evidence-based clinical practices, practitioners are encouraged to find ways to incorporate research strategies into their clinical practices. A few therapies have been the objects of such study, and their effectiveness has been demonstrated (e.g., CBT techniques; see Chapter Five), while other methods have not yet gathered sufficient scientific support. It's important to note that validation of one technique does not automatically invalidate others. Traditionally, psychotherapists have utilized strategies that are well grounded in theory and that appear to have positive results for their clients. Strategies that either include or exclude families have been utilized by child therapists. In addition, contemporary child therapists value an interactive role with children's larger systems, especially schools.

Clinicians in private practice may not have the ability (or willingness) to construct research projects that validate their work, but they often utilize goal attainment scaling (Justice & Justice, 1979) or other methods of defining, reviewing, and achieving their stated goals. Meeting stated goals might also demonstrate the effectiveness of diverse approaches. It is important to note that several studies of therapy's effectiveness in general point to clients' perception of therapists' warmth; that is, clients seem to make progress when they like and feel liked by their therapists (Miller, Duncan, & Hubble, 1997).

CBT approaches are currently at the forefront of empirically based treatment. However, it's important to note that the literature in the field of child sexual abuse repeatedly emphasizes that children have difficulty articulating their abuse or addressing it directly. In addition to children's natural resistance to talking about the abuse due to shame, guilt, fear, or lack of awareness that abuse is inappropriate, evidence also suggests that trauma memories are imbedded in the right hemisphere of the brain, and thus that interventions facilitating access to and activity in the right side of the brain may be indicated. The right hemisphere of the brain is most receptive to nonverbal strategies that utilize symbolic language, creativity, and pretend play. Thus art, play, sand, and other expressive therapies may be necessary components of trauma treatment.

It is also clear that no two abused or traumatized children are alike, and that there is no rigid, unvarying profile of such children. Therefore children will enter therapy with a wide range of emotional and behavioral problems as well as defensive strategies. In addition, child therapists need to attend to differences resulting from culture, gender, and developmental age and stage. Because of all these variables, clinicians need to remain flexible, interested, and responsive to each child's unique needs.

The rest of this text unfolds an integrated treatment approach that recognizes and values different therapeutic perspectives, and utilizes them in a purposeful and discriminating manner.

4

Expressive Therapies

Providing therapy to young children and adolescents requires clinicians to engage with them at their individual developmental levels and to invite their participation in creative and compelling ways. When clinicians work with abused and traumatized children, they cannot rely too heavily on any specific approach or on children's willingness to use verbal communication; rather, they need to have a broad range of both verbal and nonverbal techniques at their disposal. "Expressive therapies" is a term used to define the therapeutic use of the arts and play with children and adults individually, in groups, or in family sessions. The media used in expressive therapies include many different visual/manual arts and crafts, music, dance/movement, drama, play, writing (poetry and journaling), and sandplay and other sand therapies. McNiff (cited in Malchiodi, 2005), who founded the first Expressive Therapies Graduate Program at Lesley University in 1974, states, "these therapies have been used since ancient times as preventative and reparative forms of treatment. There are numerous references within medicine, anthropology, and the arts to the earliest healing applications of expressive modalities" (p. 4). We are fortunate that McNiff and many others have paved the way toward greater understanding and applicability of expressive therapies, which can be used as primary or adjunctive approaches, depending on a clinician's level of training and experience with them. This chapter highlights three specific expressive therapies that I have found useful with abused and traumatized children (i.e., play, art, and sand therapies), but I encourage readers to think of all such therapies as potentially useful.

ORIGINS AND DEVELOPMENT OF THREE EXPRESSIVE THERAPIES

Three creative, distinctive, and inspired methods for child and adult therapy were developed within the same approximate time period; were crafted for similar purposes by professional women; and have had parallel outcomes, impact, and longevity. Art therapy, play therapy, and sand therapy were advanced by psychoanalysts as innovative approaches that would help both child and adult clients externalize and manage their internal worlds, and these therapies are currently viewed as highly relevant and practical for work with children.

Art Therapy

Rubin (1987) notes that Sigmund Freud, in developing his psychoanalytic theory, recognized early that patients used expressive techniques and that their "most important communications were descriptions of visual images" (p. 7). Clearly, Freud's interest in his patients' dreams was an attempt to elicit the translation of images into words. Rubin notes that Freud would often "actively request images" (p. 7), by instructing his clients to concentrate on forgotten memories or by placing his hand on their foreheads so they could feel external pressure. Freud later abandoned this interest in visual images for a process he labeled "free association" (the process of verbalizing free-process thinking). Anna Freud, his daughter and herself a child psychoanalyst, renewed the focus on art (as well as play), because she found that her young child patients were not well suited to make use of the process of free association.

Beginning in the late 1940s, Margaret Naumburg facilitated the integration of Freudian insights about "unconscious communication through imagery and the use of art therapy" (Rubin, 1987, p. 9). Naumburg called her approach "dynamically oriented art psychotherapy" and viewed it as serving the function of a "primary therapeutic method," rather than as an "auxiliary to other forms of treatment" (Ulman, Kramer, & Kwiatkowska, 1977, p. 7). About a decade later (in the late 1950s), Edith Kramer, also a psychoanalyst, began developing a view of art therapy as complementary to psychotherapy—"bringing unconscious material closer to the surface," and "providing an area of symbolic experience wherein changes may be tried out" (Ulman et al., 1977, p. 8).

Elinor Ulman, yet another art therapy pioneer, brought the two views offered by Naumburg and Kramer together, suggesting that art therapy covers "a broad range of endeavors limited only by the requirement that they must genuinely partake of both art and therapy" (Ulman et al., 1977, p. 9). Slowly, art as a means to advance therapeutic goals became a credible resource to those who were both formally trained and/or untrained in the arts. Recent efforts have been made by Malchiodi (1998) and others (Furth, 2002; Oster & Montgomery, 1996) to bridge the gap in knowledge between specially trained art therapists and those child therapists who routinely use art activities in their clinical practices without the benefit of formal training. Recognizing that formal art therapy training may not be desirable or possible for many therapists who work with children, and that for some therapists art will never become a central therapeutic approach, Malchiodi (1998) in particular provides a comprehensive foundation that encourages more responsible utilization of art work with children—although she also emphasizes the necessity to obtain additional training and consultation in this area. In a subsequent edited text, Malchiodi (2003) once again highlights the value and power of art therapy in different settings, with different populations, and within differing treatment modalities. The usefulness of art therapy continues to be documented for different populations, and several publications describe the use of art therapy for individuals with histories of sexual abuse (Gil, 2003a; Gerity, 1999; Brooke, 1995; Cohen, Barnes, & Rankin, 1995; Cohen & Cox, 1995).

Play Therapy

It is difficult to imagine a time when children were not seen as viable candidates for therapy; however, up until Freud's first documented efforts to help a child, most analysts would only venture into the mental health treatment of adults. Due to Freud's significant influence on the clinical community, his first therapeutic success with a child's symptoms of phobia (Freud, 1909/1955) laid the foundation for later work with children. Whereas Hug-Hellmuth (1921) used play more directly with children in their own homes, believing that it was an essential part of child analysis, Anna Freud and Melanie Klein have long been regarded as the predominant forces behind the use of play with children in therapy.

Anna Freud (1965) initially viewed play as a way to lure children into therapy and to establish a therapeutic alliance between a clinician and a child patient with the goal of achieving transference responses in the child. She elicited verbalizations from children as soon as they became more comfortable with her through the use of toys and games, and once she solidified the alliance. Melanie Klein (1932), however, was much more interested in using play as a direct substitute for verbalizations (equivalent to the free associations of adult patients). She considered play a child's natural mechanism for expression and communication. Accordingly, Klein (1932) treated play activities as "primary data on which to base interpretations" (p. 11). These two pioneers viewed play interpreta-

tions as potentially therapeutic, but differed on the amount of interpreting that was necessary or useful. Esman (1983) notes that "the dominant influence in child analytic practice in the United States has been Anna Freud, her pupils, and her associates, and it is, by and large, her approach that has dominated the theory and practice of play therapy in clinical work with children in this country" (p. 12).

O'Connor (1991) suggests that the major therapeutic goal of psychoanalytic play is the "development or revision of psychic structures and functions" (p. 18), so that optimal development can occur. This is done through interpretation and working through of art or play, which may promote the child's insight and behavioral change. Psychoanalytic play therapy has serious limitations, however, because it is recommended for those children who have clearly developed personalities and whose "symptoms arise from anxiety produced by internal conflict" (O'Connor, 1991, p. 18). This type of therapy is viewed as most effective for clients who can verbalize, gain insights, and then implement behavioral changes.

Others have expanded the use of psychoanalytic play therapy. Levy (1939) developed a play therapy model called "release therapy," based on the psychoanalytic concept of the benefit of repetition compulsion. Levy's therapeutic model was most suitable to children who had experienced traumatic events and who could assimilate negative thoughts and feelings through play reenactments of the traumatic material. This model is the foundation for contemporary thinking on the value and usefulness of posttraumatic play (Terr, 1983, 1990), which I discuss in greater detail in Chapter Seven.

Since the early development of psychoanalytic play therapy, other major play therapy models have emerged—most notably behavioral (Skinner, 1972; Bandura, 1977), cognitive-behavioral (Knell, 1993), developmental (Brody, 1978, 1993; Jernberg, 1979), ecosystemic (O'Connor, 1994), Gestalt (Oaklander, 1988, 1994), humanistic (Rogers, 1951; Axline, 1947; Moustakas, 1959; Landreth, 1982; Rank, 1936), and Adlerian (Kottman, 1995). O'Connor (1991) notes that these theories share a basic respect for the various functions of play. These include biological development (skill building), intrapersonal development (fulfillment of both the human need to do something and the drive for mastery), and interpersonal development (achievement of individuation/separation from the primary caretaker, as well as acquisition of social skills). Through all three of these functions, play therapy embodies curative factors that can benefit children and adults alike (Schaefer, 1993). Amster (1982) notes that in the transition from play as play to play as therapy, several uses have been well established: to increase diagnostic understanding; to establish a working relationship; to break through a child's defenses; to facilitate communication and verbalization; to help the child act out unconscious

material and to release accompanying tension; and to promote developmental growth.

It is interesting to note that although art therapy, play therapy, and (as will be documented below) sand therapy all had their origins in psychoanalytic theory and were first developed within the same time period (the early 1900s), the developers of each type of therapy took little interest in the work of the others, and few if any exchanges took place among them. As a result, these models and approaches, now conventional tools of child therapy, evolved in relative isolation from each other.

Sand Therapy

In 1911, the British novelist and political writer H. G. Wells chronicled his work with children in a book entitled *Floor Games* (an American edition has been republished; Wells, 1911/1975). Wells and his two sons engaged in elaborate floor games, including, for example, the building of cities; they used miniatures of people and animals, and construction materials that included wood, paper, and plasticine. Margaret Lowenfeld, who read the book when she was about 21 years old, was fascinated with the description of this play and integrated this type of work with children into her later analytic practice. Lowenfeld was a practicing pediatrician for a number of years and left that profession to become a child psychiatrist. She purchased the equipment Wells suggested and kept it in what her child clients called "the wonder box" (Lowenfeld, 1979, p. 3). In 1929, she added zinc trays to her basic equipment—one filled with sand, and the other with water. She stored her miniatures in a cabinet, and found that children quite naturally brought the miniatures to the sand trays and built scenarios in the sand, which she called "worlds." Bowyer (1970) notes that within a 3-month period, these children had in fact created a new technique; Lowenfeld's remarkable ability to follow, rather than lead, allowed this amazing process to take place. Lowenfeld eventually called this process the "world technique" (Lowenfeld, 1979). Thompson (1981/1990) notes that it has remained virtually unchanged since its beginning, and includes "imaginative activity with the sand, used with or without objects, within a circumscribed space, in the presence of a therapist" (p. 7).

Lowenfeld demonstrated the world technique at several international conferences as early as 1939. Dora Kalff, a Swiss Jungian child analyst, was immediately captivated and became one of Lowenfeld's best students, consulting as well with Carl Jung, her mentor throughout her career. Kalff inspired many Jungian analysts as she taught and lectured widely on the effectiveness of what she renamed "sandplay" (Kalff, 1980), and virtually introduced this method in the United States. Kalff's Jungian

background has influenced many Jungian analysts to use sandplay; many people also associate sandplay with strict Jungian principles, which in some ways may have made this technique less accessible to the wider professional community. In fact, Spare (1981/1990) confides that her colleagues "often spoke to me of their intimidation at what they feel to be an exclusivity or even preciosity surrounding the use of the sand tray as a clinical instrument. . . . they express an intense sense of awe and wonder in which sandplay takes on something of the numinosity and power of an archetype of change" (p. 195).

Contemporary clinicians (Labovitz Boik & Goodwin, 2000; Carey, 1999; Dundas, 1978; Allan & Berry, 1987; Weinrib, 1983; De Domenico, 1988) continue to develop, present, and promote a range of expanded approaches to sand therapy. Mitchell and Friedman (1994) describe sandplay as one of the fastest-growing therapies. They aptly chronicle the past, present, and future directions of this therapeutic technique, highlighting and contrasting the contributions of the pioneers mentioned above, as well as others (e.g., Bühler, 1951) who have had an impact on professional interest and research in this approach.

Most proponents of Jungian-based sandplay agree that this process engages the active imaginative or creative process, promotes a developmental or healing process, externalizes the client's internal world, serves as an impetus for release of psychic energy, and is essentially a process that can often bridge conscious and unconscious processes. As such, a therapist is encouraged to say little throughout a client's sand therapy process, and to be cautious about interpreting what is seen. As Weinrib (1983) points out, "the specific interpretation of a particular symbol may be less important than the process itself and the relationship between [the therapist] and the client" (p. 16). Weinrib adds that "sandplay brings to the therapeutic process the element of genuinely free play, with all that it implies in terms of freedom and creativity. Sandplay is not a game with rules. It is free and encourages playfulness. Its value lies in its experiential noncerebral character" (p. 17). Although there are few specific rules per se (see Spare, 1981/1990), Weinrib notes eight basic concepts that guide the use of sandplay:

1. Psychological development, under normal circumstances, is similar for everyone.
2. The psyche consists of consciousness and unconsciousness and the interaction between them, and contains a drive toward wholeness and a tendency to heal itself.
3. The self is the totality of the personality and its directing center.
4. The unconscious is the source of psychological life in the same way that the mother is the source of physical life. The mother and the unconscious therefore can be seen as symbolic feminine equivalents, with the drive to return to the mother as the drive to the return to the unconscious.
5. Psychological healing involves restoration of the capacity to function normally, whereas ego-consciousness relates to awareness and choice of what we are doing while we function.
6. Psychological healing is an emotional, nonrational phenomenon that takes place at the preverbal level.
7. Both healing and expansion of consciousness are desirable ends in psychotherapy.
8. The natural healing process can effectively be activated by therapeutic play and stimulation of creative impulses via conditions provided in the tray.

Weinrib also emphasizes the necessity and value of the free and protected space that using the sand tray clearly provides.[1]

As the descriptions above indicate, art, play, and sand therapies can provide a clinician with astounding access to an individual's unconscious material, and the therapist's responses and engagement with the client can either enhance or dilute the client's creative process and product. Training in these specialized fields of study is therefore not only desirable, but necessary, to maximize the potential to help and minimize the potential for damage. An unforgettable book, written by a therapist who herself had a nervous breakdown resulting in part from her work with an injured child, candidly chronicles both the harmful and the healing possibilities of psychotherapy (Rogers, 1995).

These three distinct expressive therapies have their foundations in psychoanalytic theory, as noted above. They seek to engage the unconscious, glean conflicts or concerns, and promote insight, which then is viewed as a means to achieve beneficial behavioral changes. They have all been used effectively in educational and health arenas to stimulate, promote, or optimize developmental and reparative processes.

These three approaches, when used by trained professionals, have

[1] As sand therapy has gained popularity, clinicians have improvised in an effort to stock the necessary equipment at reasonable cost. Some clinicians use kitty litter boxes or Tupperware boxes as sand trays. It is important to note that Lowenfeld (1979) proposed the dimensions for a sand tray as 50 x 75 centimeters. Kalff (1980) proposed the dimensions of 19.5 x 28.5 x 3 inches. Kalff in particular discussed the importance of comfort for sand builders: The builder should be able to look at the entire tray without moving the head, and to reach all corners of the tray comfortably. She also recommended that the tray be waist-high to the user, and that trays of different heights be used whenever possible.

the capacity to facilitate a wide variety of individual strategies (e.g., withdrawal or expansion, camouflage or disclosure, integration or compartmentalization, structuring or unmassing of psychological mechanisms) that may assist in a healing outcome. In addition, all three therapies can hasten engagement with the unconscious, in that they provide kinetic, sensory, and physical experiences—they can be felt, smelled, touched, tasted, and remembered. The clinical opportunities are promising when these approaches are used independently, and awesome when they are used in combination. In my experience, children can readily go from one therapeutic mode to another (either spontaneously or by suggestion), and the combination of these three therapy options can provide clinicians with cumulative diagnostic or prognostic information. Using these three approaches interactively also appears to offer children (and sometimes adolescents and adults as well) increased reparative opportunities. The images and metaphors provided by children in one type of therapy can be amplified, enriched, made more tangible, and developed to a greater extent in another, as I will show in the clinical illustrations in the second part of this book.

SIMILARITIES/DIFFERENCES AMONG ART, PLAY, AND SAND THERAPIES

Art, play, and sand therapies have common characteristics as well as unique attributes. First and foremost, all three are universal activities that children experience throughout the developmental process, to one degree or another. Parents may promote, inspire, or facilitate their children's creativity or imagination—or, conversely, may diminish or obstruct their desire for these forms of expression. Parents seem to value self-expression through objects or symbols at varying levels of interest. For example, some parents refuse to purchase or provide formal toys for children, preferring to encourage children either to transform generic objects into play objects or to build toys for themselves.

Children themselves may use art, play, or sand therapy spontaneously or when directed to do so, and either frequently or intermittently. As they mature, they may replace these modes of communication or self-expression in favor of verbal communication and rational, concrete thinking. Adults often use their creativity and imagination minimally, making rigid separations between adult and child activities or behaviors.

Moreover, because art, play, and sandplay are familiar, user-friendly activities to children, they can engage easily with these techniques. Children tend to feel reassured as they enter therapy offices and see some of the objects (e.g., crayons and paper, miniature cars) that signal the possibility of known, pleasurable activities. They make swift, positive associations that help to put them at ease, and that may make the owner of the objects (i.e., the therapist) less ominous or distant.

Finally, art, play, and sandplay are transformed in a clinical setting, because there is a clinical goal and an observer who makes efforts to understand, decode, and provide helpful clinical responses. By definition, a therapist who uses one or more of these approaches is also creating a safe, structured, accepting environment in which a child may eventually reveal secrets, develop insight, adapt to circumstances, improve coping strategies, and repair psychological damage. For children with emotional difficulties, these three therapies allow them to bring out hidden concerns, whether they intend to reveal them or not.

Art therapy materials provide young art makers with a range of options. Some children revel in the control they can exert with a finely sharpened pencil, creating shading of light to heavy intensity. Others prefer the freedom of splattering fluid paints on large canvases that seem to catch the paints, forming images that come alive and speak not only to their makers but to others. Still other clients find using fluid paints a regressive experience; they seem engrossed with the tactile experience of placing their fingers and hands in paints, making squishy noises, and making the paints more liquid or solid. The process of art making involves the senses to differing degrees, and art makers comment on the diverse smells, feel, sound, and look of chosen media. Obviously, the materials an individual chooses to use to make art, or the materials that are made available, advocated, or avoided by the art therapist, may either hasten or obstruct contact with a range of feelings and reactions. Consequently, the art therapist and art maker alike must remain sensitive and alert to the art maker's process and potential benefits or disadvantages of using one medium or another. Art making can be done on small or large pieces of paper, on construction paper, or on formal canvases. More modern, abstract art can also be created on a variety of surfaces and materials (e.g., wall murals on buildings brighten up many cities). But the most traditional use of art is on paper, and paper of any size (or color) has edges that serve as boundaries. The art maker always reacts to a contained space, filling it as much or as little as he or she wants.

When someone completes an art process, a tangible product remains that can be either admired, appreciated, or disregarded. The art maker chooses whether to keep or discard the art, to hide it or display it openly. Once a product is created, the art maker also has the option to *see* or *not to see* the meaning of images he or she has created. Moreover, the maker decides who will see an art product and what will be told about it. Many decisions must be made once the product is complete. Some art makers leave their products behind without a second glance, may abruptly

destroy what has been made, may direct the art therapist to keep the products for them, or may want to take them home for safekeeping. The product may also produce positive, negative, or neutral feelings in the art maker. Unfortunately, some makers focus on the product's representational qualities—that is, how much it looks like what they were trying to make. Often art makers feel that they fall short in their artistic abilities, and the art product becomes symbolic of their negative self-image. Sadly, some individuals won't even engage in art because of their feelings of performance anxiety. Some can be swayed from their expectations of artistic perfection by instruction in abstract art making; others resist abstract art, finding the images disturbing and unexplainable.

When resistance to making art cannot be overcome, I suggest making art in a sand tray. As a matter of fact, some clinicians routinely ask clients to make "pictures" in sand, rather than asking them to make "worlds" in sand. In sand therapy, the individual is not expected to make representational images, but rather to use miniatures (which are provided) to create a scenario. Individuals are asked to create whatever they want, using as few or as many miniatures as they wish. The boundaries provided by the edges of paper in art therapy are made concrete by the substantial and visible walls of a sand tray in sand therapy.

Although the art maker who uses paper chooses the size of paper he or she wishes to use on any given day, the sand therapy client will be limited by the standard size of the traditional sand tray. The worlds that are created in sand are therefore created within the same dimensions each time, although children's creativity can never be underestimated. Although almost always adults stay within the boundaries of one tray, children may build bridges to other trays, or somehow link up the world in the sand to other play materials. One child with whom I worked moved a sand tray next to the dollhouse and made a path leading from the front of the house to the "beach," using the entire sand tray to make an ocean scene within walking distance for the family that lived in the dollhouse.

Sand therapy, like art, also provides opportunities for fluid or resistive activity, since water can be poured into sand trays; this allows the makers of sand worlds to shape, amass, mold, flood, or otherwise experience wet sand. Depending on the amount of water used, sand will respond differently.

The products that are created in sand trays are not permanent, since the trays are inevitably dismantled and prepared for future use. A sand world can be chronicled, however, by taking a photograph that captures the scenario created on any given day. Unfortunately, a photo does not always capture idiosyncratic detail; also, depending on the angle at which the photo is taken, one or another aspect may be emphasized, providing a less than accurate or full view of the world. Nevertheless, the photo does

provide a hint of what was created, and it allows the client an opportunity to recreate a product, pursue a theme, or simply create a new, unrelated product.

Play therapy is yet another powerful avenue for self-expression, communication, and self-soothing. Objects (toys, miniatures) are provided to the child, although children possess the ability to use imagination and fantasy to assign various meanings to each object. For example, a Popsicle stick that has just been used as a pretend gun to kill someone can immediately be transformed into a tongue depressor to medically assist the person who's been shot and revived.

Play will be used by children in representational or abstract form, depending on their age. A child goes through stages of play, much in the same way that art appears to have specific qualities, depending on the child's age and cognitive ability (Lowenfeld & Brittain, 1987). Play also has specific stages that reflect children's growth (Schaefer, Gitlin, & Sandgrund, 1991); as such, both play and art can be used for developmental assessment as well as for specific diagnostic and treatment purposes.

Play does not have the concrete boundaries offered by art and sand therapies. Children can create stories, undo them, transform them, forget them, or keep bringing them up. Once toys are used, they are put back, and the next time they may be ignored or may be assigned completely different meanings.

Children may use all three of these distinctive therapies in an absorbed, focused way, being extremely involved with their own process and screening out the environment. Or they may interact with the clinician throughout the whole process—asking for approval, attention, or direction; wanting the clinician to participate in the product development or play; assigning or taking roles; giving voices to characters; or responding to questions posed by the clinician.

THE USE OF SPECIFIC EXPRESSIVE TECHNIQUES IN ASSESSMENT AND TREATMENT

No matter what type of expressive therapy is used, a clinician is able to gather important information about a child by observing and documenting two dimensions: the *process* of the art, play, or sand therapy, and the *content* (of the product) presented. The process informs the clinician about the child's affective engagement with the materials (tone, posture, activity level, approach–avoidance, absorption, and physical involvement are observed). The content is the symbol, metaphor, or story presented through the use of the materials (organization and style, repetition, presence of conflict and resolution, and possible links to real-life issues). Both

process and content can provide significant data in the course of assessment (particularly the extended developmental assessment described in Chapter Two) and treatment. I have found in the course of my own work that certain expressive techniques yield particularly valuable information about children's perceptions of their life situations, relationships, worries, or joys; I describe these techniques below.

Play Genograms

As described in the case example of Gene in Chapter Two, children can be asked to provide play genograms. First, a clinician and child construct a genogram on a large piece of easel paper. Genogram construction can take one or a few sessions, depending on children's interest in and knowledge about their families. Some genograms can include birth, foster, or adoptive families; friends and pets; teachers; healthcare professionals; and other caretakers. The addition of friends, pets, and "other important people in your life" may actually provide a significant mapping of children's external resources—that is, the people they regard as important in their lives. Often extended family members, teachers, day care providers, or social workers may be major sources of support, warmth, or guidance to children. Finding out about "forgotten" or marginalized family members can also be informative.

Once a play genogram is completed, and all important people are included visually, two distinct instructions can be given to increase its value. The first instruction is to "choose a miniature that best shows your thoughts and feelings about each person in your family, including yourself." Children are told to pick the miniatures and place them on the circles or squares that represent family members on the genogram. The instructions do not emphasize a limit on the number of miniatures, so it is informative to watch children negotiate the need for additional miniatures, to show a wider range of thoughts or feelings about specific family members or friends.

Children approach this first task in a variety of ways. Recently a teenager seemed actively resistant to undertaking this task, and I commended her on how well she had explained her reluctance to use expressive techniques (this reluctance to use expressive techniques coincided with her unwillingness to communicate verbally). Finally she acquiesced to the task, and I opted to take a bathroom break so that she wouldn't feel self-conscious about starting the play genogram. She was so absorbed in the task that she did not hear me open the door and reenter the room, and she seemed oblivious to my presence for at least the next 10 minutes. When she looked up and told me she was "done," she had selected and used the most amazing array of miniatures, incredibly rich in symbolism

(see Figure 4.1). In spite of her initial protests, this youngster was very adept at completing this task in a way that allowed her to present new information.

As Figure 4.1 shows, this girl, Heidi, used the figure of an alien to describe herself and her internal experience of feeling isolated, different, and disconnected from others. The alien figure stood alone but was also quite central, while facing forward and turning her back to all the miniatures behind her. It was almost as if her family existed separately from her (something she verbalized when she began to talk about the play genogram). I asked this teen to tell me about the alien, and she noted, "That alien feels completely alone, weird—like everyone stares at her, doesn't understand her, and won't even give her a chance." I wondered aloud about the alien's feelings and what the alien did with these feelings. "Mostly keep them to herself . . . she speaks in a different language and no one really understands her." "And if someone could understand her," I asked, "what would become obvious?" "How much she wants to have a friend." This girl was able to talk about her true feelings as long as we were talking about the alien in front of us.

Heidi then told me about the miniatures she had chosen for her mother: a unicorn with wings, and a three-headed figure with six arms. She said, "I chose the Pegasus for my mother because she's always leaving. You never know when she's going to stay or go. And I chose the three-headed person because you never know which mother you're go-

FIGURE 4.1. Heidi's play genogram.

ing to get. Often she has lots of different moods, and sometimes she gets kind of wild and chaotic, so I thought all the heads and arms kind of show that." This teen's most distressing issue was her mother's inability to maintain a firm, consistent relationship with her. We spent two sessions further identifying the difficulty in the mother–daughter relationship and discussing a realistic strategy to protect her from feeling constant disappointment.

Very young children can complete this project as well. It's best to ask for their participation, in order to determine their ability and/or willingness to cooperate. I have obtained play genograms from children as young as 5, and there is no maximum age limit. Adults tend to assert their surprise at how difficult it can be to choose miniatures—and, at the same time, how much they can learn from them. Children and adults alike vary in their choice of abstract or concrete symbols. For example, one 7-year-old boy picked a fireman because his father was a fireman; an 8-year-old girl chose a chicken because her mother liked to eat fried chicken; a 6-year-old selected a car because his dad was a mechanic. At the other end of the continuum, a 7-year-old girl picked out a sun for her grandmother because she was always smiling and nice to everyone; a teenage boy picked out a broken ship, insisting that he felt he was sinking; a 12-year-old boy picked out a scream figure for his mother, describing her as "holding a lot in, but really being unhappy and frustrated."

Two of my all-time favorite symbolic figures were chosen by a teenage girl and a frustrated mother, respectively. The teenager could not find the right symbol for her mother and finally constructed one out of clay, making first a square box, and then a head with nose, eyes, ears, and a big open mouth. Next she asked me for a ballpoint pen (I had one, luckily), and she took it apart, using the small spring inside to put between the box and the head. "This is my mom," she said with a glint in her eye, "Jack in the Box . . . she's wound up tightly, and you never know when she's going to blow." This gave us great opportunities for further discussion. The second memorable symbol use was when a very frustrated mother used a fire hydrant to express her perception that her family was in constant crisis and that she always had to "put out fires."

The play genogram can be used in only this first way with children, adolescents, and adults, or can be further amplified to include information about children's relational perceptions. The second instruction that can be given is this: "Pick a miniature that best shows your thoughts and feelings about the relationship you have with each person in your family, and put these miniatures between yourself and the other person." Because it can take a couple of sessions to construct the genogram and then select and place the miniatures on easel paper, the "relationship" activity is best done in one full session. The use of photographs to chronicle play

genograms will allow individuals to recreate the original play genograms on their easel pages, which are carefully stored in art folders. This second play genogram activity is quite revealing. One adolescent put a small brick wall between himself and his father, noting, "I feel that I can't get through. You're like a wall and you don't give." At the same time, the father was touched by the fact that the wall chosen by his son was the smaller of two brick walls: "Well, at least this wall won't be as hard to tear down as the other one." I was impressed that this teen's father was able to accept the criticism and then convey some optimism about change.

In conjoint family sessions, all family members are given essentially the same first instruction described above: "Choose a miniature that best shows your thoughts and feelings about each person in the family, including yourself." They are then guided to explore the shelves with miniatures, and to take their time, explore, and ask if there's something they can't find.[2] Miniatures are then placed on the boxes and squares on the large piece of easel paper, and even the act of accommodating individual choices can be very indicative of family roles, alliances, collusions, and collective perceptions (Gil, 2003a).

There are no rigid or restrictive rules about how to conduct this task. The only caution I provide is that it does not seem to be productive to have each family member take an individual turn choosing miniatures. In my experience, turn-taking can contribute to individuals' feeling self-conscious, rushing selections, and looking for validation or other reactions from other family members before making choices. As a result, the task can become stymied and anxiety-provoking. It's best to allow all family members to get out of their chairs and peruse the miniatures at the same time, even though everyone choosing at the same time can also be a little difficult to track. In larger families, the selection process can generate a lot of dialogue, negotiation, fun, irritability, and challenge. The largest family group I worked with consisted of two parents, one grandparent, a former foster parent, and four young children. There were a minimum of 7 and a maximum of 13 miniatures on the easel paper. For the second task (inquiring about relationships), I drew the two genograms (for the birth and foster families) on an expanded piece of paper (two large pieces of easel paper taped together), and we moved to a room with a large oval desk on which the paper could be properly spread out. I offered each family member a small tray to collect his or her miniatures to be carried to the adjacent office.

After the miniatures are placed on the genogram, I make the follow-

[2] I keep soft, malleable plasticine in case someone is unable to find just what he or she wants and instead is willing to use clay to make the object.

ing request: "Now that you've placed your miniatures on the paper, I'd like you to look around, notice the miniatures that have been chosen, and talk a little together as a family. This is a time to show your interest, be curious, ask questions, make comments, and express anything you want about the miniatures you've placed on the paper." These dialogues usually bring a range of responses, including humor, insightfulness, defensiveness, interest, and concern. Every now and then negative feelings are expressed harshly, or several family members seem to gather strength from each other and complain about one other member. The family process is made explicit, and further discussion is elicited by clinical questions or directives.

There is an obvious need for family play genograms to be conducted by trained family therapists who can guide the family through difficult encounters and can maximize positive outcomes. My impression is that depending on the family therapist's particular orientation, the focus of the family work will take many shapes and forms. Someone interested in Gestalt therapy may ask family members to "be" the miniatures—that is, to give the miniatures voices. Narrative therapists may want to focus on expanding the range of chosen miniatures. Thus, if someone has picked a miniature that suggests anger in a family member, a narrative therapist may request an additional figure to express what the person is like when he or she is not angry. The possibilities are endless, and the family play genogram provides numerous opportunities for clearer communication, introspection, renewed family energy, and positive change.

Sand Therapy Activities: Following Clients' Leads

As described earlier, sand therapy in general is an appealing, low-difficulty task that most children and adults approach and engage with readily. Sand already has positive associations for many children, although children who have never visited a beach are likewise drawn to it. I have met a few rare individuals who withdraw from the feel of dry or wet sand, but touching and playing with sand can produce pleasurable physiological and emotional responses in most people, and clients almost always show or state their feelings of calm, relaxation, enjoyment, and delight.

Many children will respond positively to sand therapy when they seem reluctant to draw or paint. The unfortunate fear of not drawing well enough can be a powerful deterrent to children's or adults' enjoyment of art. In sand therapy, children are free simply to select from a broad range of objects, and somehow this decreases their anxiety about producing something that will be judged by others. Children may sometimes review their art products and lack confidence about what

they've produced, but these feelings don't seem to play a major role in sand therapy.

Some children spend time playing with the sand in very primitive and relaxing ways: pushing the sand from one side to another, using a paintbrush to make shapes in the box, playing hide and seek with their hands, patting the sand with the palms of their hands, using their fingers to make circles or lines, filling and pouring cups, making hills or mountains, making lakes or rivers, or simply using a sifter to clean the sand. Other children make "worlds" in the sand almost immediately and can build underwater scenes, villages, fantasy lands, zoos, wild forests, spiritual places, their homes or rooms, and other environments. They may place miniatures to "protect" or "guard"; they may put down "bad" or "dangerous" animals or people; they may include parents and children in various forms; they may present themes of danger, safety, peace, activity, or industry.

During sand activities, I record children's thematic material, miniature choices (particularly those carried over from tray to tray), statements, resolution of stories, use of particular characters, and ways these characters change from week to week. I also record the variety of ways that children utilize sand work. For example, some children make a scenario that stands complete at the end of the session, while others make dynamic scenarios and announce, "Okay, let's play now!" These children then move their miniatures around and create a story that has a beginning, middle, and end, requesting clinicians to take roles, have dialogues, or take particular actions. Some children tell elaborate stories about the miniatures in their tray and continue these stories over weeks; other children have little to say about their creations. Some children narrate the development of their sand trays, while others remain silent throughout the process. For some young children (as well as adolescents and adults), clinicians will be able to observe immediate changes in affect with sand therapy; other children approach sand work as they do other things and will move from this activity to others in the room without any particular differences in posture, tone, or affect. Some clients will choose to do sand therapy at each session; others will choose it randomly throughout therapy sessions; and yet still others will select sand therapy to signal that they are interested in working on something to do with difficult emotions.

The older I have gotten, the less I say when children or adults are making sand trays, either alone or with family members. My instruction is always the same: "Use as few or as many miniatures as you wish to make a world in the sand." I often add, "There is no right or wrong way to do this. Whatever you do is just fine." Then I sit back and I witness the process for each individual. I find myself constantly enthralled and curious, and I am finally completely comfortable allowing the process to un-

fold, because over years I've learned that sand therapy takes its own course. It's completely unique to each person, and I trust that it is providing the individual with whatever he or she needs at that particular time. I firmly believe that with practice, clinicians will learn to trust the process and develop a profound respect for it.

When writing assessment reports for referring parties or courts, I may refer to sand work as a source of information. For example, one 10-year-old African American child, Michael, had developed a range of anxious behaviors after being molested by a cousin (nightmares, tics, clearing his throat, pulling his hair). He made a series of sand worlds with similar themes (see Figures 4.2 and 4.3). I reported on the behaviors observed by parents and teachers, and then added the following paragraph describing the child's creation of scenarios in the sand:

> Michael appears to be acutely anxious and preoccupied with his family's safety. Mother reports that Michael initially confided to her that his cousin threatened to kill him and his parents if Michael told anyone about the abuse. In his play, Michael consistently reveals themes of vulnerability, danger, and fear. For example, when he creates scenarios in the sand, he builds a village he describes as "happy and safe," and he includes houses, playgrounds, trees, farm animals grazing, etc. However, he takes great care to bury snakes, lizards, "poisonous" spiders, and "scuba-diving men with explosives on their backs." He then states that these objects are "always lurking around," and that "they are quiet as mice," but "the family can't protect against them because they don't know they are there." In recent weeks, the number of buried objects has decreased, and

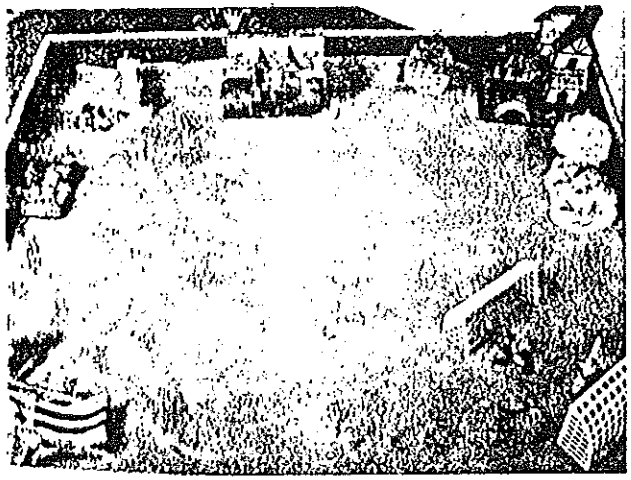

FIGURE 4.2. Michael's anxious worlds.

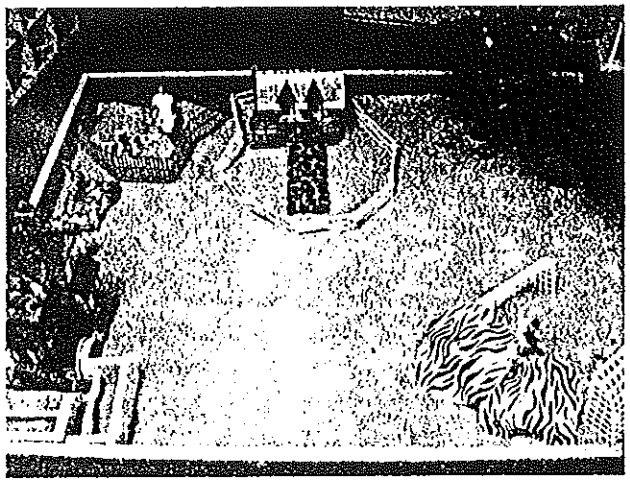

FIGURE 4.3. Michael's resources.

> Michael has added safety measures such as fences and walls around the house; these appear to be keeping the danger at a greater distance than before. This change in his sand scenarios appears consistent with parental reports that Michael is sleeping better and has started going outside to play with his friends. Michael is struggling with restoring a sense of safety and security.

Both historical and contemporary uses of sand therapy have been well documented (Turner, 2005; Mitchell & Friedman, 1994), and efforts have been undertaken to create a standardized sand play assessment process (Mielcke, 2005; Sjolund & Schaefer, 1994).

Color Your Feelings

Several techniques that involve using colors as a way of understanding children's emotional states have been documented. For example, O'Connor (1983) describes the Color Your Life technique, and Crisci, Lay, and Lowenstein (1997) use a barometer that children fill with colors.

The Color Your Feelings technique (Hopkins, Huici, & Bermudez, 2005) also draws upon children's ability to show emotional states by using color; however, it requires children first to make very clear associations between colors and emotions, and later to use their specific color–emotion palette to indicate visually their feelings about important relationships (Figure 4.4). I utilize this technique by first asking a child to "list the feelings you have most of the time." These feelings are placed on the right-

FIGURE 4.4. A color–emotion palette.

hand side of a sheet of easel paper. I then place a small box next to each word and ask the child to "choose the color that best shows that feeling." The child fills in the boxes with the colors he or she chooses (Figure 4.5).

After a child has thus created a color–emotion palette, I make a gingerbread figure to represent a particular person in the child's life. I then ask the child to use the colors to show what feelings, and how much of the feelings, he or she has about this person. I may also make two ginger bread figures to represent two people, and ask the child to show me his or her feelings about being with one person or the other. In Figure 4.6, for

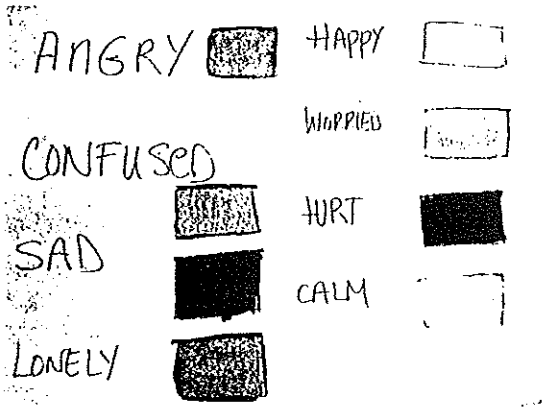

FIGURE 4.5. A Color Your Feelings chart.

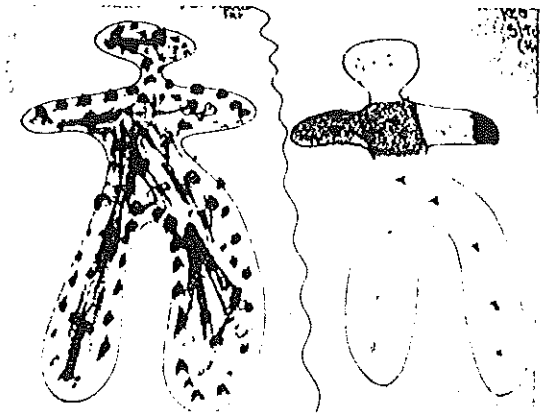

FIGURE 4.6. June's colors/feelings about alleged offender and caretaker.

example, June, an 8-year old Hispanic girl, used her color palette to show how she felt when she was with her mother and how she felt when she was with her alleged offender (her grandfather). The child's art showed a clear contrast, which she had trouble verbalizing because of her feelings of loyalty toward her grandfather. Even in this black-and-white reproduction, you can see the difference between the types and amounts of colors shown, as well as the way in which those colors are used.

This art activity presents the clinician with an interesting way to "see" how a child perceives his or her feelings in the context of relationships with important caretakers. As with any other art therapy technique, this one can be used both as an assessment method and as a bridge to therapeutic dialogue. Very young children as well as older adolescents can accomplish this task.

Other Art Therapy Tools

Among my greatest concerns in working with sexual abuse is the misapplication of art-based information during evaluations. As a consultant to many professionals over the last three decades, I have been concerned with the number of professionals who take liberties with very limited information about art therapy. For example, I frequently hear professionals base conclusions that child sexual abuse occurred on the presence of multiple windows or chimneys, or on the inclusion of "a trauma hole" in a child's tree. We must be very careful not to use a child's art alone to rule in or rule out sexual abuse, although the presence of consistent or obvious art features may suggest a need for further evaluation of possible abuse.

We need to take a conservative view when using children's art; in particular, we must not under- or overrespond to images created during single sessions, or rely too heavily on external interpretation. Projective techniques in particular have not been shown to detect child sexual abuse (Garb, Wood, & Nezworski, 2000; Palmer et al., 2000), and the confirmation of child sexual abuse through sole reliance on children's drawings is not possible (Cohen-Liebman, 1999). Art therapy procedures can yield valuable information however, and can be part of the data-gathering process as well as the treatment process.

There are a number of formal art therapy tools (Oster & Gould Crone, 2004) that attempt to evaluate drawings from a variety of domains. These formal tools have been designed and researched by art therapists and continue to be refined. They are taught to art therapists in art therapy programs across the country, and some are best utilized with formal training. In the field of psychology, most clinicians are familiar with a variety of standard art therapy tools, such as the House–Tree–Person and the Draw-A-Person. However, these projective tests have received negative evidence of their usefulness in favor of more global rating scales (Kaplan, 2003).

Self-Portrait

As just mentioned, the Draw-A-Person has been viewed as limited because it is a projective tool. I find it a little more helpful to be more directive with children and ask them to "draw a picture of yourself." When I ask for a self-portrait, the child is likely to become somewhat introspective and make a picture that is associated with his or her self-image at that particular moment in time. I have found it most useful to get at least three self-portraits during my work with children, because their self-image can be grossly distorted by daily life events (academic performance, altercations with peers, being chosen to participate in a project or ignored, etc.). Once a self-portrait is generated, a clinician can glean a subjective view of its emotional content, evaluate the developmental aspects of the drawing, ask the child to say a little about the picture, and note any features of the drawing that may be unusual. Obviously, the more formal training clinicians have in art therapy, the greater the utility of any type of art for assessment or treatment purposes.

Peterson and Hardin (1997) have developed a screening inventory that allows clinicians to look at children's drawings (self-portraits) and endorse the presence of certain variables, such as encapsulation (when children put a square or circle around the figure) or concealment of genitalia. I have used this screening tool before and after group therapy sessions, to study changes in children's self-portraits. The screening instrument enables a numerical value to be given to each picture, and we hope to see the number decrease as children feel better about themselves or their situation. Again, I emphasize that this instrument (for any other art therapy tool) cannot be used to rule in or rule out child sexual abuse. However, it can help clinicians organize their thoughts and perceptions as they look at children's art. This is an adjunctive or ancillary strategy that is best used within the context of comprehensive assessment and treatment.

Kinetic Family Drawing

Kinetic Family Drawing is a well-documented art therapy tool that is used by individual and family therapists alike as an indicator of a child's view of family relationships (Burns & Kaufman, 1972). This type of drawing usually gives clinicians insights into children's perceptions of closeness and distance, absences, preferred activities, and other related issues (e.g., increased interest in one vs. another family member, or dislikes or likes of specific persons). In common with the other techniques mentioned above, the Kinetic Family Drawing allows the clinician to express therapeutic curiosity about the child's thoughts and feelings. Other art therapy tools that I utilize routinely, and that I believe have the potential to provide substantial information, include Person Picking an Apple from a Tree (Gantt & Tabone, 2003) and Draw a Person in the Rain (Oster & Gould, 1987).

Symbol Work

Often children seem reluctant to do "talk therapy," or they simply are so young that they are not comfortable doing so. Other children (or older people) are so prone to overuse language that it is difficult to gauge their emotional states or prioritize what's important to them. In any or all of these instances, it is useful to "cut to the chase" with a very simple exercise that most people will thoroughly enjoy.

For instance, I was working with Caroline, a Hispanic 13-year-old who was having a bad day. She came into my office, plopped herself in the chair, and announced, "I'm not into talking today. I had a rotten day, and I'm tired." I empathized by noting that "everyone has days like this." She looked away and seemed mostly angry. "No worries," I said. "I won't ask you to talk when you don't feel like it." I got up, moved over to the play therapy room, and motioned for her to follow. "I've got an idea. Look around the shelves, or anywhere in the room. I'd like you to find a miniature that best shows the 'rotten day' that you just had, and then find a couple of things that might help you deal with the rotten day." It took

her about 10 minutes to find two miniatures that represented her rotten day. These were two dolls, a boy and a girl, whom she placed in close proximity to each other; she also placed a group of brown-skinned children in one group and a group of white, blond children in another group, with a wall between them (see Figure 4.7).

This led to a discussion about her crush on this particular boy and her worries that she was "not his type" (she was dark-skinned and dark-haired). She worried that the boy she liked only liked blond, blue-eyed girls. We spent some time talking about cultural identity and her comfort with her brown skin and eyes. I introduced the idea that there were lots of different "looks" and that she would be pleasing to some boys and not to others, just as she would like and not like boys for similar or different reasons. I decided to read her a book about racial differences later on, and we then moved to talking about how she might continue to feel better.

When I asked her to pick a miniature that showed something that would help her with her rotten day, she picked a table, chairs, and some fruit, setting up a little dinner table (Figure 4.8). She noted that she was going out to dinner with her father tonight, and that she would have fun going out with him: "He always makes me feel really special, like we're going out on a real date." This child had spent the session talking about her rotten day, and had refocused and looked forward to an experience that would cause her to feel happy. She had identified some of her self-

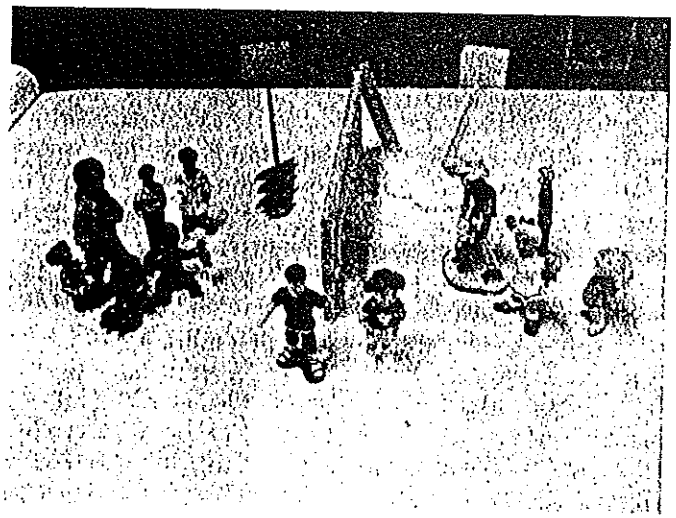

FIGURE 4.7. Caroline's bad day.

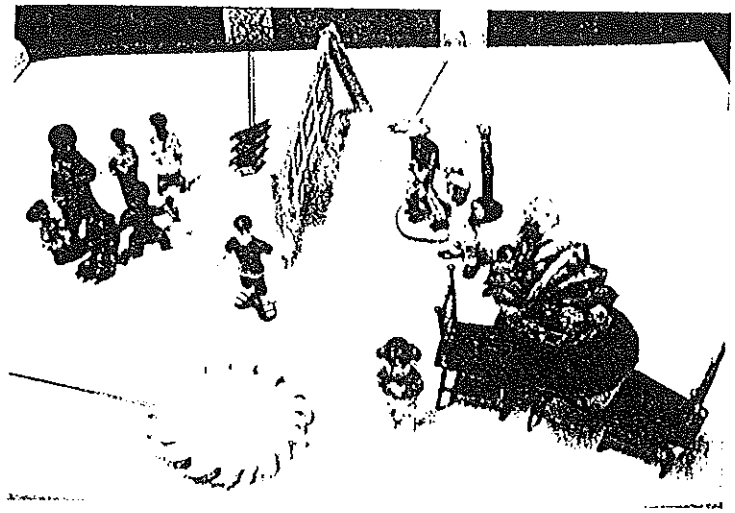

FIGURE 4.8. Help with Caroline's bad day.

image concerns at school and her current worries about boys liking her, and we had talked about how to cope with difficult experiences/emotions. We'd then shifted to talking about how to feel better (less rejected), and she was able to identify her supportive relationship with her father as a resource for herself.

I have used symbol work with groups and families in very specific ways. For example, when the sniper crisis of 2002 occurred in the Washington, D.C., metropolitan area, the anxiety level was understandably very high in all my coworkers. A number of meetings were held to discuss how our personal anxiety was affecting our work relationships and our clients. These were very helpful meetings, except that some people did not feel as comfortable as others did about speaking in groups. Instead, I offered times for people to come to my office and work with symbols. I asked group members first to find miniatures that showed their thoughts and feelings about the crisis that was going on, and then to place those miniatures in a smaller circle inside a larger circle.

After they placed all the symbols of crisis inside the inner circle, I asked them to "find a miniature that best shows the first and second and third step in responding to this crisis—in other words, some possible help or support that might occur in response to the crisis." The final result depicted the crisis as contained or surrounded by symbols of hope, healing, recovery, and resiliency. Those who attended these meetings found this

exercise helpful, and a few commented that these images seemed to "stay with them" for quite a long time. One woman commented that she had a dream that included some of the miniatures.

Combining Verbal Communication with Expressive Strategies

Some children are very adept at verbal communication and seem to enjoy sitting with their therapists, talking, sharing information, and responding to questions. Even when this type of open and facile verbal communication occurs, I still encourage experimenting with expressive arts from time to time, just to amplify, complement, or augment what is being said. These youth tend to enjoy expressive work and often are capable of great insight about their creations. In addition, some highly verbal youth need to develop a comfort level with expressive strategies. The degree of receptivity or noncompliance they exhibit to such strategies can itself be informative.

Play, Puppet, Storytelling, and Dramatic Play

Play therapy offices are usually equipped with puppets and with games and toys for storytelling and dramatic play. All of these techniques can be useful to children and may be employed more or less often, depending on their age and personality (Gerity, 1999; Weber & Haen, 2005). Puppets, for example, can be used by both boys and girls, and in individual, group, or family therapy environments. Puppets can facilitate communication, can spark creative storytelling, or can become instant invitations to create and act out plays. Clinicians must remain tuned in to thematic material, repetition of themes, and the ways stories evolve and get resolved. Chapter Nine discusses a young client whose puppet play served as the pivotal strategy for revealing and processing her feelings about maternal abandonment.

The use of these three techniques cannot be overemphasized as an opportunity for children to take active roles in shaping stories that may symbolically reveal inner concerns and distress. By creating stories and acting them out, children can literally change their perceptions of personal mastery and control. This occurs through their physical movement, attention to detail, narration of a story that might reflect internal concerns, and ability to alter the outcome of such a story (by a change from passive to active mode). These three forms of play therapy are most helpful to children who can use fantasy to compensate for real losses and for those who can discover new options and possibilities, creating a sense of hope.

INTEGRATING EXPRESSIVE THERAPIES AND FAMILY WORK

Play therapy, and other expressive therapies as well, can be incorporated with family therapy sessions (Riley & Malchiodi, 2003; Combs & Freedman, 1990). In my experience, however, many family therapists seem skeptical, hesitant, or ambivalent about using such therapies in their work with families with young children. In fact, some family therapists have questioned the apparent exclusion of young children from family therapy. Green (1994) finds three reasons that might explain this exclusion: some family therapists' inability to relate to children as individuals; the fact that the most influential leaders in the family therapy field were most interested in adults and suggested indirect treatment of children; and some family therapists' lack of basic training and confidence in how to work with children, even when they are motivated to do so. This exclusion continues to be the status quo, despite active and visible encouragement from respected leaders such as Carl Whitaker and Virginia Satir, and recent efforts to promote a crossover between the fields of play therapy and family therapy (Schaefer & Carey, 1994; Gil, 1994). Sadly, neither play (and other expressive) therapists nor family therapists routinely exchange or promote their ideas, strategies, and approaches—partly due to some unwillingness among members of both groups to receive yet more training, and/or because the techniques of one group are viewed by the other with skepticism (as undesirable or impractical).

ESTABLISHMENT OF PROFESSIONAL STANDARDS FOR EXPRESSIVE THERAPIES

By now, groups of clinicians who provide art, play, and sand therapies have instituted professional standards by creating associations and governing and credentialing boards, developing respected journals, and sponsoring annual conferences. Membership in these professional associations has grown over the last two decades, as have high-quality training programs, scientific research, and increased status.

ART THERAPY

The American Art Therapy Association (AATA) was founded in 1969 and has approximately 4,750 members. In 1970, the AATA began to provide certification for registered art therapists, and the certification function is

now provided by the Art Therapy Credential Board (founded in 1993). There are currently approximately 3,000 registered art therapists.

Play Therapy

The Association for Play Therapy (APT) was founded in 1982 and currently has over 5,400 members. Guidelines for becoming a registered play therapist were developed in 1994, and currently there are approximately 620 registered play therapists and 340 registered play therapist supervisors.

Sand Therapy

The International Society for Sandplay Therapy (ISST) was founded by Dora Kalff in 1985, with the help of several international colleagues. Membership in the ISST currently numbers approximately 60 members worldwide, is open to qualified therapists, and is based on a certification process. In the United States, Weinrib and Bradway have been strong leaders in the development of Sandplay Therapists of America, which publishes a journal twice yearly called the *Journal of Sandplay Therapy* (Mitchell & Friedman, 1994).

SUMMARY

Those working with children, particularly child victims of sexual abuse or other forms of maltreatment, recognize their natural reluctance to speak about what's happened to them, how they feel, how they think about things, and how they feel the injuries affect them. Young children in particular have greater difficulty with perceiving such events accurately and reporting them in ways that are clear in meaning. Children have a much broader way of communicating that doesn't rely on their verbal repertoires, and thus clinicians seeking to understand children need to become conversant in expressive strategies.

"Expressive therapies" is a term that includes the therapeutic use of many different expressive techniques, such as visual/manual arts and crafts, play, sand therapy, drama, dance/movement, writing, music, and many more. Pioneering professionals have sought to create a bridge between the expressive arts and mental health; they recognize and honor the many curative and abreactive powers of expressive communication.

In this chapter, special emphasis has been placed on art, play, and sand therapies, since children tend to have a particular affinity for these therapies. However, many other creative interventions are possible. Indeed, many professionals who work with children and adolescents find it necessary to develop a broad repertoire of engaging, dynamic, and creative activities in order to elicit children's attention and participation. The expressive therapies have much to contribute and can be easily integrated with other, more traditional strategies. Case studies further illustrate the potential uses of expressive therapies in work with traumatized children (Gil, 2003b); four such case studies are included in the second part of this book. Finally, readers are encouraged to read the ample literature on expressive therapies and obtain additional training in them, in order to maximize their potential to be useful to children and their families.