Blending Play Therapy with Cognitive Behavioral Therapy

Evidence-Based and Other Effective Treatments and Techniques

Edited by Athena A. Drewes

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She is Secretary for the Child and Adolescent Special Interest Group of Division 56 Trauma of the American Psychological Association. She is on the editorial board for *Training and Education in Professional Psychology*, and the *International Journal of Play Therapy*. Drewes has written and lectured extensively about play therapy nationally and internationally. She is co-editor and chapter author of *School-Based Play Therapy* (Drewes, Carey, & Schaefer, 2001), *Cultural Issues in Play Therapy* (Gil & Drewes, 2005), and *Supervision Can be Playful: Play-Based Techniques for Child and Play Therapist Supervisors* (Drewes & Mullen, 2008).

She is also on the Disaster Mental Health Leadership Team of the Red Cross in Greater New York, and a member of the Disaster Response Network of the New York State Psychological Association. She has worked for over 25 year across all settings with children and adolescents, specializing in treatment involving sexual abuse, trauma, attachment disorder, foster care children, supervision, and play therapy in the schools.

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Preface

THIS BOOK IS borne out necessity and from over 25 years of professional clinical experience with children and adolescents. My career began after obtaining my master's degree in clinical psychology from New York University. I was employed by the Jewish Board of Family and Children's Services (then known as the Jewish Board of Guardians, Inc.) and worked at the Child Development Center testing and treating latency age children. Eva Landauer was my supervisor and mentor in psychodynamic play therapy. She had been trained by Anna Freud. It was there, at JBG, that my passion for play therapy began and I saw how potent it was to use play *as* therapy, with children using metaphor and play while not saying one word in the session. I was witness to children who made gains, blossomed, and interacted over time through symbolic play.

After five years at JBFCS, I moved to Orange County, New York, with my husband to start a family. My work shifted to being a play therapist at an outpatient clinic, and I worked with a wide variety of ages and problems, but most notably sexually abused children who were living in foster care. The field of sexual abuse was relatively new, and the work often felt like we were improvising and flying by the seat of our pants. We were all struggling for ways to engage the children and find skills that would work with every child in treatment. In time I worked in a special education preschool doing play therapy and parent and teacher consultation, and I also worked a few years in regular education as a school psychologist. As the need for a license loomed by New York State mandates, I returned for a doctorate at Pace University in New York City. Its combined school and child clinical program was the best of both worlds in allowing me to get clinical practicum placements. My clinical internship was at the Astor Home for Children in Rhinebeck, NY, a large, multiservice, nonprofit mental health agency that had an APA-accredited program with a strong play therapy component.

I was fortunate enough to be hired upon completion of the internship and have remained there since, more than 16 years. I worked for 10 years

as a clinical coordinator and senior psychologist in the Residential Treatment Center in Rhinebeck seeing children from 5 to 13 years of age whose presenting problems were predominantly the result of sexual abuse and attachment disorder, along with a dysfunctional family.

It was at that point that I saw how traditional child-led therapy was not productive with some of the sexually abused children I worked with. Our work became stagnant. If I did not talk about sexual abuse, they were more than happy to avoid talking about it too. Their play avoided the topic and gave no insights. We were at a stalemate, and I had no tools with which to move the treatment forward. Having discovered the Association for Play Therapy in 1992, I attended a workshop by Beverly James, author of *Treating the Traumatized Child*. She introduced the idea of a developmentally sequenced treatment approach and the need to be directive using play therapy materials and play-based techniques. This was the piece that was missing in my work. Applying her techniques and others learned through attendance at the Association for Play Therapy conferences and workshops with the leading play therapists, an integrated treatment style developed. I realized that in order to work with severely abused and traumatized children, who also had attachment deficits, I needed to become flexible in moving between child-led and directive approaches. I needed to become a prescriptive therapist. I needed to apply the best practices, evidence-informed treatment with this child, at this time, for this symptom.

No longer could it be one size fits all in my treatment of trauma. I needed to use play *in* therapy as well as play *as* therapy. This thinking went against other play therapists who believed, and still believe, that child-led treatment is the only way to work with children. They believed it was the only form of play therapy. I believe you need both: not only child-led, nondirective work with children, but also for some children you need to be directive, and at times you need to do both within the same session. And moreover, I believe you need to bring in cognitive behavioral therapy to help deal with affect regulation, self-esteem issues, problem-solving, and coping and social skills deficits, among other things. Attachment issues often were beneath the severe abuse issues both in the Residential Treatment Center and with the children I see in Astor's Therapeutic Foster Care program.

It was at this point that I realized that the worlds of play therapy and cognitive behavioral therapy can blend together very well. Susan Knell's book *Cognitive Behavioral Play Therapy* confirmed what I had felt intuitively. With the advance of credentialing bodies dictating and mandating the use of evidence-based treatments with the children and adolescents seen at Astor, as an agency, we needed to show that what we