Therapy Methods

My approach when working with children and families is dependent on assessment data, presenting issues, best practice standards (i.e., modalities informed by research), and the training I have received. Below are the methods of treatment you can expect from me.

Parent Education, Support & Training

When my kids become wild and unruly, I use a nice, safe playpen. When they're finished, I climb out. ~Erma Bombeck

Few, if any, experiences in life are more important to most of us than raising healthy, well-adjusted children. Parenting brings joy and meaning to our lives but can also be challenging and exhausting. This is especially true when parenting children with special needs or children who are experiencing difficult life circumstances.

I generally spend ample time educating parents about their child's disorder or the circumstances causing their child's distress. When parents have a thorough understanding of how these factors impact the psychological functioning of their child, they are better able to understand why their child is displaying emotional or behavioral problems. This knowledge empowers parents and better equips them to successfully help their child.

I also find value in helping parents reflect on their parenting style, attachment style, and their own families of origin. Forty years of research has linked specific aspects of parenting style to several key outcome areas in child development. For example, traits of high parental warmth, responsiveness and sensitivity balanced with maintaining reasonable expectations of children is linked with children who understand and regulate their emotions well, display healthy self-esteem, and show greater social-emotional competence (e.g., the ability to get along well with others, negotiate social conflicts, manage their emotions). Adult attachment style is also predictive of how parent's view and feel toward their children and is worth exploring. There are, of course, many factors beyond parenting and attachment style that impact the mental health of children, but when parents explore these factors they sometimes can make changes that help their children.

I often spend time teaching parents specific strategies designed to address their child's disorder or the situation causing the child's distress. In alignment with child development and parenting outcome research, I recommend strategies which involve strengthening the parent-child relationship and focus on positive methods of engagement and discipline. In many instances misbehavior can be viewed as a child trying to get his or her needs met in an ineffective manner. It's helpful to discuss ways in which parents can respond to their child's emotional and behavioral problems that will teach their child healthier ways to get his or her needs met.

Parenting foster and adopted children with maltreatment histories is particularly difficult, especially when children have experienced chronic or long-term maltreatment. In such cases I help parents deal with acting-out behaviors (e.g., anger outbursts, defiance, passive-aggressive behaviors such as lying and stealing) as well as children who exhibit insecurity and chronic anxiety (e.g., worrisome, clinginess, fearfulness). I help parents identify and respond to their child according to their child's developmental age, and I educate parents about communication, daily interactions, and play behaviors they can use to facilitate healing and develop a more secure parent-child relationship. I also explore with parents effective behavioral management strategies and work on structuring the home environment to decrease or prevent some of the problems from occurring. Parenting / caregiver programs in which I am trained and often refer to include **Circle of Security™**, Hughes' model of **Attachment-Focused Parenting**, **Conscious Discipline®**, and **Trust-Based Relational Intervention®.**

Copyright® 2018: Greta Zuck, PhD, LPCS, NCC, RPT-S

Infant/Toddler Mental Health Therapy

Whenever I held my newborn baby in my arms, I used to think that what I said and did to him could have an influence not only on him but on all whom he met, not only for a day or a month or a year, but for all eternity - a very challenging and exciting thought for a mother. ~Rose Kennedy

It is hard to believe that emotional development in infants was uncharted territory until the 1930s. To that point experts did not uniformly believe that infants experienced emotional pain or were negatively affected by it. Modern infant research shows that infants have a rich emotional base from birth onward, and that infants who experience early environmental adversity (e.g., medical trauma, unresponsive parenting, child maltreatment) are at-risk for developmental delays, particularly delays in social-emotional development and problems related to parent-child attachment. Many infants and young children recover when risk factors are removed, but some do not fully recover and struggle with social-emotional developmental tasks.

A well-established method of mental health care for infants is **Infant-Parent Psychotherapy** created by Dr. Selma Fraiberg in the late 1970s. The infant-parent relationship is the focus of treatment, and the method focuses on addressing parents' own unresolved psychological problems which interfere with parents developing a healthy relationship with their infants. In other words, there is often a trans-generational transmission of mental health problems (such as attachment style) passed down from parent to infant. Through working directly with parent-infant dyads, the goals of treatment are to help parents become consciously aware of unhelpful interactional patterns, modify misperceptions and mistaken beliefs they may have about their infants, develop empathy toward their infants, and develop a mutually satisfying relationship with their infants.

Dr. Alicia Lieberman's **Child-Parent Psychotherapy** is heavily influenced by Fraiberg's work. The model is a relationship-based form of treatment for parents of children up to age five which integrates psychoanalytic and attachment theory with intervention strategies from cognitive behavioral and social learning theory. Treatment involves joint play sessions with parents and children. During sessions the therapist translates the developmental and emotional *meaning* of the child's behavior to the parent similar to the work done in Infant-Parent Psychotherapy. In doing so, parents often develop a new understanding of their child. The therapist may also provide teaching and role-modeling to parents (e.g., how to engage in protective parent-child caregiving, helping parents become aware of their own trauma triggers which interfere with caregiving, crisis intervention planning, etc.)

Within the last ten years a few additional innovative research projects and early intervention programs have been developed for young children who have experienced early adversity and interpersonal trauma. Such programs have been created for birth, foster and adoptive parents caring for young children, infancy through approximately age five. Two programs are described below.

The Circle of Security™ treatment model was developed by doctors Kent Hoffman, Glen Cooper, and Bert Powell of Spokane, Washington. Circle of Security™ emphasizes teaching caretakers the basic tenants of attachment theory. Parents are taught to recognize and sensitively respond to their young children's needs using detailed graphics and video-based training. The model implements decades of attachment research in a step-by-step process for use in parenting groups, home visitation, and individual counseling. In 2016 I completed the 4-day Circle of Security® Parenting™ (COS-P) training program and became a **Circle of Security Parent Facilitator.**

Led by Dr. Mary Dozier of the University of Delaware, **Attachment & Biobehavioral Catch-Up** is part of the Infant-Caregiver Project. Biobehavioral Catch-up aims to help primary caretakers understand and sensitively respond to their infant's emotional needs. There is an emphasis on responding to young children even when they ignore or reject parental attention and helping parents to consistently nurture their children even when it does not come naturally for them to do so.

Copyright® 2018: Greta Zuck, PhD, LPCS, NCC, RPT-S

I've had the good fortune to attend presentations and trainings by doctors Alicia Lieberman, Robert Marvin, Kent Hoffman, and Mary Dozier over the years. I typically use components of these four models when I work with caretakers of children from birth to age five who are in the foster care system as well as parents who have adopted children. The California Evidence-Based Clearinghouse for Child Welfare rates these programs as supported by research evidence. Attachment and Biobehavioral Catch-Up rates at a Level 1 (Well Supported), Child-Parent Psychotherapy rates at a Level 2 (Supported) and Circle of Security rates at a Level 3 (Promising Practice).

Play Therapy

The beloved American pediatrician, Dr. Benjamin Spock, is quoted as saying, *"A child loves his play, not because it's easy, but because it's hard."* This statement encapsulates Spock's training in psychoanalysis and his belief—revolutionary during his time—in the critical importance of the emotional lives of children and the function that play serves in processing difficult feelings and life events.

Over the last fifty years play therapy has evolved to become one of the most frequently chosen methods of mental health treatment for children. Children, particularly those under the age of ten, lack the abstract language ability and cognitive development necessary to benefit from traditional talk therapy. Play is their natural medium for self-expression, coping, and problem-solving.

As a **Registered Play Therapist Supervisor** since 2008, I am trained to engage children in a variety of play therapies that cover a range of presenting issues. Play therapy is not a singular model of treatment; rather, it is a model that uses differing techniques based on the theoretical orientation being applied. I tailor the play therapy approach I use to the individual needs of each child and family I service. Below is a description of the orientations I use.

Client-Centered and Filial Play Therapy

Child-centered play therapy is one of the most popular methods of play therapy used today. The client-centered approach to psychotherapy was originally created by psychologist Dr. Carl Rogers, and Dr. Virginia Axline refined the method in the 1950s in her work with emotionally disturbed children. Client-centered play therapy is a relationship-based method of treatment which posits that children are able to psychologically grow and change for the better when a safe and accepting environment free from agenda, direction, and constriction is provided for them. This type of play therapy allows children to freely express themselves—their conscious and unconscious thoughts, feelings, and actions—through the use of carefully chosen toys and art supplies.

During client-centered play therapy specific toys are present which allow children to express and process a variety of emotions (e.g., toys for nurturing, acting out aggression, developing mastery skills). Children are free to play as they wish while therapists closely track and verbally reflect back to children what they are doing and the feelings they are expressing in their play. Doing so helps children feel understood and validated in the context of a safe and trusting relationship.

Parents can learn client-centered play therapy to use at home. This play method, originally developed by doctors Bernard and Louise Guerney in the 1960s, is referred to as **Filial Therapy**. One effective filial model, developed by Dr. Garry Landreth, is **Child Parent Relationship Therapy (CPRT)**. Teaching parents how to therapeutically play with their children is a highly effective way for parents to build more connected and fulfilling relationships with their children. The play sessions provide an opportunity for children to get their emotional needs met which, in turn, often leads to improved communication, better emotional control, and more cooperation from children outside of play sessions. CPRT is a well-researched parenting model with numerous studies investigating its effectiveness and the majority showing statistically significant results and moderate to large treatment effects for the superiority of CPRT over control groups.

Copyright® 2018: Greta Zuck, PhD, LPCS, NCC, RPT-S

The mother of a former client comments on using filial therapy with her 7-year-old son, with whom she was experiencing defiance, anger, and tension in their relationship:

> *"Learning how to play with my child in therapy has completely changed our relationship, but it took me a while to buy into it. At first I was uncomfortable with him having so much control of the play. I felt like just an observer sitting there watching and verbalizing what he was doing, and it seemed strange and pointless. But after several sessions he began to ask me to play more with him. After a while I got used to completely following his lead and letting him be the boss when he played, and then his play changed—he then seemed to work through a lot of heavy feelings in his play. It makes sense that this may have been a result of me backing off and giving him the space and control he needed to totally be himself. I think he felt like I was really beginning to understand him and accept him. At home he became easier to be around, and he seemed happier."*

I most often use client-centered play therapy with young children suffering from developmental delays, low self-esteem, depression, and adjustment difficulties. I frequently teach parents filial therapy when there is a conflict in the parent-child relationship or when parents desire to improve their relationship with their child.

Psychoanalytic Play Therapy

The origins of psychoanalytic play therapy belong to psychoanalysts Dr. Anna Freud (daughter of Dr. Sigmund Freud, founder of psychoanalytic theory) and Melanie Klein. This play method attempts to holistically understand and appreciate children by providing a safe and accepting environment for them to explore their thoughts and feelings through symbolic play. Children re-enact difficult life situations through play while therapists provide a psychological "holding" environment for them by empathically listening and allowing children to project their difficult thoughts and feelings onto them. In doing so, children's defenses to their emotional pain are respected and they are able to maintain a safe psychological distance from their troubles.

Psychoanalytic play therapy provides an environment similar to client-centered play therapy, but differs in that psychoanalytic theory asserts children require encouragement and direction from therapists to confront painful thoughts and emotions. Therefore, during psychoanalytic play therapy, therapists gently confront and interpret children's play behaviors in an effort to help them clarify and understand their problems and develop greater self-acceptance. I often use psychoanalytic play therapy when working with children struggling with loss, depression, anxiety, and children coping with major life changes.

Object Relations Play Therapy

It is in playing, and only in playing, that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self. ~D.W. Winnicott

Object relations play therapy incorporates object relations theory and attachment theory. This developmental treatment model integrates the work of Melanie Klein and doctors Donald Winnicott and Margaret Mahler. Objects relations theory posits that early interactions between infants and their caretakers become internalized, forming mental templates that filters the view infants have of themselves, others, and their world. Thus, this play method is often used with children who have experienced significant trauma and maltreatment during their first few years of life. Such children often develop rigid, disturbed internal working models and have trouble trusting adults and their environment. This leads to difficulty in trust and attachment (i.e., connecting positively with others, receiving and accepting nurturing) and emotional regulation.

Copyright® 2018: Greta Zuck, PhD, LPCS, NCC, RPT-S

The goal of object relations play therapy is to help children develop a more positive internal working model and a more secure style of attachment. Using both non-directive and directive play in a highly attuned, developmentally sensitive, and invitational manner, therapists confront and challenge unhealthy themes in children's play. Through this approach a "secure base" is provided for children in the play room which assists them with building trust in adults, encouraging their receptivity to nurturance while decreasing their defensiveness.

I often use this model of treatment with children who have experienced early relational trauma and parental loss, such as children in foster care and adopted children.

Theraplay®

Invented by Dr. Ann Jernberg in the late 1960s, Theraplay® is a directive, specialized form of developmental play therapy based on attachment theory, object-relations theory, and self-psychology. Theraplay® consists of play-based activities designed to facilitate healthy parent-child relationships in a playful atmosphere of empathy and attunement—eye contact, gentle touch, close physical proximity, sensory motor stimulation, and rhythmic movements are used. Further objectives are to help children develop a positive sense of self, improve their ability to be self-reflective/self-aware, and improve their ability to feel more secure in relationships.

Emerging research indicates that Theraplay® provides high levels of stimulation to the brain structures involved in emotional regulation and regulatory processes. Although originally developed for high-risk children and their caretakers, Theraplay® has since been adapted to work with foster and adopted children, children with autism and other pervasive developmental delays, children with selective mutism and other anxiety disorders, and children with fetal alcohol syndrome.

Training by the Theraplay Institute in Chicago is available for clinicians who wish to use the method. I attended the standard 4 day training, Level 1 Theraplay® and Marschak Interaction Method in 2006 and Level 2 Theraplay® in 2017. I use Theraplay often with adoptive families. The California Evidence Based Practice Clearinghouse for Child Welfare has given Theraplay a scientific rating of Level 3 (Promising Practice).

Expressive Play Therapies

Rather than healthily expressing their difficult feelings children may act their feelings out (e.g., tantrums, defiance, hitting, toileting issues) as well as hold their negative feelings in (e.g., depression, self-injurious actions, somatic symptoms). Expressive therapies involve the creative use of **music, writing, movement, art,** and **drama** to provide children with a non-threatening outlet for self-expression and the expression of emotions. Both directive and non-directive approaches are used to encourage children to express themselves in both verbal and non-verbal ways. I often use expressive art therapies with children who have difficulty with self-expression and children who have a natural desire to express themselves using music, writing, drama, or art.

Copyright® 2018: Greta Zuck, PhD, LPCS, NCC, RPT-S

Therapeutic Stories: Narrative Therapy, Bibliotherapy, and Lifebooks

Narrative therapy and bibliotherapy techniques are based on the belief that we make meaning of our lives through the stories we hear and tell. Books and stories can illustrate various problem situations relevant to children in either direct or metaphoric language. Most children easily relate to characters in stories and a dialogue can then open in a non-threatening way to discuss difficult situations children experience. Stories are particularly useful when children have difficulty understanding and expressing their feelings, and they also are helpful when providing mental health assessments since children project their own needs and experiences into their understanding of stories.

I use bibliotherapy and narrative therapies often with children struggling with major life changes such as divorce, blended families, school-related challenges, and behavioral challenges. With foster and adopted children I often create a Lifebook which is a unique story constructed to provide children with an orderly, cohesive narrative of events in their lives (e.g., facts about their birth, their birth family, why and how they were removed from their birth family). Lifebooks help children make sense of their lives, reduce magical thinking, and correct distorted ideas children may have about themselves and their birth families.

Cognitive Behavioral Play Therapy

The cognitive behavioral model is used frequently in the mental health field with individuals of all ages with various presenting problems. The model, originally developed in the 1950s by cognitive theorists doctors Aaron Beck, Albert Ellis, and Donald Meichenbaum, asserts that it is not events that cause negative feelings and outcomes; instead, negative feelings come from our appraisal and belief systems about ourselves and events. They posit we often feel badly about ourselves, others, and situations due to distorted, irrational, or unhelpful belief systems that we've developed and are maintaining. These beliefs become internalized and cause us to feel and behave in negative ways. Thus, the goal of cognitive behavioral therapy is to change maladaptive thinking patterns. The Greek philosopher Epictetus summed up the essence of cognitive therapy well by stating, "What disturbs men's minds is not events but *their judgment* on events."

Cognitive behavioral therapy joined with play therapy in the late 1980s, beginning with psychologist Dr. Susan Knell. Dr. Knell began modifying adult cognitive therapy techniques by using developmentally-based play methods of engagement with children to help them modify maladaptive thinking patterns. Cognitive behavioral play therapy uses directive and structured techniques to teach children how to identify and use positive self-talk, identify and refute negative or helpful thought patterns, and teach children how to cope with stressors. Skills are taught, modeled, and role-played in sessions using puppets, bibliotherapy, narrative therapy, and games.

I often use cognitive behavioral play therapy for children experiencing depression, anxiety, chronic worry, and insecurity. I've also been trained in **Trauma-Focused Cognitive Behavioral Therapy,** an evidence-based treatment method for children who have experienced significant traumatic events such as sexual abuse. Treatment includes psychoeducation, teaching emotional regulation and coping skills, and completing a trauma narrative with children (i.e., gradual exposure to decrease trauma symptoms)

Copyright® 2018: Greta Zuck, PhD, LPCS, NCC, RPT-S

Skills Training: Social Skills, Anger Management, Coping Skills

Many children with social-emotional problems, mental health conditions, learning disabilities, and processing problems benefit from direct skills training. Not all children intuitively understand, for example, how to behave in socially acceptable ways with their peers. Some children may not have been taught or modeled acceptable social behaviors. Other children may have had adequate teaching and exposure, but may have difficulty accurately reading, processing, and responding to social cues as with children who have Non-Verbal learning Disorder or Autistic Spectrum Disorder. Some children may simply be excessively anxious in social situations causing them to have impairment.

Some children—both with and without mental illness—have difficulty regulating strong emotions such as frustration, anger, and anxiety. These children often benefit from learning to label their feelings, identify their triggers, and develop a realistic coping plan for themselves. Furthermore, many children will benefit from learning how to systematically relax and calm their minds and bodies. There is a growing body of research validating the benefits of such mind-body work.

I utilize a variety of interventions when engaging in skill building with children. Therapeutic board games and activities are often useful for practicing and rehearsing skill sets. Such games often operate from a cognitive behavioral orientation and children are required to use positive self-talk, refute unhelpful thoughts, or practice coping techniques during game play. Behavioral modeling and role-play are also beneficial. For instance, children may watch their parents and I act out a challenging scenario with dolls, puppets, or ourselves as the actors. After observing, children participate as actors in scenarios, practicing appropriate ways to socially engage, handle anger, etc.

Meditation, Mindfulness, and Yoga

Over the last few years neuroscience has informed us that there is value in learning to regulate stress and challenging emotions by learning meditation and mindful techniques, and emerging research shows positive results. Meditation and mindfulness can help with physical problems, emotional problems, and coping with life stressors.

I utilize techniques from Jon Kabat-Zinn's **Mindfulness-Based Stress Reduction (MBSR)** program, a method of using meditation and yoga to cultivate awareness and reduce stress. It is based on the ancient practice of mindfulness, which involves present moment awareness, deep relaxation, and gentle movement. Through mindful meditation children learn to consciously observe their reaction to stressors before responding. Those who practice MBSR report an increased ability to relax, greater enthusiasm for life, improved self-esteem, and increased ability to cope more effectively with stressful situations.

I also incorporate yoga when I believe it will be helpful for the children I service. I became a certified children's yoga instructor in 2012 through **YogaKids® International, Inc.** after completing 200 hours of Yoga Alliance approved training. Please visit the "Yoga for Children" link under "Services"on my website for more information.

Parents can access many free and low cost apps and downloads to help children learn breathing techniques, visualization and guided imagery, progressive muscle relaxation, and other techniques to positively manage stress. Over 1,500 free audio and video recordings can be found online at Mindfulness Exercises at: https://mindfulnessexercises.com.

Copyright® 2018: Greta Zuck, PhD, LPCS, NCC, RPT-S

Family Therapy

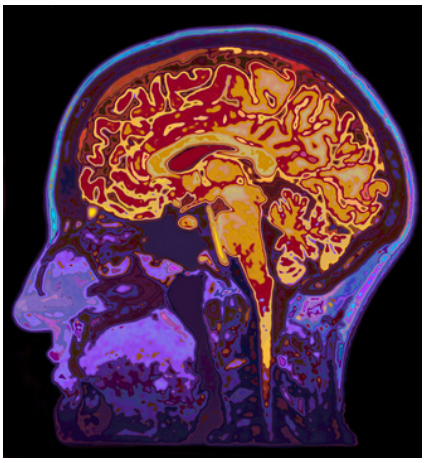
Family systems theory proposes that an individual's psychological problems can develop and be maintained in the context of family functioning. Family therapy focuses on exploring the interactions that occur among family members and how these interactions may be reinforcing problematic beliefs, feelings, and behaviors in family members and the family as a unit.

I find family therapy to be especially useful in families experiencing conflicts passed down generationally, as well as for families experiencing situations involving major life changes (e.g., divorce, new baby, blended families).

Family therapy is a useful model to use with **adoptive families**, especially with older adopted children. Issues in adopted children who have experienced maltreatment prior to adoption often impact not just the child, but the entire family system, including the parent-child relationship, other children in the family, and marital relationships. Children who have experienced maltreatment and multiple changes in caregivers often have a very different view of a family than do children born into stable, loving families.

Family therapy can serve to safely explore the dysfunctional beliefs and behaviors that such children have developed and may be maintaining within their new adoptive families. In 2001 I completed a 4 day training with Dr. Daniel Hughes in his model of care, **Attachment Focused Family Therapy**, also knows as **Dyadic Developmental Psychotherapy** when used with adoptive families. This family-based approach involves teaching parents to employ an attitude of playfulness, acceptance, curiosity, and empathy when addressing their children's emotional and behavioral problems which are rooted in the parent-child attachment relationship. Parents are taught the critical skills of how to use affective-reflective dialogue in communication with their children, manage their children's sense of shame, understand the disrupt-repair cycle in parent-child interactions, and consider their own attachment style.

Eye Movement Desensitization and Reprocessing



Eye Movement Desensitization and Reprocessing, also known as EMDR, is a method of psychotherapy developed by psychologist Dr. Francine Shapiro in 1989 to address the distressing symptoms associated with traumatic and adverse life experiences.

Treatment works by accessing memory networks in the brain which store disruptive or traumatic experiences. Traumatic memories (i.e., inadequately processed memories and their associated images, thoughts, emotions, and physical sensations) are re-processed using a therapeutic technique called bilateral stimulation. Through the unique processing of EMDR, troublesome memories are desensitized, insight emerges, and a shift in consciousness allows for new learning and experience. Traumatic event and memories are not erased; rather, they have been redefined and cease to hold power and control over the individual.

Research supports the effectiveness of EMDR for children and adults who have experienced life events which cause traumatic stress, generalized anxiety, depression, phobias, grief/loss, and attachment trauma.

EMDR is used across the globe and has gained significant validity over the last decade. Over 30 randomized controlled trials now support effectiveness, and EMDR is endorsed as an effective treatment by the World Health Organization (WHO), the American Psychiatric Association, and the Department of Veteran Affairs. In 2017 I completed Basic Training in EMDR through the EMDR Institute, which includes 4 days of instruction taught over 2 weekends.

Copyright® 2018: Greta Zuck, PhD, LPCS, NCC, RPT-S