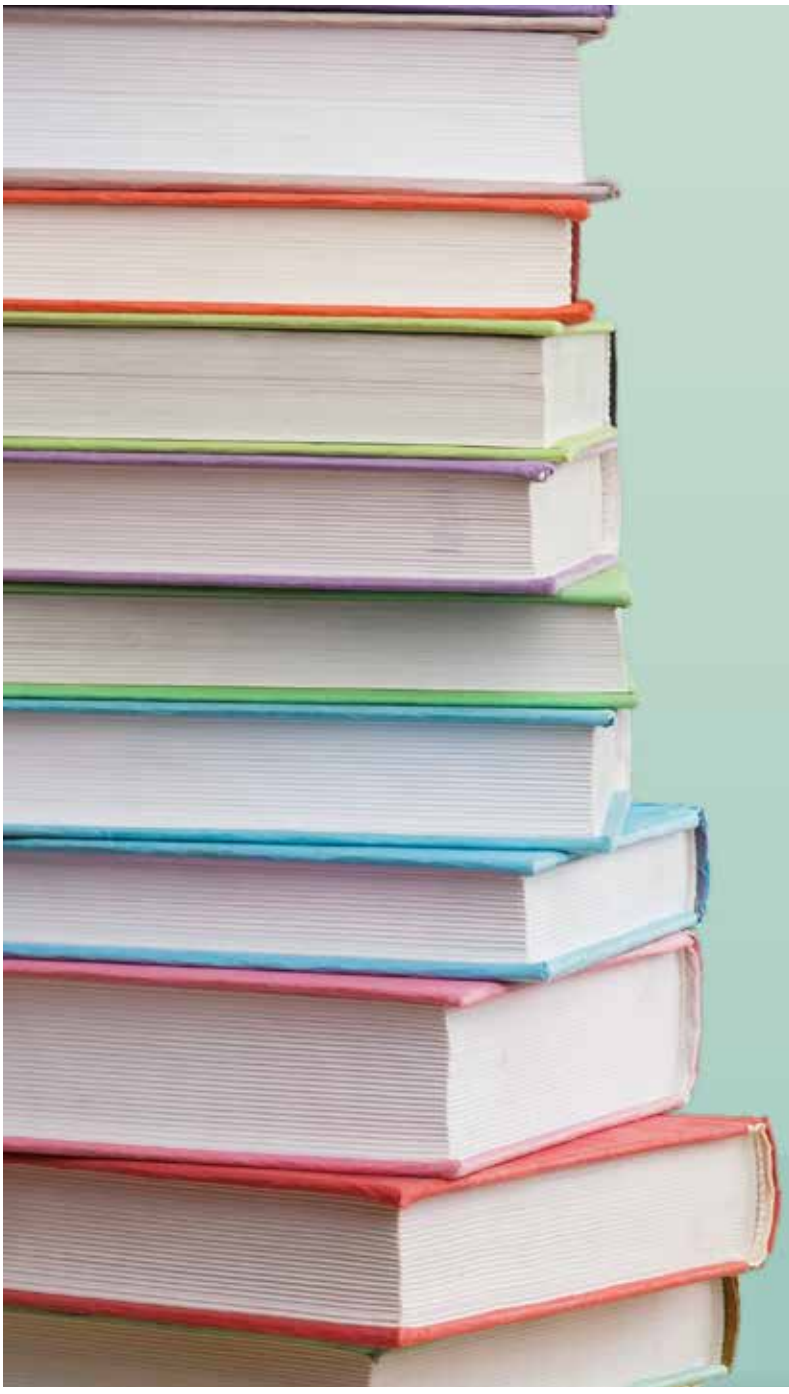

Trauma Literature Review from CACPT Playground Fall/Winter 2015, 2016 and 2017

By Chantal Piercy and Ricky McIntyre, MSW, RSW, BSW

Introduction

As we learn more about the brain and the development of children, we start to understand more why children act the way they do. Since children often lack the insight and language skills to explain to us how they feel, we can rely on their language, play, to begin to see into their worlds. One of the most common themes that we observe in our playroom is trauma. We wanted to create a review of past articles written by members of the Canadian Association for Child Play Therapy (CACPT) to help us synthesize the brilliant work of our colleagues. The purpose of this article is to address three important aspects of play therapy with traumatized children to help us guide our interventions. First, we want to understand trauma and how it shows up in play. We then look at strategies to help families heal after trauma has occurred. We also show how play therapy and Theraplay can be used with the First Nations community.

What is trauma and how does it show up in play?

Trauma presents itself in different ways in children's lives. Children mostly show signs of trauma when they have experienced a loss in their safety (Hotson, 2016). This can be triggered by grief and loss, direct abuse, or indirect abuse, e.g., exposure to domestic violence. It can also be defined as a loss of the child's control over their life or body (van de Ven, 2015). Play can be a powerful tool to help children deal with traumatic loss and grief. Through play, a child can understand and accept the loss in his life and come to terms with his grief (van de Ven, 2015). Children can also learn to verbalize or express their feelings in different areas of their lives, such as school, community, and home (Koblitz, 2017). Expressing these feelings can help the adults in the child's life to understand how the child views their world. To some adults in the life of the child, trauma can often present as a form of aggression. Children dealing with trauma can sometimes be physically aggressive with their loved ones and their toys, and this aggression can be exhibited throughout the themes of their play sessions (Hotson, 2016). For some children, trauma is expressed as anxiety or refusal of tasks (ibid). Their play becomes unfocused, chaotic, messy, and centered around dark themes such as death and people getting hurt.

We can teach children to regulate and create safety with different elements from our own therapeutic toolbox, from building blocks to different sized balls, puppets, and sand tray, but also dollhouses, art materials, drama, and story cards. (Fraser, 2015; Fraser, 2016; Hotson, 2016). By using these tools, we can create activities that will make the child comfortable and safe enough to share their story with us. Activities that can teach children to understand their feelings include bibliotherapy, art, puppets etc. Non-directive work such as letting the child tell a story with dolls and a dollhouse or in a sand tray. (Hotson, 2016).

However, a key element that we have as a play therapist, that sets us apart from other professionals, is our ability to create a relationship with the child. We create a safe and permissive environment by participating in the child's play (Saldanha, 2015). This helps the child to build a unique relationship with the therapist. It also lets the child make decisions to focus on themselves and not the problem. The goal of therapeutic intervention is to let the child create a sense of accomplishment and mastery (van de Ven, 2015). These goals can be accomplished via various mediums such as directive work.

How can we use Theraplay to support families in reconnecting after trauma?

Theraplay posits four key dimensions: structure, engagement, nurture, and challenge (Booth and Jernberg, 2010; as cited in Klein, Johnson & Hughes-Bise, 2017). Theraplay practice is thoroughly focused through an attachment theory lens, homing in on the child's emotional and social needs (Sutherland, 2017). Theraplay seeks to generate trusting bonds between child and caregiver through playful interactions (Crowe, 2016). It involves directive play-based interventions and games that build healthy attachment (Sutherland, 2017). When carried out through the parent/caregiver-child dyad, the duo can experience joyful moment-to-moment experiences through attunement. These experiences fuse new positive neural pathways in the brain of the child client, which reinforce the notion that the world is a safe place where their needs are met. This alternative schema then replaces previous schemas generated through trauma responses, allowing the relationship to heal, repair and consequently thrive.

Theraplay can be used as an effective cross-cultural intervention within the First Nations community. The therapist must be cognizant of the complex web of trauma and acknowledge the genocide which has occurred within this community. Sutherland (2017) works with indigenous children, some of whom are being brought up by foster carers or their grandparents. Sutherland (2017) uses Theraplay to help repair relationship ruptures that inevitably occur through misunderstandings within the cross-cultural foster parent-child dyad and as a tool to bridge the connection between grandparents and their grandchildren from the First Nations community.

Sutherland (2017) conveys that many grandparents, from indigenous backgrounds, profess the profound meaning that the sessions hold for them, due to the lack of play within their own childhood. Sutherland (2017) often uses indigenous symbols and/or games within her Theraplay practice and reports that although this is not necessary, it can be a valuable tool.

Theraplay activities are based in the creative right brain, therefore transcending cultural and language barriers, and providing a medium to facilitate social and emotional connection.

Theraplay is conducted in a positive, holistic light, working on all aspects of the relationship, including social, emotional, intellectual, and spiritual, as is the case with use of the medicine wheel (Sutherland, 2017). The foundation of Theraplay encourages open discussion where clients feel safe enough to exhibit vulnerability and speak freely (Sutherland, 2017). Theraplay, which is typically a short-term intervention (Klein, Johnson & Hughes-Bise, 2017), can take many years in First Nations communities, but it is important and can allow healing and growth within familial relationships (Sutherland, 2017). Theraplay produces a strong therapeutic foundation from which trauma and loss can be explored, brought into awareness, and processed within the safe holding environment (Sutherland, 2017). A key postulate of Theraplay is that everyone has the ability to heal and form healthy bonds (Booth & Jernberg, 2010; as cited in Klein, Johnson & Hughes-Bise, 2017).

Ideas on how to practice play therapy through a multicultural inclusive lens using the example of the First Nations community

With recent discoveries related to residential schools, we are now more aware of some of the challenges that complexify the cases of children of First Nation communities. Intergenerational trauma has had a significant impact on First Nations communities; this results in higher rates of children in care, domestic violence, abuse, neglect, mental health, and physical health issues, compared to the rest of the Canadian population (Koblitz, 2017; Hyder, 2017; Sutherland, 2017). But how can we use play therapy in a way that is more culturally appropriate for our First Nation clients?

One of the most important tools that we can easily use in our interventions is the medicine wheel. By balancing all four directions: east, south, west, and north, we can create balance and healing opportunities for the child's mind (Koblitz, 2017; Sutherland, 2017). In the east, we can observe the child's spiritual well-being. This can include their origins, roots, self-esteem, culture, religion. The south looks at their mental health, development, attachment, diagnosis. The west focuses on their emotional well-being such as naming, regulating, and expressing emotions. The north looks at the child's physical well-being such as physical health, self-care, and diet (Koblitz, 2017). By looking at this framework, a lot of the activities that we already know and use can be adapted to help create balance in the four directions. As mentioned by Sutherland (2017), "the essence of the relationship, not the activity, is always at the forefront. It's not so much what we do, but who we become when we are together" (p.13).

An important element of our therapy with First Nation clients is their connection with nature. Children tend to connect more with symbols and toys that represent nature (Hyder, 2017). A great way to connect with children of First Nations is with animals. First Nations communities believe that every animal possesses their own unique skills and strengths (Hyder, 2017). By asking a child which animal represents their spirit animal, we can easily connect with the child and start to access their view of the world. Children can gain comfort and connect well with animals. They teach children to develop empathy towards each other's needs, they learn to speak about emotions, self-control, and affection (ibid). By ensuring that we include various symbols we can create an environment that helps the child develop a sense of control while allowing them freedom to express chaos through non-directive play therapy (Koblitz, 2017).

Conclusion

Play therapy and Theraplay can be efficacious in helping children heal after suffering trauma. Play is the language of children which transcends all barriers. Play therapy creates a safe space for children to express big feelings through play mediums within the play therapy tool kit. The play is often shrouded in metaphor therefore shielding the child from any damaging content but allowing for integration. Theraplay allows for healthy attachment and bonding, creating joyful moments between children and family members. These moments surpass the trauma experienced to generate positive attachment schemas. A key tenet of Theraplay is the belief that everyone has the ability to heal from trauma and it is touching to know that as a play therapist, we can be part of this journey.

About the Authors

Chantal Piercy is a Therapeutic Play Practitioner currently practicing child centered play therapy (CCPT) at Alice House in Halifax, Nova Scotia, a second stage domestic violence charity. She also provides therapeutic group programming for children and youth; outreach prevention education; alongside parenting support. Chantal initially undertook teacher training in the UK in 2003 and predominantly worked as a Special Needs Teacher before commencing her Masters in Play Therapy in the UK in 2016. She is currently enrolled in a Masters program in Counselling and Psychology with Yorkville University, Canada.

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CAPT DIVERSITY AND INCLUSION COMMITTEE NEWS

By Helena Kogas

When we think of Diversity and Inclusion, a variety of emotions and questions come up in one's mind. How do we, as a collective, work to create spaces that are inclusive and anti-oppressive and put lasting motions into effect?

In 2020, CAPT struck a Diversity and Inclusion committee that is comprised of both CAPT Board of Directors members and association members. The current committee members are: Donna Starling, Whitney McGeary-Khunte, Chenoa LaCaille, Kevin St. Louis and Helena Kogas.

Our committee is determined to create meaningful and genuine policies that will create and maintain change. To begin the conversation with our larger community we asked all CAPT members who attended our 2021 Annual General Meeting to share their ideas about how CAPT could communicate that Diversity and Inclusion is a strong value to our association and members. These ideas are noted below:

Play for everyone, anywhere, anytime EXPLORING CULTURAL LEARNINGS TO CELEBRATE HUMAN DIVERSITY Playing our way to understanding and celebrating each other Playing together with unique differences PLAYING OUR WAY THROUGH A JOURNEY OF DIVERSITY Playing our way to diversity and inclusion Leading the way through play and diversity You can't have play without diversity Playing our way through a journey of diversity PLAYING OUR WAY…DESTINATION DIVERSITY Playing our way to diversity and inclusion Come play with us Playing together with difference and uniqueness We talked about using something like the slogan…"leave no child behind" The Power of Play Therapy is that it Empowers All! Our story has meaning when we play together EVERYONE IS WELCOME TO PLAY IN OUR SANDBOX Our sandbox is stronger when we play together Our story has strength when we play together Creating meaning together PLAY AND EDUCATION FOR EVERYONE We stand in wonder and gratitude for the diverse creativity and curiosity that emerges in play Play for everyone

2020 has taught us a great deal. We have weathered an onslaught of defeating news almost around every corner.

- Global Pandemic
- The murder of George Floyd
- Food insecurities
- Massive political unrest
- Social Isolation
- Residential school horrors
- Financial Instability

These events are forcing us to take a hard look at ourselves and re-evaluate our values. We are examining what needs to change to address structural racism especially among white settlers. We are also faced with a great deal of questions.

Where do I start? Where do WE start? How can I be an ally? What can WE specifically do to support change?

It begins with education

Students in Canadian schools have not been taught accurate history of systemic racism. So, we first need to become educated on oppressive experiences of the past but also situations that are current. We need to ensure that everyone becomes educated so we can identify how to heal. For example, if you haven't had the chance to take the course Indigenous Canada, please do so right away. This course is offered by Coursera though created by the University of Alberta and is free, thanks to the kind support of Canadian Actor Daniel Levy.

The Future

We are committed to create a Diversity and Inclusion committee that is purposeful, educated, effective and representative of BIPOC communities. We invite you to share with us any strategies or tools that you have found useful in your journey. Our hope is that healing happens in ourselves as well as those communities we are privileged to work in.

Healing Spaces

Healing Spaces is an ongoing article in Playground. If you would like your therapy playroom to be featured please contact Theresa Fraser at theresaannfraser@gmail.com.

This edition of Healing Spaces is happy to focus on Josefina Martinez, a Chilean Clinical Psychologist. Josefina is the co-founder of Metafora, a play therapy center located in Santiago Chile.

Translation and editing provided by Urvashi Sirohi Joseph, MA, MSW, RSW. Urvashi is a Certifying Play Therapist in Mississauga, Ontario. She has a private practice offering services in English as well as Hindi, Urdu, Punjabi and is the Manager of Clinical Programs at Catholic Family Services Peel Dufferin.

1. Tell us a little bit about yourself. How long have you been practicing Play Therapy?

I have been practicing as a Child Psychotherapist since 1994. In those days there was no formal training in Play Therapy in Chile. My practice was mainly intuitive and based on all the reading material I could find on the subject. In 2003, I met my colleagues Elena Sepúlveda and Rossana Culaciati, and together we founded Metafora, a Play Therapy center located in Santiago, Chile. Today, Metafora has expanded to a team of ten Clinical Psychologists interested in the subject of Child and Play Psychotherapy.

At the beginning, my colleagues and I travelled to other countries, seeking training with authors whose books had impressed us. Throughout the years we have continued to travel to different trainings and have also invited several authors to Chile to continue our training. We invited Lorri Yasenik and Ken Gardner to Chile and later the entire Metafora team visited the Rocky Mountain Play Therapy Institute in Calgary, Canada.

2. What drew you to the field of Play Therapy?

When I was faced with the challenge of practicing Child Psychotherapy, I found it was impossible to apply with children, the traditional psychotherapy model which relies on verbal exchange. However, beyond technical issues, it seemed to me that play therapy was a developmentally sensitive, friendly, and above all, a respectful way of working with children. In Metafora, we adhere to a form of work that focuses on children's rights. We feel that Play Therapy, more than verbal therapy, allows children a way of being in therapy more in accordance with the way they have of being in the world.

3. What is your primary theoretical orientation and how did you evolve into that orientation?

My original approach was Systemic, and after receiving my degree as a psychologist I trained as a Family Therapist. However, in those days Family Therapy tended to exclude children from the sessions and prioritized working with the adult members of the system. Play was incorporated only so that the children would be entertained and not get in the way of the "grown-ups" talking. Fortunately, Family Therapy evolved, but the frustration of this exclusion of children led me to explore other ways of working. Today, I can say that an integrative approach in Play Therapy makes sense to me, and I find myself trying to adapt my way of working to the consulting child rather than forcing the child to fit my theoretical model. The Systemic approach still makes a lot of sense to me, as it takes into account the context and is a relational model.

4. What is your Play Therapy environment like?

I have always felt that the door to the playroom is

actually a portal, and that by passing through it, child and therapist enter a world that is ruled by laws somewhat different from what happens outside those boundaries. I like to think of the therapy room more as a workshop than as an office, and as a place where children can experiment, make, create, and where they can search to find themselves. For this, the playroom must be a free space offering possibilities, but at the same time, safe and containing. I am fortunate to have a large space, which allows freedom of movement and different types of play (motor, artistic, dramatic, symbolic). Although there are many objects and toys in my room, everything is ruled by the motto "a place for everything and everything in its place". This allows it to be a structuring space that is at the same time predictable, recognizable, and easy for the children to handle. The idea is for each child to take ownership of the space, to feel it as "their therapy room", and to use it in the way they need. Therefore, in its arrangement, what matters most to me is that it conveys the message "children are welcome here, this is a space for you".

5. What is your favourite technique or play material and why?

Undoubtedly, my favorite is the Sandtray and my love affair with it is evident by the place that the shelves with miniatures occupy in my playroom. Working in the Sandtray has the magic of creation, of what emerges spontaneously without passing much through our consciousness. This allows children to externalize and miniaturize their intimate processes, even those they do not know about themselves or those that cannot yet be named, so that they can then manage them and give them an order. It is almost like the process allows children to build a bridge to their therapist so that they can communicate, creating an inter subjective space or a shared experience.

However, I ensure that my passion for the Sandtray does not become an imposition on children. I love it when children allow themselves to freely use the elements in the playroom in a creative way. For example, the miniatures sometimes end up inside the dollhouse or the puppets inside the sand tray. For us, at Metafora,

there are no rigid limits between one Play Therapy technique and another. Although, it is important for us to learn each technique in depth, we know that in practice the intermodal wins and the child who comes to consult takes what is useful and uses it in a new and creative way.

6. What was your Play Therapy training and supervision like and what do you recommend to new Play Therapists about it?

My training as a Play Therapist has been very experiential, which has allowed me to deepen my understanding of the effect and potential of this way of working. I would recommend considering training as a gradual process, which never really ends. For me, it would be quite boring and unrealistic to feel that I have learned everything. It seems to me that one part, which by the way I like very much, is the studying (reading and attending courses). But I think the most important part is the consolidation of learning and the integration of new knowledge and, in this, supervision plays a central role. I can say that I have learned a lot in each of the trainings I have attended; some of them have been transformative. I think, without a doubt, my greatest source of learning has always been children, who always challenge and question the knowledge I thought I have achieved so far.

7. What challenges did the current pandemic bring to your Play Therapy practice? What innovations came out of it?

For a person as technologically unskilled as I was, the challenges that the pandemic imposed on my clinical practice were paramount. My biggest challenge was to achieve online play psychotherapy and to really manage to play therapeutically with children THROUGH the screen or ON the screen. And I say this because video calls are understood as a conversation and usually rely on the verbal. The fact of sitting face to face, with a screen in between, tends to induce a passive posture in both interlocutors and, therefore, I look for ways to transform online attention into a play experience.

In a country like ours, where a significant proportion of the population lacks the opportunity to access the internet or have access to equipment such as cell phones or computers, the biggest challenge was to find ways to maintain the connection with the consulting children during the long months of confinement. Here we must acknowledge the thousands of professionals throughout Chile who sought creative ways to make the impossible possible.

8. What do you envision your practice will be like in the next 10-15 years? Will you be doing the same thing or something different?

In 10 or 15 years, I will be older and maybe I will have less energy.... but I will for sure have more experience and wisdom. So, I see myself passing on my knowledge and experience to the new generations. I want to continue learning much more about the fascinating world of Play Therapy, and I would love to know more about corporeality and play. I think we Clinical Psychologists get fascinated with symbolic play and its projective value, sometimes neglecting other forms of play, such as physical play, to which we often give less value. That is my next challenge. Never stop learning! And never stop playing!

9. Any words of wisdom that you might want to share with other Play Therapists?

Never lose the curiosity to look at children and respect their way of being in the world. Never cease to be surprised by their resources, their innate wisdom, their flexibility, and their great capacity for resilience. In other words: follow the child, follow the Child, follow the child!

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The 2021 Monica Herbert Award

Elizabeth Sharpe CAE and Kip Sharpe B.Sc.

The following speech was given by past CAPT president Lori Walton about the 2021 Monica Herbert award winners Elizabeth and Kip Sharpe.

Every year our wonderful organization calls for nominations for those who have contributed to the world of Child Play Therapy.

This award was developed from the inspiration shown by Monica Herbert, who demonstrated courage, devotion, hard work and commitment to working with children and helping families.

Monica used her skills to help many children and showed an interest in working with clients with autism. Her future included Certification as a Child Psychotherapist and Play Therapist with the Canadian Association for Child and Play Therapy, completion of her education and the continuation of a private therapy practice with children.

The establishment of The Monica Herbert Award allows us to recognize and appreciate the accomplishments and contributions Monica made to her family and the children she worked with.

This annual award works to recognize outstanding achievements in or contributions to the field of play therapy. The recipients chosen have made a significant impact on CAPT through dedication, competence and exceptional performance, as demonstrated by one or more of the following categories:

- Outstanding clinical work using play therapy
- Research related to play therapy through a book, article, or paper;
- Community or Committee work supporting CAPT by furthering the field of play therapy;
- Make exceptional contributions to the lives of children

It is our honour this year that we presented this distinguished award to two very deserving candidates Elizabeth Sharpe, CAE, Executive Director, CAPT and Kip Sharpe, Training and Operations, CAPT. I met them quite some time ago, back in 2008, when I was just starting my first year as President of CAPT. Our board was given the mission to help our organization expand its work Nationally across Canada. Our beloved play therapy membership was growing and we needed to find a team that would help us manage, grow and support the office side of running this expanding association.

Our board at the time was unsure of how to tackle this task, but we put our heads together and we researched a variety of association management teams who we invited to be interviewed for the position. After meeting several of them during a very long day in the city of Toronto, we felt like it was an impossibility. None of those teams were a good fit for the vision we had nor were they financially unattainable. I can remember the day well, it was cold, gloomy and we were feeling defeated. We had one more interview to go – and that interview changed our associations life! I can remember walking into the room and meeting Elizabeth and Kip and within minutes felt a connection of hope and inspiration. They were organized, energized and ready to hear our vision of CACPT.

It didn't take us long to make the decision to hire them. During my 6-year Presidency, I had the pleasure of working closely with them – I learned so much from them regarding association management and growth and was inspired by their passion, commitment, loyalty and willingness to learn as much as they could about Child Psychotherapy.

Their commitment to our Play Therapy community across Canada was and continues to be inspirational. Through their vision and guidance, I can honestly say they have furthered the field of Play Therapy and have helped CAPT become what it is today!

Elizabeth and Kip, we want to thank you for everything you have done for us. We will miss you but we are excited to see you plan for your retirement and wish you wonderful blessings and good wishes as you embark on this new phase of your lives.

Congratulations Elizabeth and Kip. …. This Award is well deserved and your contribution to CAPT and its members, will never be forgotten.

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