PRESIDENTS OF THE CONFERENCE

Susan M. Knell,
Clinical Psychologist, Ph.D.
Private practice and Case Western Reserve University
Cleveland, Ohio, USA

Maria A. Geraci,
CBT Psychotherapist, PTP.
Director of the CBPT Research Center
Rome, Italy

Dear colleagues,
We are very happy to welcome you to Rome, at the eCampus University, via Matera 18, on 8th and 9th June 2024 for the First International Conference on Cognitive Behavioral Play Therapy (CBPT). This conference will bring together industry experts in the field, as well as practitioners, researchers and students interested in CBPT.
The conference will take place in the beautiful and historic city of Rome, where the CBPT Research Center is located. For two days we will be immersed in CBPT presentations, symposia and posters. We invite you to follow the program to find out about all the interventions.

We hope to create a stimulating discussion and growth for all of us!
We wish everyone a good start to the Conference!

Greetings,
Susan M. Knell and Maria A. Geraci

SCIENTIFIC COMMITTEE

	Ornella Argento Psychologist, Psychotherapist CBT, Researcher Head of Research for CBPT Research Center Rome, Italy.
	Carlo Baldari Professor (Full) and Delegate of eCampus University Novedrate, Italy
	Marco Cavallo Professor (Associate) at eCampus University Novedrate , Italy
	Meena Dasari Clinical Psychologist, PhD Private Practice, New York Case Western Reserve University, Adjunct Professor New York, USA
	Didem Altay HCPC reg Counseling Psychologist at Therapy, Ph.D, RPT & EMDR Europe London, United Kingdom

8TH JUNE MORNING

9.00 h – 10.00 h **INSTITUTIONAL WELCOMES**
Magnifico Rettore of the University eCampus, **Professor Enzo Siviero**
Delegation from UNICEF Italy – **Valentina Zerini**

WORK OPENING
Presidents' Presentation Maria A. Geraci and Susan M. Knell

SESSION: COGNITIVE BEHAVIORAL PLAY THERAPY
(Chairman: Maria A. Geraci)

Susan M. Knell,
Clinical Psychologist, Ph.D.
Private practice and Case Western Reserve
University Cleveland, Ohio

10.00 h -11.00 h

History of Cognitive Behavior Play Therapy (CBPT)

The history of play therapy is traced to Sigmund Freud and his treatment of Little Hans. Although Freud had little interest in working directly with children, his observations of play suggested that children repeated overwhelming and unpleasant experiences from their lives. Child psychoanalytic therapists, in particular Melanie Klein and Anna Freud, worked directly with young children, believing that play allowed unconscious materials to surface. By the mid-1940s, Carl Rogers' client centered approach took root in Virginia Axline's

non-directive, child centered play therapy (CCPT). Later, play was incorporated into other theoretical approaches, such as Adlerian, Gestalt, and Filial play therapies.

As the field widened, there was growing interest in using play in psychotherapy. Several "firsts" in the play therapy field are noted, including conferences, graduate level training, and professional organizations, such as the Association for Play Therapy. For clinical practitioners interested in working with young children, these opportunities lent some credibility to play as a tool in psychotherapy.

However, the mere use of play in child psychotherapy was not enough to solidify its credibility. Empirical studies, many of which documented that play therapy had a positive effect on social-emotional development, played a prominent role in improving its acceptance. However, most of these studies over the last 20 years have included only treatment with Child centered play therapy as the primary orientation. In other studies, the theoretical orientation of the play therapist was not considered, referring to a somewhat "generic" play therapy, which made it more difficult to understand the mechanisms of change. The empirical study of play therapy has strengthened the field, but future studies would benefit from specificity and clear descriptions of exactly what is being studied. Currently, accurate, peer reviewed research on play therapy is available from the Play Therapy Outcome Research Database, maintained by The Center for Play Therapy at the University of North Texas (https://evidencebasedchildtherapy.com).

Behavior therapy with children, later in combination with Cognitive therapy, became more widely accepted and used. During the time in which play therapy was receiving more positive acceptance, the field of Cognitive behavioral therapy (CBT) for children and adolescents was blossoming. The field of Cognitive behavior therapy with children became the gold standard for children with diagnoses such as Depression, Anxiety and PTSD.

The field of Cognitive Behavior Play Therapy was a logical step in the development of CBT with young children, as it became possible to find developmentally sensitive approaches to incorporate CBT and play therapy. In CBPT, the child takes an active role in the process of change and mastery of problems. Currently, there are many case reports with a wide range of

presenting problems and some small-scale studies that support the use of CBPT. More empirical studies are underway.

A growing body of research utilizes Cognitive behavioral play interventions (CBPI) with non-clinical samples, sometimes in group settings (Pearson, 2008, Fehr et al, 2017). This approach is not psychotherapy, per se, but is based on CBPT principles. CBPI contributes to our understanding of CBPT by providing empirical support for specific cognitive behavior play techniques and strategies which are the basis of CBPT. Studies have shown positive results for children with issues such as sleep difficulties (Fehr, et al, 2016).

The term Cognitive Behavior Play Therapy was first mentioned at a 1986 national conference for clinical practitioners (Knell, 1986), with the first published article on CBPT in 1990 (Knell & Moore, 1990). The book, Cognitive Behavioral Play Therapy (Knell, 1993) was translated into Italian (1998) and Turkish (2021). Over the last 30 years, CBPT has been the subject of edited books, published articles, and case studies. An important development in promoting CBPT research, training and dissemination of information was the establishment of the CBPT Institute in Rome, Italy, in 2020. As part of this initiative, the 1st international conference on CBPT, held in Rome brings together professionals in the fields of CBT, Child Psychotherapy, Play Therapy and Developmental Psychology.

Guidelines for the implementation of CBPT are important and are reviewed to enhance the promotion of a unified understanding of what CBPT is and what it is not. These guidelines include how CBPT should be introduced to a child and parents, the structure of sessions, setting limits and using modeling in play, and consideration of making clinical decisions from the perspective of case conceptualization. A review of CBT treatment manuals for children, and the development of a CBPT Manual to treat anxious children (Dasari & Knell, in preparation) will be discussed. Future recommendations are considered as CBPT steps out of its infancy and moves along its developmental trajectory.

Meena Dasari
Clinical Psychologist, PhD
Private Practice, New York
Case Western Reserve University, Adjunct Professor
New York, USA

11.30h- 12.00

Using Cognitive Behavioral Play Therapy to Treat Social Anxiety

Cognitive Behavioral Play Therapy (CBPT) is a developmentally sensitive treatment which has been developed and used with young children (ages 3-8 years). CBPT is based on integrating two effective treatments - cognitive behavioral therapy and play therapy. This presentation will demonstrate the use of CBPT to successfully treat Social Anxiety in a 5-year-old boy.
Social Anxiety occurs in approximately 3% to 7% of children but is frequently seen in clinical settings. For children with this disorder, their anxiety centers around being rejected or unliked, which leads to avoidance or distress in performance situations. This results in significant impairment in social or academic functioning.
Henry was diagnosed with Social Anxiety and seen for 17 sessions across 5 months. Therapy sessions were a balance between unstructured and structured play. Case conceptualization will be included and linked to CBPT intervention. Specifically, the individual and environmental factors will be discussed as well as the connection to development and maintenance of the presenting problem. Treatment goals for CBPT for social anxiety are designed to help the child feel in control of anxiety and increase approach behavior. Each CBPT technique used to treat Social Anxiety will be described and include:

- Psychoeducation to increase awareness and ability to verbalize anxiety
- Relaxation to calm physical sensations of anxiety
- Cognitive change strategies
- Extinction or distraction

- Modeling using a puppet
- Exposure (systematic desensitization) with modeling built in
- Parent Involvement - only 1 phone session and 1 post treatment check in

Overall improvement in anxiety based on parent report and preschool anxiety rating scale. Henry's symptoms were in the developmentally typical range after CBPT intervention.

At the end of this session, participants will be able to:

- Understand and apply CBPT strategies to treat anxiety in young children.
- Describe the importance of CBPT case conceptualization and list key individual factors, environmental factors, and components of presenting problem
- Design and evaluate CBPT intervention based on diagnosis

Francesca Romana D'Angelo
Psychologist Psychotherapist CBT in training
CBPT Research Center
Rome, Italy

12.00 h- 12.30 h

The Puppet Sentence Completion Task

Play, having a fundamental role in child development, has received considerable attention from mental health professionals who deal with the diagnosis and treatment of school and preschool children. Play is universally recognized as important for cognitive, social, emotional, physical and linguistic development and although it represents children's natural language and the means through which to communicate what cannot be expressed in words, there is still no research to support the the use of gaming as a valid and reliable tool for psychological assessment (Russ, 2002).

Very often today, the clinical diagnosis of children relies on formal tests and although the majority of children of school and preschool age are able to engage in the tasks required by the cognitive and projective tests used, young children are often unable to cope with language and cognitive demands of these procedures due to characteristics related to their development. Since young children learn and communicate through play, it is of primary importance to use early childhood psychological assessment systems that rely on play rather than verbal skills in clinical practice. The Puppet Sentence Completion Task (PSCT) fits in this direction, a play-based evaluation tool built by Susan Knell (Knell, 1992, 1993) which is included among the sentence completion tasks. Although sentence completion activities have not yet been psychometrically validated, they appear to be interesting methods of investigation since the qualitative analysis of the responses allows the clinician to collect useful information on the child's functioning and on the reason why the task was requested. Initiation of psychotherapy within clinical practice. The use of traditional sentence completion tasks is generally not appropriate for children younger than 6-7 years old as they may experience difficulty understanding the expectations of the task, and consequently responding coherently to questions. However, having recognized the importance of the clinical material that can be collected from a sentence completion task, Knell (1992, 1993) proposed the integration of the use of puppets with the traditional instrument. With this intervention, you recognize the importance of PSCT by recognizing its value as a more accessible and appropriate tool for preschool children. The objective is to deepen the integration of puppets in psychological evaluation and underline the importance of a more sensitive approach to development that allows the clinician to carry out a direct evaluation even on the 2 ½-7 year old child.

Adriana Lis
Psychologist, psychotherapist
Full Professor, University of Padua
Padua, Italy

12.30 h- 13.00 h

The use of the Affective Play Scale" by Sandra Russ in Italy: history, developments and research and clinical applications

A. Lis*, C. Mazzeschi**, D. Di Riso*, E. Del Vecchio**

*University of Padova ** University of Perugia

Play represents a very widespread means of communication and a natural language for the child, making it a universal means of communication with children regardless of their linguistic and cultural differences. Play offers itself as a mediator when one finds oneself working with young people in difficulty, even whether they come from different cultures or backgrounds (O'Connor, 2005). Within the various ways of defining and specifying the play, what is defined as "symbolic play" or "pretending", plays a very important role. Although symbolic play acquires a specific developmental meaning for toddlers and at the beginning of preschool age (Bergen, 2002; Pellegrini, 2010), and reaches its peak in this narrow age range (Singer & Singer, 1990), it takes on a very important role not only in the entire preschool age but also in school age. For preschool and school age children it represents the integration of cognitive and affective skills, different domains that must be kept in mind to evaluate the child's development through play (see for example the reviews by Russ (2004) and Singer et al. (2006). Symbolic play is the result of cognitive and affective integration which is responsible for the development and acquisition of skills related to: Cognitive development (e.g. divergent thinking), Emotional development: (e.g. emotional recognition, emotion regulation); Adaptation (e.g. social and educational adaptation); Mental health (e.g. internalizing and externalizing disorders). In observing and evaluating the cognitive and

emotional dimensions present in the child's symbolic play, research in this field has underlined the importance of standardized measures that evaluate the cognitive and affective processes that occur simultaneously in play sessions (e.g. Russ, 1993 , 2004; Kaugars & Russ, 2009). Furthermore, research has often created tools aimed at ascertaining the cognitive and affective domains separately in the play. Finally, many of these tools still do not have clear and standardized administration procedures (e.g. Gitlin-Weiner et al, 2000; Chessa et al., 2012). Sandra Russ (2004) was one of the first authors who attempted to satisfy all these conditions in designing a series of measures that all fall under the general heading "Affect in Play Scale (APS)": (a) "Affect in Play Scale (APS)" a standardized measure of symbolic play for use with school-age children (6-10 years); (b) "Affect in Play Scale-Preschool Version (APS-P)" a standardized measure of symbolic play for use with preschool children (4-5 years), then extended to the (c) Affect in Play Scale Preschool Version (APS-PS) Extended Version (application of the APS-PS to children aged 4 to 10 years). The purpose of this presentation is to illustrate the various versions of the scale, their use in Italy and the importance for their use in the clinical setting.

Jacqueline B. Toner,
Clinical Psychologist, PhD
Baltimora, USA

13.00 h- 13.30 h

The use of Workbooks in Cognitive Behavioral Play Therapy

Most young children find picture books enjoyable and are accustomed to learning from them. Therapists can capitalize on children's past experiences with books to present principles of Cognitive Behavioral Therapy (CBT) in the context of a familiar and comfortable activity. Using books communicates to a child that their own struggles are not unusual or specific to them. They are

introduced to fictional characters who share fears and anxieties like their own. This helps to normalize common childhood challenges. In fact, the mere existence of a book on the topic of their concern suggests that they are not alone. Another advantage of bibliotherapy is the structure it provides the therapist to introduce the ideas of Cognitive Behavioral Therapy, as well as other strategies, in a nonthreatening but systematic fashion. By reading about what fictional characters experience, children may be more open to learning than if confronted with how to deal with their own intense feelings. And, as with all learning, practicing new skills is important. Working through a book with simple exercises ensures that concepts are presented in an organized way with opportunities for practice.

Used at home or in schools, CBT based books can teach concepts which may boost coping skills to prevent childhood anxieties and fears from escalating. For children in therapy, books can provide a bridge for important adults in the child's life (including parents and teachers) to the ideas that the therapist is presenting. They then have a model and language for reinforcing this information at home and in other environments. Books provide a model for caregivers on how to talk to children about challenges as they arise in real world situations.

The American Psychological Association, through Magination Press, offers a wide variety of books aimed at children of all ages. Many are based on principles of CBT (including the WHAT TO DO WHEN…series for elementary aged children) and all are vetted by professionals in the field.

13.30 h – 14.30 h LUNCH BREAK - POSTER SESSION

08TH JUNE AFTERNOON

SESSION: Cognitive-behavioral play interventions in school, rehabilitation and hospital settings.
(Chairman: Ornella Argento)

Maria A. Geraci,
CBT Psychotherapist, PTP.
Director of the CBPT Research Center
Rome, Italy

14.30 h- 15.00 h

The effects of cognitive behavioral play intervention at school

School is of fundamental importance for the psychophysical and relational development of children and adolescents. School research highlights the importance of play starting from nursery school as it contributes to the cognitive, social, motor and linguistic development of children (Lynch, 2015; O'Connor and Stagnitti 2011; Fazio-Griffith and Ballard, 2014; Spivack et al., 1986; Spivack and Marcus, 1987).
In the school context, scientific literature widely supports the use of play therapy, albeit expressed in different theoretical approaches, as an effective intervention to help children cope with a variety of needs, including behavioral difficulties (Cochran et al., 2011; Flahive & Ray, 2007; Garza & Bratton, 2005), self-efficacy (Fall et al., 1999), self-esteem (Baggerly & Parker, 2005), family

change, grief, trauma (Kot & Tyndall Ind, 2005) and academic concerns (Blanco & Ray, 2011).

The Cognitive Behavioral Play Intervention (CBPI) theorized by Pearson (2008) and inspired by Knell's cognitive behavioral play therapy (1993), as underlined several times, is not a psychotherapy in itself, but represents an important initial contribution to the empirical support that is consolidating around cognitive-behavioral play therapy.

This speech will present Pearson's study (2008) that provides empirical support for the effectiveness of applying cognitive-behavioral play therapy within the school context. Pearson experimentally conducted a Cognitive Behavioral Play Intervention (CBPI) aimed at increasing hope and school adaptation in pre-school children. This intervention was structured on the basis of the theorization of cognitive behavioral play therapy (CBPT) by Knell (1993a; 1998) and, in parallel, on the conceptualization of hope in children proposed by Snyder et al. (1997). Through this intervention it was possible to teach, indirectly, to children that when facing a problem they can use their thoughts in a conscious way in order to mediate the event. Specifically, they were taught to use hopeful thought statements that enhance their sense of agency and a problem-solving method to generate direct paths to achieving their goals. Many aspects of Knell's cognitive behavioral play therapy (1993a; 1998) were incorporated into the cognitive behavioral play intervention: specific plays and dolls for the target problems were chosen; modeling and praise were used to teach hopeful thinking skills; Children were taught to use self-instructions and practice positive self-affirmations during play sessions. The study was conducted on 48 preschool children randomly assigned to an intervention condition of cognitive behavioral play or two control conditions (free play and play with puzzles and drawings with neutral content), which differed mainly in terms of different types of interaction between the researcher and the child through play. In the cognitive-behavioral play intervention, the researcher essentially modeled the children's hopeful thinking and problem solving skills in a directive approach, and at the same time encouraged imagination and subjective affective expression in the narrative using commonly used play therapy techniques. used.

The results of the study demonstrated the effectiveness of the cognitive-behavioral play intervention on the hopeful thoughts and social competence of preschool children, together with a decrease in anxiety-withdrawal symptoms,

in accordance with the reports compiled by the teachers. Furthermore, it was found that engaging in pretend play, even when specific skills are not explicitly taught, is useful for reducing anxiety and stress and improving children's social skills.

The objective of future research in this context could focus on the implementation of the Cognitive Behavioral Play Intervention also as a support for teachers to help students overcome challenges that can hinder their growth, their emotional well-being and their academic success. It is therefore desirable that the principles and strategies of Knell's CBPT are used to develop other cognitive behavioral play interventions aimed at other specific problems, for example improving self-esteem, relationships with peers and the sense of self-efficacy (Pearson, 2008). Since school plays a fundamental role in the growth and development of adequate skills, acting as a source of reinforcement or extinction of the child's adaptive or maladaptive behaviors, in recent years the need for prevention in school contexts has been growing more and more .

Martina Zanaboni
Psychologist and rehabilitator
“Mondino” Hospital
Pavia, Italy

15.00 h- 15.30 h

The effects of cognitive behavioral play intervention on the quality of life of children with epilepsy syndromes with onset in childhood

The intervention "The effects of Cognitive Behavioral Play intervention on the quality of life of children with epilepsy syndromes with onset in childhood" will present an experimental protocol of Cognitive Behavioral Play Therapy (CBPT) on a sample of children with epilepsy at infantile onset.

The project involves a randomized controlled trial with a control condition. Children with epilepsy will be randomly assigned to one of the two intervention conditions.

The primary objective of the study will be to promote the improvement of quality of life through a cognitive behavioral play intervention. Specifically, the primary objective will be to verify whether there is an improvement in the quality of life in children with epilepsy following a cognitive behavioral play intervention. The intervention was structured according to the theoretical approach of Cognitive Behavioral Play Therapy and whether in this group these improvements are superior to the group of children who will carry out a free play intervention.

The secondary objective of the study will be to stimulate positive thinking and improve problem solving and coping skills which are crucial for the psycho-emotional development of children. Specifically, it will be verified whether through a cognitive behavioral play intervention structured according to the theoretical approach of Cognitive Behavioral Play Therapy it is possible to induce an improvement in positive thinking, problem solving and coping strategies and whether this improvement is significantly greater in these children compared to those who will carry out a free play intervention.

With this study we expect to begin to verify the effectiveness of specific protocols of cognitive behavioral play interventions to be applied in hospital contexts and which support clinical medical work.

The hypothesis underlying the study is that children with epilepsy, by accessing structured play sessions according to the CBPT model, can acquire the tools for better management of the quality of life aspects of treatment linked to their pathological condition and hospitalization experience.

The presence of internalizing and externalizing behaviors, coping strategies, positive thinking, problem solving ability, together with their quality of life will be assessed at baseline (T0) and at the conclusion of the intervention sessions (T1). During the presentation, the neurocognitive and emotional characteristics of subjects with epilepsy will be presented and the research protocol will then be presented.

For the purposes of the study, children aged between 6 and 10 years of both sexes will be recruited. Children diagnosed with epilepsy of the type will be included: self-limiting focal epilepsy of childhood (SeLFE); Childhood absence

epilepsy (CAE), Self-limiting epilepsy with central-temporal paroxysms (SeLECTS); Self-limiting epilepsies with autonomic seizures (SeLEAS); Childhood Occipital Epilepsy (COVE); Photosensitive occipital lobe epilepsy (POLE). Current therapeutic treatment will not be considered in the exclusion criteria but taken into account during the statistical analyses.
Children with epilepsies comorbid with neurological pathologies, significant cognitive disabilities (relevant cognitive disabilities must be specified with IQ) and such as not to allow the understanding or carrying out of the procedures under study, and/or with reduced visual, expressive auditory acuity will be excluded. (visually impaired or deaf).
During the presentation, the clinical, neurocognitive and emotional characteristics of self-limiting epilepsies will also be presented.

Karla Fehr
Clinical Psychologist, Ph.D
Associate Professor, Education, Health & Behavior
UND University of North Dakota
North Dakota, USA

15.30 h- 16.00 h

Application of a Cognitive Behavioral Play Intervention to Pediatric Populations

Cognitive Behavioral Play Intervention (CBPI) is a brief, structured intervention based on cognitive behavioral play therapy principles. It is a developmentally sensitive intervention approach that allows young children to develop and practice cognitive-behavioral coping strategies through play for stressors that they are not yet able or comfortable to discuss. A specific presenting concern is targeted during the manualized CBPI play sessions in order to improve coping skills. During each play session, multiple story stems

are presented corresponding with a range of stressors relevant to the presenting problem. Children are instructed to play out how to help the character feel better, and the interventionist engages in play with the child to model, teach, and reinforce coping strategies including a problem-solving approach and positive self-talk. The CBPI typically includes three 20-30 minute sessions. Practicing multiple story stems at each session provides an opportunity for the child to generalize coping skills to a variety of anxiety-provoking situations. CBPI was originally developed to address school anxiety in preschool children (Pearson, 2008). In that study, preschoolers who received CBPI displayed less anxiety and withdrawn behavior, more hope, and greater social competence compared to children in an active control group.

CBPI has the potential to improve coping and symptoms for many youth, including those who present in pediatric medical settings. This presentation will review the CBPI adaptations for pediatric populations to date including 1) CBPI for young children with sleep difficulties, 2) CBPI for siblings of children with cancer, and 3) CBPI for siblings of children with autism spectrum disorder. Implementation of the CBPI via telehealth will also be discussed. The first adaptation of CBPI for pediatric populations was for young children (ages 4-6 years) with sleep difficulties (Fehr, Russ, & Ievers-Landis, 2016). As an adjunct to behavioral treatment for sleep difficulties, CBPI addresses the child's distress at bedtime by practicing coping strategies to address separation anxiety, nighttime fears, and fears of bad dreams. In a pilot study, the CBPI improved sleep habits and decreased sleep anxiety in preschool-aged children, and parent satisfaction was high (Fehr et al., 2016).

CBPI was subsequently adapted to target adjustment in siblings (ages 4-10 years) of children that had been diagnosed with cancer in the past 12 months (Fehr, Russ, Anderson, Leigh Josie, & Cousino, 2017). There are many stressors and changes experienced by the entire family after a child is diagnosed with cancer, and the CBPI was developed to target these stressors and the associated emotions including isolation and disruptions, emotional reactions (anger, resentment, shame, guilt), and helplessness and a loss of control. This CBPI protocol was appropriate for a wider age range due to the complicated nature of feelings that may be experienced and the difficulty that children may have expressing these complex feelings. In a pilot study with four children, internalizing symptoms decreased for all participants. In addition, some

participants experienced improvements in certain types of coping and decreases in parenting stress, though there was more variability among participants on these factors (Fehr et al., 2017).

The CBPI was adapted to improve adjustment in siblings of children diagnosed with autism spectrum disorder. To target stressors and worries that many siblings of children with autism spectrum disorder experience, the story stems focused on parent attention, the relationship with their sibling, and social stressors related to having a sibling with autism spectrum disorder. Given the sensitivity and emotional complexity of these stressors, this intervention was also developed for children ages 4-10 years.

The strong theoretical basis and preliminary evidence suggest that CBPI can be an effective approach to addressing distress and coping in many pediatric populations. Additional applications for pediatric populations will be discussed. In addition, future directions for research will be reviewed.

16.00 h – 16.30 h COFFÈE BREAK

Sandra Russ
Clinical Psychologist, PhD
Distinguished University Professor
University Case Western Reserve – Cleveland
Ohio, USA

16.30 h- 17.00 h

Pretend Play Research Findings: Implications for Clinical Practice

Pretend play is an essential tool of many forms of child psychotherapy. Research findings that focus on the activity of pretend play have implications for the use of play in psychotherapy. My research program has focused on 1) measuring processes in pretend play with the Affect in Play Scale and 2) developing play protocols that can improve play skills (Russ, 2014). The Affect in Play Scale instructs the child to play with toys for 5 minutes. The play is videotaped and scored according to a detailed manual. There are different toys and instructions for younger (4-5 years old) and older (6-9 years) children. The Affect in Play Scale (APS) measures imagination, organization of the story, amount of emotion in the play narrative, and engagement in the play and has acquired good validity with a variety of theoretically relevant criteria. By assessing a child's ability to use pretend and imagination and to express emotion in play, we can determine whether and how play can be used in a psychotherapy setting. The APS could also be used as a pre and post measure of change in psychotherapy. For example, has the child become more open in expressing emotion in a play situation?

Play intervention protocols have been developed for children 3-10 with the goal of improving processes important in child development through the activity of pretend play. The basic intervention consists of 3-8 individual sessions of 20 minutes during which the adult facilitator plays with the child. There are a standard set of story stems that are used and a standard set of techniques that the adult uses to facilitate the play. Studies have found that this play protocol

and adapted versions have been effective in increasing imagination and emotional expression in play for both typical children (Hoffmann & Russ, 2016) and children with neurodevelopmental disorders (Dimitropoulos, et al.,2021). Increasing the capacity to pretend is especially important for children who have deficits in the capacity to pretend. For example, in a study with children on the autism spectrum, this brief intervention protocol increased children's imagination on the APS and emotional understanding on a different task. when compared with a waitlist control (Doernberg, et al., 20.21). This protocol was also effective over a remote platform for children with Prader-Willi Syndrome (Dimitropoulos, et al., 2021.). This play intervention protocol could be incorporated into treatment programs for children with neurodevelopmental disabilities.

In recent studies, we have focused on the question of 'which specific techniques used by adult researchers were most effective in facilitating imagination and emotional expression in play.'? Results in several studies suggest that modeling of pretend and reflection of play activity were most frequently followed by imagination (Gordon et al., 2023). Prompting, for example by asking how does the boy doll feel about losing his dog, facilitated expression of emotion. Of note, general questioning was followed by less play. Implications for using play in therapy to achieve goals would be to use modeling of pretend and expression of feelings as well as prompts of what will happen next or how the doll feels. General questions might interfere with the play. Children with neurodevelopmental disabilities need more scaffolding of their play. Finally, incorporating empirically supported pretend play modules into child therapy programs could help children use play more effectively in solving problems.

Eva L. Feindler
Clinical Psychologist, PhD
Long Island University
Brookville, New York USA

17.00 h- 17.30 h

Playful Approaches to CBT with aggressive children: using the Turtle Magic Program- The Turtle Magic Intervention for young children

Over the years there has been an increased interest in the role of emotion regulation in the development of childhood psychopathology. The ability to identify emotions, express emotions, and modulate emotions are key components of children's adaptive social functioning. The presence of self-regulation skills in childhood has been associated with academic success and social competence later in life. However, children that display deficits in the ability to regulate their emotional experiences lack the appropriate coping skills to manage intense emotions, such as anger, and exhibit excessive or inappropriate emotional responses, such as aggression. Aggression is one of the most common referrals in preschool aged children, however, many treatment interventions focus primarily on the management of aggression in school age children or adolescence. Since the presence of aggressive behaviors and deficits in emotion regulation are individually associated with negative outcomes later in childhood, it is essential that programs are developed that focus on preschool aged children. The focus of this intervention is on skill development for young children rather than on the management of aggression by parents or other adults in the school/caregiving environment.

The Turtle Magic Intervention (TMI) was developed based on the book titled, Turtle Magic, to address the cognitive, school, and emotional functioning of preschool children at-risk for aggressive behaviors. Turtle Magic Intervention (TMI) is a short term therapeutic treatment program developed for young children, informed by the tenets of cognitive-behavioral play therapy (CBPT). Designed for children who demonstrate disruptive and aggressive behavior at home and in the classroom, TMI can be implemented with individual or small groups of children. TMI is a psychoeducational emotion regulation approach that aims to teach children the skills necessary to identify and express emotions,

to regulate their emotional responses and to use effective coping and problem-solving skills. The program is a nine-session intervention with activities consistent with the developmental level of the participating child(ren). The treatment includes eight core sessions that integrate the use of puppets, stories and activities to teach emotion identification, coping skills, problem-solving strategies, and principles of positive reinforcement, as well as one booster session that occurs one-month post treatment
This presentation will fully describe TMI treatment protocol for individual children and small groups, present preliminary data on outcomes and address treatment acceptability and implementation issues.

Andrea Manuel Meana de la Vega
Psychologist and DSA Team Coordinator for
"CBPT" Research Center
Rome, Italy

17.30 h- 18.00 h

Cognitive Behavioral Play Training: the use of play in cognitive rehabilitation

In the context of rehabilitation programs for Specific Learning Disorders (DSA) and the Executive Functions connected to them, the integration of structured play is not to be understood as a break or a moment of simple entertainment, but becomes a fundamental rehabilitation tool. Within this intervention, Cognitive Behavioral Play Training will be presented and the following will be explored: the choice and use of structured play in the rehabilitation programs of DSA; their integration with the use of behavioral techniques and strategies and finally the presentation of a clinical case.
Cognitive Behavioral Play Training integrates the use of play and CBT techniques within Cognitive Rehabilitation paths. Among the techniques used

are behavioral techniques such as: Reinforcement Programs, Modeling, Fading, Prompting and Shaping; and cognitive techniques such as: Psychoeducation, Positive Self-Affirmations, Problem Solving and Self-Instruction.

The benefits of using the play within rehabilitation programs are multiple: it makes the assimilation of knowledge easier and more fun, promotes greater involvement and greater adherence to treatment, strengthens attention spans and increases the sense of self-efficacy; making learning more stimulating.

Structured Play do not have entertainment as their intention, but use the playful aspect to achieve educational, informative and rehabilitative objectives. In particular, within rehabilitation treatments these tools are designed to offer an engaging and stimulating experience, aiming to improve the cognitive, learning and behavioral abilities of those who play.

Behavioral and Cognitive Techniques are integrated during the performance of play activities and following them, with the aim of encouraging the acquisition and consolidation of skills and abilities, providing suggestions and positive reinforcements during the execution of the activities and encouraging the modeling of adaptive behaviors and thoughts.

Cognitive Behavioral Play Training (CBPTr) is included in rehabilitation programs that aim to strengthen executive functions such as: Inhibition; Working Memory; Cognitive Flexibility; Planning; Focused Attention and Emotional Self-Control.

During the presentation of the clinical case, the processes of choosing and using the play suited to the needs of the individual case will be shown; the use of these and the integration with behavioral techniques. The results obtained during the follow-up will then be discussed.

In conclusion, the importance of using structured play and cognitive and behavioral techniques in the rehabilitation and support of children and young people with DSA lies in the possibility not only of enhancing cognitive and learning abilities, but also of structuring a more engaging, motivating and tailored to unique needs that also encourages a greater sense of self-efficacy.

09TH JUNE MORNING

SESSION: Theoretical approaches to Play Therapy: comparisons and contrasts
(Chairman: Maria A. Geraci)

Didem Altay
HCPC reg Counseling Psychologist at Therapy,
Ph.D, RPT & EMDR Europe
London, United Kingdom

9.00 h- 9.30 h

Child Centered Play Therapy: A Peek into Child-Centered Play Therapy

Child-centered play therapy (CCPT) is one of the oldest and most widely known models of play therapy. It is frequently found in the repertoire of many play therapists in the United States (Lambert et al., 2005) and around the world. CCPT is a strongly research-supported and developmentally sensitive therapeutic intervention for children. Research findings provide strong evidence for the positive impact of CCPT as a therapeutic intervention; in particular, CCPT demonstrates its efficacy as a counselling approach that is sensitive to both developmental and cultural factors, effectively addressing a wide range of presenting issues (Baggerly, Ray, & Bratton, 2010; Lin & Bratton, 2015).
Moreover, it is a therapeutic approach specifically designed for working with children between the ages of 3-10 who have yet to develop the ability for abstract thinking to a full extent. CCPT, unlike talking therapies and directive play therapy models, does not require the child to use words to express

themselves and guide the child to do a certain activity in the playroom as it recognizes that children often lack the necessary verbal and cognitive skills to articulate their emotions and experiences in the same way adults do.

CCPT draws heavily from the principles of person-centered therapy established by Carl Rogers (1940s). Adapted from a person-centered approach and developed by Virginia Axline (1947), this model of play therapy is based on the belief that a child has the capacity for growth and the ability to solve problems if brought into an atmosphere of acceptance, warmth, and freedom to lead his/her own way in working through personal conflicts. It is rooted in the belief that children have an innate tendency towards growth and healing and that they naturally express themselves through play. The crucial element of the CCPT is building a strong therapeutic relationship between the child and the therapist, as the relationship is the most important healing factor and therapeutic agent for change (Ray, 2011).

As a CCPT therapist, one adopts a non-directive stance by allowing the child to lead the play sessions, creating a safe and supportive environment where the child feels comfortable expressing themselves freely, reflecting the child's feelings and experiences back to them, helping the child to develop a deeper understanding of their emotions, showing unconditional positive regard by accepting the child without judgment, providing empathetic responses to validate the child's experiences and foster a sense of connection. The attitudes adopted by the CCPT therapists and the play allow children to explore emotions, thoughts, and experiences, express themselves creatively, delve into areas of their lives that may be difficult to articulate verbally and learn coping skills to manage their emotions/behaviours.

This presentation will provide an overview of the basic principles and importance of child-centered play therapy.

Giandomenico Bagatin
Psychologist, Psychotherapist
Founder and coordinator Gestalt Play Therapy Italy
Trieste, Italy

9.30 h -10.00 h

Gestalt Play Therapy: Healing through play, storytelling and awareness

Violet Oaklander was the first therapist to apply the principles of Gestalt therapy to psychotherapeutic work with children and adolescents.
By being the first to integrate elements and tools from many therapeutic approaches, you effectively produced an integrated and integrable model that she taught for 27 years to professionals on five continents and summarized in books translated all over the world.
In Violet's model there are two main problems that bring children to psychotherapy, regardless of the explicit problem with which they present themselves.
One is contact difficulties. A good ability to contact others, with activities, with oneself implies the possibility of having presence, focus, concentration, contained internal dialogue, physical and emotional awareness.
The other is the sense of the poor self. The self is not understood here simply as the definition of one's identity, but in a broader way. A child with a good sense of self is a child who has internalized boundaries and limits, feels a sense of control and trust, knows how to clearly say what he likes and what he doesn't like, and knows how to express emotions in a constructive sense. Emotions, in particular anger and aggressive energy, which Oaklander calls "the most misunderstood of all emotions" are addressed.
In the first family session Violet Oaklander used to state "I don't Fix Kids".
What helps children, Violet explained to parents, and precedes the symptoms, is a work of reinforcement, acceptance, integration and awareness for which play is an instrument of choice, representing the primary language of children.

In particular, the play in the Oaklander model is used in a projective manner.
That is, it is taken for granted that whatever we use as a media (means of expression), what we perceive as people, and what our patients perceive, and that what we say about any object, be it a drawing, the shape of a piece of clay or a scene in the sandpit, will be colored by our beliefs about the world, our ideas and our emotions. In this sense Violet used to say that everything is projection.
However, the use of projections, consistently with the humanistic approach, is not used in an objective or interpretive sense. The children's works come to life through a game of mirrors and stimuli that helps them to give a creative and constructive meaning to what happens to them.
And this same experience of having an adult present, who is non-judgmental and who does not say "your problem is", or "you have to do" is often a revolutionary experience.
Children's creativity in expressing, integrating and giving new meaning to their life events and feelings is the true strength of therapeutic work. In this sense, what is truly significant and (above all) transformative is the experience that children have in the session, much more than the explanations and concrete problem solving.
In this presentation we will see an overview of the peculiarities of Gestalt Play Therapy, how they are inserted into clinical practice and how it is possible to integrate them into the way a professional works.

Gianluca Biggio
Psychologist, Psychoanalytic Psychotherapist, Psychosociologist
University of Viterbo
Viterbo, Italy

10.30 h-11.00 h

The use of play in a psychodynamic perspective
The role of play in psychoanalytic psychotherapy

Play has an important role in psychoanalytic psychotherapy. Originally introduced by Melania Klein in the psychoanalysis of children, it has had important clinical results but also methodological consequences because we can find in the introduction of the play the first major change in the analytical setting, previously considered unchangeable. This has paved the way for numerous changes among which we can include other types of setting changes and also the use of the play itself in therapy with adults in certain conditions that are certainly metaphorical and not comparable with the play of child therapy. As Winnicott taught in psychoanalysis: *"It is in playing and only while playing that the individual, child or adult, is able to be creative and make use of the entire personality, and it is only in being creative that the individual discovers the self*." (Winnicott D.W., (1971) Play and reality, Armando, Rome, 1974).

Play is a primary and early activity. It begins with the body and with bodies, in a "field of highly sensitive sensoriality", in which the experience of being in relationship with "that which is not me" occurs.

Thus we see the similarity appear between this playing and that "Let's play again" which, again Winnicott, attributes to the specific way of being together, between patient and psychoanalyst: *"Psychotherapy takes place where two areas of play overlap, that of the patient and that of of the therapist. Psychotherapy is about two people playing together."* (Winnicott D.W., (1971) Play and reality, Armando, Rome, 1974) play begins with the play of bodies, we see it in human beings but also on an ethological level.

As Winnicott taught in psychoanalysis: "It is in playing and only while playing that the individual, child or adult, is able to be creative and make use of the entire personality, and it is only in being creative that the individual discovers the self." (Winnicott D.W., (1971) Play and reality, Armando, Rome, 1974).

Play is a primary and early activity. It begins with the body and with bodies, in a "field of highly sensitive sensoriality", in which the experience of being in relationship with "that which is not me" occurs. But he puts it inside himself and works on them intensely, recording sensations, emotions... returning them in his own way the next moment, giving rise to experiences that produce a style of intimate communication.

In therapy, the play allows an understanding by distinguishing, setting boundaries between inside and outside, between illusion and reality, between you and me. Until we get to the play that autonomously stages fictional theaters that tell the story of internal reality, in that area suspended in time and in a "transitional space" between real and invented, a space that seems essential for

the psychotherapy process analytical in order to create a "relational field" that belongs to both actors in the analytical process and which allows it to unfold. For this reason it is believed that the play, born as a specific working tool in the analysis of children introduced by Melanie Klein, can also have an important value in the therapy of adults.

Francesco Montecchi
Neuropsychiatrist, former head of Neuropsychiatry
“Bambino Gesù” Hospital in Rome
Teacher a.c. of La Sapienza University and “Tor Vergata”
Rome, Italy

11.00 h- 11.30 h

Sandplay Therapy. Image psychotherapy (S.P.T.) in developmental age

The Sand Play, also known as Sand Play Therapy, is an original application of Jungian thought and practice that integrates images of sand paintings with verbal analysis. Together with the therapist, are used in the same way as a three-dimensional dream; facilitates contact with internal images, activates the comparison between conscious and unconscious, allows us to contact and elaborate archaic conflictual issues. It can be used both in analysis with children and adults.
Created by Dora Kalff - Jung's student - as a variant of the "Play of Worlds" method used in London by Margaret Lowenfeld.
In the Sand Play the image takes shape as it is created, it is the hands that give shape to the image which, not present in the patient's mind, allows the ego to confront the unconscious. It is not so much the patient who creates the image but it is the image itself that "calls" "takes the hand" and manifests itself as a process through which conscious and unconscious meet and dialogue. The

unconscious situation coordinates the physical event of moving, choosing, building, with the psychic condition of the moment.
When the patient, during the game, has many objects in front of him, due to a certain state of mind he chooses some of them, and will choose those to which he is particularly attracted and which are significant images for him at that moment.

With the help of images, the psyche orients itself in the world and adapts to it and is thus able to live and develop.
The resulting picture represents a work of synthesis of internal and external, of subjective psychic and objective psychic, it is possible to recognize in the space of the sandbox some analogies to what Winnicott (1974) calls "transitional space", a different third space from internal psychic reality and the real world.
Those who work with sand agree with Jung's statement (1957-58) maintaining that: "it often happens that the hands are able to reveal a secret about which the intellect worries in vain". In fact, hands sometimes speak more clearly than words.
The patient, through the "play", will represent the uncomfortable situation, the negative and painful aspects of his own psychic situation. Unknowingly, he may also represent the opposite aspect, that is, in addition to what is "negative", the "positive" inherent in his problem may also be identifiable; in this space he will thus have the possibility of activating and contacting those internal images full of energy from the two opposite poles finally united in the space of the sandbox, a third, unifying symbol will emerge. The risk in psychotherapeutic treatment is to want to understand and overestimate the content aspect and the intellectual interpretation, subtracting its essentially symbolic character: the representation needs understanding, and the understanding of the representation.
In building a "sand picture", the playful gesture, inscribed in space, becomes a sort of psychodramatic play of one's emotions. The sandpit is the center of the activities, a "psychic theater" of the internal world which evokes theatrical representations in its construction: the hands are capable of revealing secrets that are often untranslatable.
The "free and protected space" of the sandbox as a metaphor for life.
For the enjoyment of life it is necessary to learn and tolerate limits and renunciation. The imagination of those who play is limited by the boundaries of the sandpit, but can be freely represented within it. The transformation process

that takes place through the "Sand Play" could not in fact take place in an unlimited space, but needs a delimited field. The "empty" space, in the initial encounter with the sandbox, brings us back to the experience of using space, closely linked to the development of the body schema

Space and body scheme

The perception of the body and space long precedes their representation and bodily perception finds in the use of space a means to express its capacity for representation in an even more differentiated way.

Maria A. Geraci,
CBT Psychotherapist, PTP.
Director of the CBPT Research Center
Rome, Italy

11.30 h- 12.00 h

Differences and similarities between different play therapy approaches

Play therapy is a paradigm that has developed evolutionary within different theoretical orientations. Although they have been mainly separated into directive play therapy and non-directive play therapy, the most salient similarities and differences derive from the theoretical approaches on which they are based: psychoanalytic play therapy (Klein, 1932; Freud, 1946) child centered play therapy (CCPT, non-directive, Axline, 1947) and cognitive behavioral play therapy (CBPT, directive, Knell, 1993, 1998b). Knell (2009) describes the main similarities and differences between these three approaches by analyzing: the direction and objectives of the therapy, the play materials and activities, the educational value of the play, the interpretation of the play and the role of praise. In psychoanalytic play therapy, direction and goal setting are not defined by the therapist, the therapist is a participant observer, not a

playmate, and does not suggest any materials or activities. Education is not considered a goal of therapy, therefore, play is not used to educate; instead, the interpretation of the play is central but is applied as the final part of the therapy and finally praise is not considered appropriate (Geraci, 2022). In child centered play therapy the direction and objectives of the therapy are not accepted as the child must be accepted as he is, without any type of external approach; the material, activities and direction of the play are always chosen by the child. Education is considered a form of direction and, therefore, inappropriate and the therapist does not interpret the child's play but shares his most unconditional acceptance. Finally, praise is not contemplated because it would mean communicating to the child that the therapist does not accept him as he is, but rather would like him to be different (Geraci, 2022).

In cognitive behavioral play therapy, therapeutic objectives are established and the direction towards these objectives constitutes the basis of the intervention; the play materials and activities are selected by the child and the therapist. Play is used to teach alternative and more adaptive skills and behaviors, the therapist introduces the child's interpretation of the play, bringing the most significant issues to be expressed verbally. Finally, praise represents a crucial component of therapy, it communicates to the child which behaviors are appropriate and ensures that these are positively reinforced (Geraci, 2022).

Didem Altay
HCPC reg Counselling Psychologist at Therapy, Ph.D Central
London, Regno Unito

12.00 h-12.30 h

Integrated play therapy: using non-directive and directive play therapy when working with children

Integrating non-directive and directive play therapy combines elements from various theoretical modalities into a cohesive framework within play therapy. Unlike using a single theoretical perspective, integrated play therapy draws from multiple theories such as humanistic, cognitive-behavioral, adaptive information-processing, attachment, and trauma. This approach was initially introduced and popularized by figures such as Kaduson, Cangelosi, and Schaefer (1997), Gil (2006), and Goodyear-Brown (2012). In the integrative approach, therapists value the child, accept the child as is, and understand the importance of meeting the unique needs of each child. The therapist uses a variety of play interventions into one more comprehensive, tailored treatment plan, drawing from diverse grounding theories. It involves a collaborative process between the therapist, the child, and caregivers. By providing a solid therapeutic alliance and ongoing assessment, the therapist continually adjusts and refines the treatment plan to ensure it remains responsive to the child's evolving needs and progress in an integrative and holistic way that addresses the child's emotional, behavioral, and developmental needs (Gil, 2011) - focusing on the needs of the child and the family to maximize the effectiveness of therapy and promote positive outcomes for children experiencing a wide range of emotional, behavioral, and developmental challenges. This presentation will offer an overview of integrating different modalities when working with children who have experienced adverse experiences.

Sandra S. Pimentel,
Clinical Psychologist, PhD
Associate Professor, Montefiore Medical Center
Albert Einstein College of Medicine
New York, USA

12.30 h- 13.00 h

Creative CBPT with school aged children: Integrating pop culture into CBT with youth: Sports, superheroes, and songs to personalize and build "play"-ful interventions

Cognitive behavioral therapy (CBT) is an efficacious intervention approach for treating a range of mental health conditions across age ranges, including for children and adolescents. Working with youth and families generally requires an ability to deliver our treatments in principle-driven, developmentally appropriate ways. Child clinicians may require added flexibility, creativity, and ability to explain cognitive and behavioral principles and therapeutic strategies to 5-, 10-, and 15-year-olds alike. Furthermore, these youth are unlikely to have self-referred for treatment.

How can clinicians tailor and optimize CBT for 7- to 14-year-old children across levels of treatment readiness, engagement, mental health literacy, cognitive development, symptom presentations, and functional impairments? Youth clinicians may benefit from learning strategically to incorporate pop culture content to their assessment and treatment planning. Pop culture, by definition, is broadly available and accessible via a multitude of formats and offers opportunities for adding individualized fun and play while maintaining fidelity to core cognitive- behavioral principles.

This presentation includes several aims, including to: 1) enhance participating clinicians' awareness of how to intentionally incorporate various pop culture domains in the context of CBT case conceptualization and into their assessment and treatment of youth across presenting problem, 2) propose how to personalize treatment delivery and cultural responsiveness based on youth pop culture interests, 3) demonstrate how to utilize pop culture references to build and enhance rapport, increase treatment engagement, and destigmatize mental illness, 4) consider youth developmental level in functionally assessing how to harness pop culture references to infuse fun and play in sessions, and 5) more specifically, present multiple examples drawing from music, television, streaming services, film, sports, superheroes, videogames, and other domains for key CBT interventions (e.g., psychoeducation, modeling, cognitive strategies, exposures, behavior plans, etc.). There will be metaphors, creative teaching strategies, and concrete ready-to-go tools. Oh, and we will have fun!
At the end of this session, the learner will be able to:

- Identify at least 3 strategies for incorporating pop culture references into CBT case conceptualization and teaching youth about the CBT model.
- Identify how to functionally include pop culture-derived play into CBT components (e.g., psychoeducation, cognitive restructuring, exposures).
- Discuss how pop culture can be utilized to increase treatment engagement and destigmatize mental health and treatment-seeking.
- Consider at least three pop culture references for creating therapeutic materials and props for younger and school-aged youth.
- Discuss how to introduce a superhero narrative in the application of CBT.

13.30 h – 14.30 h LUNCH BREAK - POSTER SESSION

09TH JUNE AFTERNOON

SESSION: COGNITIVE BEHAVIORAL THERAPY IN CHILDHOOD
(Chairman: Marco Cavallo)

14.30 h- 15.30 h

SYMPOSIA: Play and Cognitive Behavioral Therapy: general characteristics, satisfaction of needs, emotional regulation and trauma processing

Roberta Bacchio
Psychologist, Psychotherapist CBT.
A.T.BecK Institute
Rome, Italy

The function of play in cognitive-behavioral therapy

In cognitive-behavioral therapy for the young children, play covers a kaleidoscope of functions, often underestimated. In fact, it allows you to create imaginary and modifiable scenarios through which the child can learn to use new skills including both emotional and behavioral management and interpersonal. Furthermore, play provides the therapist with important information on the psycho-physical state of the child: for example, through the distinction between traumatic repetition and therapeutic play, the professional

is able to understand when the child is re-enacting traumatic events, and to encourage processing (Levine & Kline, 2009). Play also takes on fundamental importance in building the therapeutic relationship: the child feels he has a space dedicated to himself, regardless of the physical place he is in (Godino-Iáñez et al., 2020), in which to feel at ease even when emotionally complex contents emerge, because they will have an additional tool to manage them and channel their emotions. Finally, play is often a very powerful vehicle in working with parents and families: it allows us to build (or re-build) the relationship based on the sharing of time and space, and to develop communication skills, both of the child and of the caregiver (Öztekin, et al., 2023).

Roberta Rubbino
Psychologist, Psychotherapist CBT
Head of the Developmental Age Area, A.T.Beck Institute
Rome, Italy

Therapeutic work on the child's needs: the contribution of Schema Therapy (ST-BA)

Play is the most powerful and effective means of expression that every child has and its importance extends beyond the early years of childhood. Using puppets or dolls of various types allows you to talk about your experiences in a simpler and more spontaneous way. Therapeutic play can become a moment of integration and healing where the child elaborates, reinvents and rewrites even painful stories. In Schema Therapy for children and adolescents (ST-BA) play becomes the main tool to support the expression and satisfaction of primary needs as the child can access his own inner world through a familiar modality (Loose et al. 2013 translated into Italian, 2023). Symbolic play becomes the place in which the young patient's primary needs emerge and are satisfied in a representative way (exactly as happens in imagery re-scripting used with adults). Not only needs but also emotions are represented. Play in fact becomes the place where the primary emotions are expressed by the child, legitimized by

the therapist (though his puppet), who provides protection and care similar to the limited reparenting used in adulthood. After a brief introduction to the theoretical model of Schema Therapy dedicated to the developmental age, the contribution will focus on the description of the elements that constitute play therapy within this treatment model.

Rosetta Cappelluccio
Psychologist, Psychotherapist CBT
Head of the Developmental Age Area of the A.T.Beck Institute
Caserta, Italy

DBT-children as a play therapy intervention in the presence of Trauma

The play therapy intervention is based on clear guidelines that lead to the design of an effective intervention for various developmental age problems. From a DBT-children perspective, the importance of modeling and reinforcement of skills, ignoring maladaptive responses, validation and acceptance by adults, is a key to achieving profoudn and lasting changes. These changed in the emotional and behavioral regulation of the litte ones is important, even in the presence of trauma. In practicing the program, adapting to the child's word, and translating the teaching materials specifically to the chronological age of the users, is critical. Board game and play in general, multimedia material, role-playing play are used, the handouts are colorful, the exercises are experiential. The objectives of the DBT-children program are to teach children coping skills and a problem-solving method, and caregivers are taught the same set of skills to create and validate the flexible environment for change from the play therapy perspective. This contribution provides evidence in support of DBT-children as a play therapy tool, showing its effectiveness in bringing benefits both to those with high emotional vulnerability and to those without problems, providing useful skills for regulating emotions and behaviors and improving interpersonal relationships.

15.30 h – 16.00 h COFFÈE BREAK

Francesca Pergolizzi
Psychologist, Psychotherapist, IESCUM Supervisor, ACTFORKID Representative, ACTITALIA member, CBT, ABA-IT
Milan, Italy

16.00 h- 16.30 h

Acceptance Commitment Therapy e Play Therapy. A new perspective

Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) represents one of the most recent developments in the field of cognitive behavioral psychotherapy. The ACT model has its theoretical roots in Relational Frame Theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001), which, from a clinical point of view, could be defined define as a basic research program on the functioning of human mind and on the role of language mechanisms in determining some of the processes that lead to suffering. The general goals of therapeutic work in ACT are 1) to develop skills to deal with painful thoughts and 5feelings effectively by reducing their impact on personal functioning 2) to make clear what is truly important (values) and to set goals and actions in that direction. ACT identifies six key processes, which guide the person to change and which can be represented by a hexagon whose central heart is occupied by psychological flexibility, and are specifically: Being in the present moment with awareness, Defusion, Acceptance, Self as context, Acting with commitment, Having your values clear. The literature highlights how ACT is well suited to interventions aimed at children and adolescents. First of all for

a therapeutic style in which the therapeutic experience that is created within the ACT setting, unlike what happens in other contexts of psychotherapy does not take on a didactic connotation. Furthermore, it is characterized by the child and adolescent's active role in decisions related to treatment: in fact, ACT sessions with children involve both the child and the therapist in exercises to be carried out together. The clinician's fundamental task is to create a pleasant, motivating and validating context with respect to the complex contents on which one will have to intervene, a context of clinically significant change, using verbal environments familiar to children. Play Therapy based on the ACT perspective promotes in children the ability to observe and respond in a new and flexible way with their own internal experiences (thoughts, images, memories, emotions, sensations, impulses, etc.). Through a series of experiential recreational activities, with the creation of verbal and physical metaphors, the suggestion of evocative cards, storytelling, cartoons, comics, video games, mindfulness, drawing and other artistic expressions compatible with the cognitive and linguistic skills of young patients are used. The communication will present the Kidflex model, an adapted version of the Hexaflex, the conceptualization of the case according to the act perspective, the mapping of the six processes using procedures, tools, and materials that refer to Platherapy-Act-oriented.

Liana Lowenstein,
MSW, RSW, CPT-S
Toronto, Ontario, Canada

16.30 h- 17.00 h

Creative CBPT Interventions for Children with Anxiety

Anxiety disorders represent one of the most prevalent forms of psychopathology among children. As such, many children are referred to therapy to help them

cope with anxiety symptoms. The most efficacious treatment for childhood anxiety in the research is Cognitive Behavioral Therapy (CBT). Anxious children can be difficult to treat because they're more hesitant to trust, have a tendency toward avoidance and negative thinking, and are typically reluctant to face their fears. The challenge of working with younger clients in therapy is further compounded by their developmental capacity which makes it harder for them to express their thoughts and feelings and understand CBT concepts. Children are even more resistant to participate in therapy when it is talk-oriented and workbook-based because this approach is not very engaging and they may lack the skills to verbalize their thoughts and feelings. By integrating play into CBT, such as therapeutic games, art, stories, and puppets, you'll captivate children's interest, put them at ease, and motivate them to learn and apply core skills. Children who might otherwise be resistant in therapy are more likely to participate in playful activities designed to cover the CBT components. In this 30-minute presentation, learn creative CBPT interventions to treat anxious children aged 4-12. Although the focus of this training is on treating children with anxiety, the interventions can be adapted for use with other treatment populations. Participants will come away with new and innovative interventions that they can use immediately in their clinical practice.

Elizabeth J. Short
Clinical Psychologist, Ph.D, Professor, Director of DCAS Program
Department of Psychological Sciences, Case Western Reserve University
Cleveland, Ohio, USA

17.00 h- 17.30 h

Individual Differences in Play and Executive Function Skills in Preschoolers: Can Differences in Play be Used to Predict Differences in Executive Function?

Elizabeth J. Short, Rita Obeid, & Doroteja Rubez

The preschool period is a time of great change. Advancements in language, memory, attention, problem-solving and behavioral self-regulation position young children to be successful at home, school, and the social world. One important and complex skill of great importance during this period is executive functioning (EF). EF involves a diverse set of skills thought to regulate behaviors and emotions for us to successfully achieve our goals. These skills include such things as working memory, inhibitory control, and cognitive flexibility. Foundational components of EF that will later develop into more advanced cognitive, adaptive, and goal-directed behaviors are first exhibited in the preschool period (Garon, Bryson, & Smith, 2008). That said, there are large individual differences in the development of EF skills, with children with atypical development showing early signs of EF impairment. Thus, it seems critical to be able to reliably measure EF skills in young children prior to school entry. The challenge is "How to Do this?"

Assessment of EF is often problematic due to the complicated directions and task structure in traditional EF measures. Child-friendly executive function measures (i.e., Shape School, Espy, 1997; Day/Night Task, Gerstadt, Hong, & Diamond, 1994) tend to assess a limited array of EF skills (i.e., inhibit, initiate, & shift). The employment of an EF measure that assesses standard skills (i.e. inhibit, working memory, & shift) and employs a supplemental scoring system targeting a broader array of EF skills (i.e., emotional control, working memory, or planning/organizing) appears critical for better understanding of individual and group differences in EF in the preschool period. In this study we will compare behavior-based measures of EF (i.e., the Shape School) scored in the standard and supplemental way to data obtained from the parent-based EF measure (i.e., the Brief-P; Gioia et al., 2003) among children with diverse developmental skills. Our hope is to better understand strengths and weaknesses in EF skills in the preschool period and the utility of behavioral and parent-based techniques for understanding individual differences.

Next, we will turn our attention to understanding individual differences in play skills in our diverse preschool population. Why Play you may ask? By examining the everyday world of play, we have the potential to open a window into the cognitive, affective, and social world of the preschooler. For most young children, the world of play is a non-threatening and enjoyable way to learn and practice new skills, as well as perfect old skills. There has been considerable interest in whether play is an important arena to foster the development of executive skills in young children (Doebel & Lilliard, 2023). In their recent Developmental Review article, these authors contend that play supports the development of executive functioning in several ways: 1) through practice in low-stakes settings, 2) through the acquisition of cultural-specific

knowledge that can be used in goal- activities, and 3) through the acquisition of social knowledge that can foster increased behavior and emotion regulation (Doebel & Lillard, 2023). Additionally, research by Gibb and colleagues (2021) has supported the argument that executive functioning skills in preschoolers can be improved using play-based programs. While improvement in EF skills has been demonstrated in the medium of play, less is known about whether we might use differences in play skills to identify children at risk for EF deficits.

The purpose of the present study is to examine individual differences in executive functioning and play skills among children differing in developmental status. The primary purposes of this study were as follows: 1) To describe performance differences among 90 children who differed in developmental status (typically developing, Developmental Language Disorder (DLD), Attention Deficit/Hyperactivity Disorder (ADHD), & Autism Spectrum Disorder (ASD)) in EF and play skills; 2) To determine whether differences in play performance predict differences in EF performance on behavioral- and parent-report measures, and 3) To determine whether a novel and supplemental way to score play task performance predicted group differences in EF performance among children of varying developmental abilities. All children completed a battery of tasks including a five-minute free play task (Affect in Play-Scale Preschool version (ASP-P)) and the Shape-School (Epsy, 1997), with parents completing the BRIEF-P.

Preliminary Results: Despite no differences in intelligence between our groups, cognitive, behavioral, and affective differences emerged on the EF and play tasks. Group differences in EF performance as a function of developmental status emerged, with the traditional scoring method primarily distinguishing typically developing peers from their peers with developmental delays. However, the traditional score of the play task was not sensitive enough to discriminate subtle differences between groups of children varying in type of developmental delay (DLD, ADHD, ASD). In contrast, the supplemental scoring system captured important differences in EF skills in our sample. Compared to their typically developing peers, children diagnosed with a developmental delay (DLD, ADHD, ASD) in the preschool period appeared to show significant difficulties with impulsivity, responsiveness/joint attention, active engagement, non-compliance, emotional control, working memory and planning/organization, shifting and initiation. Detailing group differences. Children in the DLD group only evidenced significantly more difficulty with active engagement than children in the typical group. In addition, children in the ADHD and ASD groups showed significantly more difficulty with impulsivity, responsiveness/joint attention, and active engagement than children in the typical group. Finally, children in the ASD group demonstrated

significantly more difficulty with working memory and planning/organization than children in the typical group. Group differences on the cognitive measures from the APS-P were observed. Children with DLD and ASD scored lower on imagination, organization, and complexity in play compared to children who were typically developing. In addition, children with DLD and with ASD were less organized and less complex in their play than children with ADHD. Play proved to be a useful medium for assessing preschoolers cognitive and affective performance, with only children with ASD showing evidence of discomfort in their free play. Interesting individual differences were noted in the play patterns of the children in our sample, with many of these differences seeming reflective of differences in EF skills. In summary, children in the typically developing group were the best players, with their play characterized as organized, complex, rich in themes, and affect-loaded. As expected, the children in the ASD group were the weakest players, as reflected in their lack of comfort, disorganization, and underdeveloped themes. The children in the DLD group and in the ADHD groups resembled typically developing children in some instances and their ASD peers in others. For example, the children in the DLD group resembled the children in the typically developing group in terms of positive affect expression and organization. Still, they resembled the children in the ASD group in terms of linguistic redirections. Similarly, the children in the ADHD group resembled the children in the typical group in terms of cognitive aspects of play (i.e. organization, imagination) but resembled the children in the ASD group in terms of behavioral measures (i.e. need for behavioral redirection). The clinical implications of these findings and the predictive utility of play for understanding executive functioning differences will be discussed.

Robert D. Friedberg
Clinical Psychologist, Professor, PhD, ABPP
Altamont Center for Cognitive Behavioral Training and Consultation San Jose
Palo Alto University
Palo Alto, Canada

17.30 h- 18.00 h

Integrating improvisational theatre exercises into CBT with youth

Improvisational theatre is a modern iteration of *commedia dell arte* founded during the Italian Renaissance. Improv is an unscripted, spontaneous, and playful activity that prompts flexibility, attention to the here and now, empathy, tolerance of uncertainty, and divergent thinking. However, the method is not only for actors anymore. The approach is increasingly used in training medical students and is being introduced to behavioral health professionals. Moreover, it is a natural fit with playful applications of CBT with youth due to its focus on immediacy and experiential nature. Recent research has specifically evaluated this intervention with socially anxious youth. Additionally, anecdotal data suggests improvisational theatre procedures might be helpful with depression, other forms of anxiety, social skills difficulties, and executive functioning compromises. This presentation explains the basic principles of improv, describes clinical applications, and offers several examples suitable for practice with children and adolescents.

WORK CLOSING 18.00 h

POSTER SESSION

1

Identifying Effective Facilitation Strategies in Play-Based Interventions

Rachel A. Gordon, M.A., Anastasia Dimitropoulos, Ph.D., Sandra W. Russ, Ph.D.
Case Western Reserve University

Introduction: Children with developmental disabilities may benefit from pretend play-based interventions to build upon closely linked social, emotional, and cognitive skills (Dimitropoulos et al., 2021; Doernberg et al, 2021; Lifter, Mason, & Barton, 2011). Pretend play interventions hold preliminary efficacy for improving these cognitive and affective skills and pretend play in children with Prader-Willi Syndrome (PWS) and autism.

Aims: The present study examines the effectiveness of specific intervention techniques, such as modeling, reflecting, and questioning, within a pretend-play intervention for school-aged children with PWS.

Materials: 28 children ages 6-12 with PWS participated in a remote pretend play. Four sessions per child were transcribed and coded for type, level, and frequency of interventionist facilitation strategies and child play behaviors.

Method: By pairing each interventionist strategy with the immediately following child behavior, comparisons were made to discern how often certain intervention techniques preceded child imagination and affect expression in pretend play. Pearson's correlations and hierarchical linear modeling also examined these relationships across the full intervention program.

Results: Findings revealed that reflection and summarization, (for example, reflecting "the girlis sad" when the child makes a doll cry) and modeling

strategies (such as, “this block could be a table”), most often preceded children’s pretend play and may predict these skills over time. Questioning was related to non-play.

Discussion: Subtle, non-directive strategies such as modeling and reflection may represent essential facilitation techniques that help children with developmental disabilities generate cognitive and affective content in their pretend play.

Conclusion: Subtle, non-directive play intervention strategies may best support cognitive, affective, and play skill development in children with developmental differences. This work may inform future efforts to refine interventions and support play and socioemotional skill development during the school-aged years.

2

Integrative Approaches in Child Therapy: Cognitive Behavioral Sandtray Therapy and Its Enhancements

Leon Li Hsiang Yang, counselor specializes in Cognitive Behavioral Therapy (CBT)
Taiwan

Abstract: This paper presents an integrative approach to child therapy, combining Cognitive Behavioral Therapy (CBT) principles with sandtray therapy, and further enhancing it with Cognitive Behavioral Play Therapy (CBPT). The focus is on addressing emotional and behavioral issues in children and adolescents, highlighting therapeutic factors and interventions that promote psychological well-being and positive change.

Introduction: Cognitive Behavioral Sandtray Therapy is an innovative approach blending CBT with sandplay therapy. It aims to address complex emotional and behavioral challenges in children and adolescents. This therapy emphasizes

self-expression, cognitive and behavioral modification, and emotional regulation through unique interventions.

Therapeutic Factors and Interventions:

1. *Sandtray Therapy:* Utilizes a sand tray and miniature objects, enabling children to create symbolic representations of their emotions and experiences.
2. *Cognitive Behavioral Play Therapy (CBPT):* Integrates CBT principles to assist children in recognizing and modifying negative thoughts and behavior patterns.
3. *Emotional Regulation:* Focuses on teaching children effective techniques to manage various emotions.
4. *Behavior Modification:* Aims to help children alter negative behavior patterns through education, role-playing, and positive reinforcement.

Enhancements with Cognitive Behavioral Play Therapy (CBPT): Building upon the foundations of sandtray therapy, CBPT is integrated to further support emotional expression, behavior pattern modification, emotional adjustment, and problem-solving. This enhancement is particularly effective in fostering a deeper understanding and management of emotions in children and adolescents.

Case Study Analysis: The paper examines 12 cases of sandplay therapy, each involving over 20 sessions. This in-depth analysis reveals how children often express their inner pain and fragmented experiences non-verbally. Therapists focus on the process and feelings surrounding the sandplay, resonating with concepts of the therapeutic working alliance, real relationship, and transference relationship.

Conclusion: The integration of Cognitive Behavioral Sandtray Therapy with CBPT offers a comprehensive approach for mental health professionals working with young clients. This combination not only strengthens therapeutic outcomes but also enriches the therapeutic experience. It equips children to better cope with emotional challenges, underscoring the critical role of therapist interventions in facilitating effective therapy.

Gender	Age	Diagnosis and Medication	Behavioral Characteristics and Comments
F	10	ADHD, takes half a dose of Ritalin and one dose of Concerta daily	Slower pace of tasks, weak emotional processing skills, requires assistance and time to clarify emotions. Mother uses corporal punishment in parenting with issues of domestic violence.
M	8	Diagnosed with ADHD, takes one dose of Ritalin daily	Weak emotional control, expresses anger and sadness through throwing objects and shouting, limited reflective abilities, engaged in theft behaviors (approximately 5-10 times, mainly toys and snacks).
F	6	Prefers to report on classmates, poor interpersonal relationships, often expresses reluctance to attend school when assigned tasks	Younger in the class, dislikes reporting on classmates, affects interpersonal relationships, often expresses reluctance to attend school when assigned tasks.
F	11	Easily attacks siblings, especially called little baby and teased him as being too attached to their mother. Classmates also join in teasing.	

M	10	ADHD, irregular medication, prone to explosive emotions, lacks self-confidence, requires affirmation from adults.	ADHD diagnosis, unstable medication usage, prone to emotional outbursts when unhappy, lacks self-confidence, needs affirmation from adults.
M	7	Struggles to integrate with peers, eager to interact with others but unsure of how to do so, vulnerable to being targeted by classmates.	
F	9	Attention difficulties, good interpersonal relationships.	
M	10	Previously diagnosed with ADHD and separation anxiety, currently symptom-free, good peer relationships.	
M	7	Good interpersonal relationships, slightly mischievous.	
M	9	Recent conflicts with school homeroom teacher, noticeable mood swings, clear expression of dissatisfaction when upset. New student in the class.	
M	10	Inattentive, poor emotional and behavioral control, multiple theft incidents and collection of snails. Mother describes him as not considering others' fear. Mother uses strict disciplinary strategies.	
F	9	No reported interpersonal issues, performs well according to mother.	

3

A Nonconcurrent Multiple Baseline Evaluation of a Novel Independence Intervention to Treat Child Anxiety

Camilo Ortiz, Ph.D. Associate Professor of Psychology
Director of Clinical Training Doctoral Program in Clinical Psychology Life Sciences
Long Island University, C.W.

Rates of child and adolescent anxiety have increased markedly over the past decade (Haidt & Twenge, 2023). Exposure-based cognitive-behavioral therapy is the gold standard in the treatment of anxious children (Hofmann et al., 2012). However, many clinicians refrain from using exposure due to concerns about its safety, effectiveness, and ethics (Deacon et al., 2013; Whiteside et al., 2016). We propose a novel treatment approach for child anxiety composed of independence activities (IAs), which are child-directed, fun, unstructured, developmentally challenging tasks that are performed without any help from parents. These tasks are purposely topographically unrelated to the stimuli that cause anxiety, in direct contrast to exposure therapy. Despite this dissimilarity, IAs target putative mechanisms involved in the development and maintenance of child anxiety (e.g., parental accommodation and overinvolvement, child avoidance, unhelpful thinking styles). Using a nonconcurrent multiple baseline design, this five-session treatment resulted in high treatment acceptability from children and parents. Medium to large improvements were reported in child anxiety and avoidance, parent and child (behavioral and cognitive) mechanisms involved in the maintenance of child anxiety, and untargeted secondary outcomes such as child happiness. Results may suggest a new treatment paradigm, which is desperately needed, given unabated increases in child and adolescent anxiety despite vast resources being directed toward the problem.

4

Case report: KETOLAND the psychoeducation program for ketogenic diet

Arianna Zaliani 1, Valentina De Giorgis 1,2, Ludovica Pasca 1,2, Costanza Varesio 1,2, Monica Guglielmetti 3,4, Anna Tagliabue 3, Serena Grumi 2, Maria Angela Geraci 5, Martina Paola Zanaboni 2

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Glucose transporter type 1 deficiency syndrome (GLUT1DS) is a rare neurological disorder characterized by a wide spectrum of symptoms: epilepsy, movement disorders and neurocognitive impairment. The gold standard treatment for GLUT1DS are ketogenic dietary therapies (KDTs), specifically classical ketogenic diet (CKD) (1). Despite the benefits, CKD often represents a challenge for patients and their families since meal preparation is extremely demanding and deviates a lot from normal diet (2). To assure an optimal compliance to CKD, a psychological support for parents and patients with GLUT1DS is highly recommended; specifically, a psychoeducational intervention that ameliorates the knowledge about the illness and its therapy to improve treatment's adherence and efficacy (3). In this case report, we propose a psychoeducational program based on the theoretical model of Cognitive Behavioral Play Therapy (CBPT). The aim of this work is to investigate the effectiveness of our model of intervention in a patient with GLUT1DS who presented a worsening of her clinical picture due to a sparse knowledge of KDTs principles, which determined a low adherence. The adopted program was named "Ketoland" and consists of two independent yet matched sections, one meant for the child affected by GLUT1DS and one for the parents. Both interventions face

the same topics using several techniques and tools, such as questions and answers, brainstorming, slides, videos, and therapeutic storytelling. The treatment lasted 3 months and consisted of 1 once-a-week session. To investigate the effectiveness of the psychoeducational intervention, the following measures have been analyzed before and after the KETOLAND program: ketonemia, EEG, dietary treatment knowledge, and CKD adherence using a 7-day food diary and semi-structured psychological interviews. An increase in the ketonemia levels and a significant electroclinical improvement in terms of both seizure freedom and normalization of the electroencephalogram were registered. The psychological interviews with the family and the patient revealed an improvement of knowledge regarding CKD: foods that need to be reduced, the importance of adhering to nutritional prescriptions, and the identification of the KETO team as a point of reference in case of doubts and needs. Consequently, the improvement in CKD knowledge led to a better dietary adherence. This work emphasizes the importance of identifying factors that hinder adherence to treatment to promote psycho-education programs aimed to increase not only treatment compliance, but also the patients' and families' general well-being and quality of life.

5

A CBPT intervention in a 7 years old girl with food selectivity

Brunella Voltarelli, Psychologist and Psychotherapist
Florence, Italy

Food selectivity widely affects the quality of life, and it is associated with rigid and perfectionist temperaments, engendering both parental stress and difficulties in managing children. CBPT is an innovative and effective approach for treating this difficulty by working on thoughts, emotions and behaviors using children's main language: play!

Aim: expand the range of foods offered and consumed by the child; lower parental stress levels and improve the parent-child relationship; structuring functional beliefs and behaviors to implement the family's quality of life. Materials: Standardized tools were used such as PSI; CBCL; JTCI; IDC; SCARED; CPDM. A small Theater with wooden characters was used as the main game tool; finally, the psychoeducational protocol "The ABC of my emotions" was used.

Method: Standardized instruments were administered pre- and post-treatment; therapeutic sessions were carried out during which the principles of CBPT were used. The treatment was combined with a Parent Training intervention and a subsequent psychoeducational intervention on emotions for the child, with the aim of consolidating the cognitive aspects of the intervention in a maintenance phase.

Results: From data analysis emerges that the levels of parental stress are within the normative range for both parents (PSI), even the behavioral checklist does not show clinical scores (CBCL). The Character Indices (JTCI) are increased for both parents.

Discussion: Following the CBPT intervention carried out, the clinical indices that started the intervention returned to the non-clinical range, at the end of the intervention the child no longer showed food selectivity and the parent-daughter relationship was more peaceful and satisfactory. The emotional awareness of the child and the parents regarding their daughter's emotions were configured as protective factors with respect to the follow-up which took place 3-6 months and one year after the end of the treatment.

Conclusions: The CBPT intervention is defined as a complete and effective intervention to treat food selectivity in children with typical development, working both on specific symptoms and on the quality of life of the family unit. This intervention applied in its entirety allows us to work simultaneously on both the needs of the child and those of the parent, creating a virtuous circle of new learning that is generalized first in the playroom and then outside in everyday life.

6

Pretend play in the assessment of children with neurodevelopmental and behavioral disorders.

Mirandi Maria; Mazzeschi Claudia; Delvecchio Elisa

University of Perugia

Perugia, Italy

Pretend play is a natural mode of expression for children and is a fundamental aspect of their lives because it promotes connection with the inner and surrounding world, promoting affective and cognitive development. Assessing the pretend play of children with neurodevelopmental and behavioral disorders can be particularly useful because traditional assessment tools, due to the high linguistic and cognitive burden, often underestimate their level of development while neglecting other important cognitive and affective abilities. However, to date, few studies have investigated through pretend play the affective and cognitive abilities of children with ADHD, LDs, and ODD. This exploratory study aims to delineate the functioning profile and assess differences in affective and cognitive abilities of children with neurodevelopmental and behavioral disorders. The Affect in Play Scale Preschool-Extended Version was administered to assess the cognitive and positive and negative affective abilities in 60 Italian children aged 6-10 years (M= 8.31±1.35; 56.7% male) of whom 50% were diagnosed (LDs n=10; ADHD n=10 and DOP n=10). The results of the Kruskal-Wallis test showed significant differences in the cognitive categories of organization, imagination, and positive affectivity with differences in the ODD group showing lower values in organization, imagination, and positive affectivity compared to children with neurodevelopmental disorders (ADHD and LDs). The study, despite the numerical limitation of the sample, highlights the importance of using play in developmental assessment and the usefulness of the APS-P in delineating the functioning profile of children with different diagnoses.

7

PLAY THERAPY USE TO DISCOVER IRRATIONAL BELIEFS IN AN ARFID CASE: RAPID EFFECTIVENESS

Annalisa Patriarca, Psychologist and Psychotherapist

Private Practice, Pescara, Italy

Introduction: ARFID (Avoidant/Restrictive Food Intake Disorder) as described in the DSM-5, is characterized by food avoidance, which can include a strong aversion to certain foods; their smell, taste, texture or appearance and can occur throughout the lifespan, in infants, children, teens and adults. In the case studied the disorder caused a distress in the patient exacerbated by the fact that it occurred in a young child who exhibited strong resistance to discussing the problem with all significant adults and it was challenging to approach the child with traditional clinical interviews.

Objective: This study verifies the efficacy and the efficiency of Cognitive Behavioral Play Therapy (CBPT) used in a preschool-aged child with ARFID.

Methods:The study was conducted on a case of a 5-and-half-year-old child treated with CBPT (Knell,1999).The therapy was developed in: 2 clinical interviews with parents , 5 CBPT sessions with child (one per week),1 relapse prevention meeting (after 1 month after the treatment), 1 follow up with retesting (after 4 month after the treatment ended).The treatment was evaluated by administering the CBCL (Achenbach,1991) to the mother at two times points(during the assessment phase and during the follow up) and by checking the frequency of problematic behavior in both the school and home contexts.

Discussion: The American Psychiatric Association (2014) also suggests that ARFID may be correlated with avoidance of a trauma related to eating.

Indeed, in the described case, the beliefs underlying the phobic behavior are linked to a traumatic event that the child couldn’t articulate.

The treatment involved structured play sessions, using a variety of CBPT techniques to explore fears and to discover the child's irrational beliefs about eating. Through the puppies' use and various creative activities, he learned self-relaxation techniques and was able to expose himself to talking about food, understand the workings of fear, and not fear the symptoms of anxiety that were affecting him. Systematic desensitization was possible and the child immediately resumed eating.

Results: CBCL results before and after the CBPT treatment and the avoidance grids show significant improvement in the reduction in food related anxiety after only 5 sessions of therapy.The reduction in the frequency of food avoidance in this case not only demonstrates the effectiveness of CBPT in preschool-aged childrens but also its remarkable speed (only 5 play therapy sessions to the reduction of problematic behavior).

8

CASE STUDY: SEPARATION ANXIETY IN A GIRL WITH DOWN SYNDROME DUE TO MOSAICISM

Marta Chemello, Psychologist and Psychotherapist

Private Practice, Bassano del Grappa, Italy

Cognitive Behavioral Play Therapy (CBPT) was utilized to reduce separation anxiety in a girl with mosaic Down syndrome. The girl exhibited anxiety and fear, accompanied by nausea and vomiting, when sleeping alone in her room or when her parents were absent due to business trips. The girl, chronologically 10 years old, had a mental age of 7.5 years. Twelve individual sessions were conducted over four months, supplemented by two initial and two follow-up meetings with the parents. Knell's model (1998) was applied during the sessions. In the assessment phase, parents completed the CBCL scale (Achenbach, 2001), and a grid was used to monitor the nights when the girl slept

alone in her room. Observation of the girl's play behavior was conducted, and she was given the Puppet Sentence Completion Task (Knell, 1992). From clinical history, assessment, and subsequent case conceptualization, it emerged that the girl's pretend play was adequate and cognitive functioning allowed for intervention implementation. Techniques such as modeling, role-playing, contingency management, exposure, relaxation, and self-instructions were utilized using puppets, storytelling, and expressive arts. Treatment outcomes monitored at three and six months post-treatment, using the same assessment tools, showed increased frequency of falling asleep in her own room, even without parental presence, improved emotional regulation during separation from her parents, and a reduction in cognitive distortions; physical symptoms of nausea and vomiting were no longer present. The use of CBT techniques adapted to the girl's age and the tools employed also facilitated a good therapeutic alliance. Therefore, CBPT proved to be an effective technique in reducing separation anxiety in a 10-year-old girl with Down syndrome due to mosaicism.

9

COGNITIVE-BEHAVIORAL PLAY THERAPY AND SELECTIVE EATING: A SINGLE CASE STUDY

Marta Chemello, Psychologist and Psychotherapist

Private Practice, Bassano del Grappa, Italy

Cognitive Behavioral Play Therapy (CBPT) is an adaptation of cognitive-behavioral therapy for preschool and school-aged children, in which major cognitive-behavioral techniques are proposed through experiential play interventions (Geraci, 2022). The aim of this study is to illustrate the effectiveness of applying CBPT in a 6-year-old child with selective eating, associated with Language Comprehension Disorder and Attention-Deficit/Hyperactivity Disorder. Knell's model (1998) was applied, which involved an orientation session with the parents, two assessment meetings, and the subsequent implementation of a ten-session intervention on a weekly basis.

During the assessment phase, the parents completed the CBCL scale (Achenbach, 2001), which revealed only attention difficulties, and they reported that the child exclusively consumed milk, water, biscuits, and crackers of specific brands. In the assessment meeting with the child, pretend play appeared appropriate, intelligence quotient was within the normal range, and the Puppet Sentence Completion Task was administered. Intervention objectives were therefore aimed at both increasing eating repertoire and enhancing flexibility in trying different brands. Subsequent sessions utilized techniques such as modeling, role-playing, exposure, systematic desensitization, cognitive self-affirmations, and cognitive restructuring using puppets, storytelling, and expressive arts. Treatment outcomes showed increased flexibility in trying new foods of different brands and introducing new items such as pasta, ham, and sweets into the child's diet. Follow-ups were conducted at 6 and 12 months using the previous instruments, which demonstrated the stabilization of new behaviors and generalization to the school environment. CBPT appeared effective in increasing the variety of foods tasted and making the child's diet more flexible; the experiential element in CBPT motivated and engaged the child in experimenting with new foods, proving to be an effective intervention.

10

THE EXPERIENCE OF USING IT TECHNOLOGIES IN COGNITIVE BEHAVIORAL THERAPY (TF-CBT) FOCUSED ON TRAUMA IN CHILDREN AND ADOLESCENTS REFUGEES FROM UKRAINE WHO SUFFERED FROM THE WAR.

Natalia Urus- Child psychologist

"Ukrainian House in Latvia" Latvia-Ukraine - Mental Health & Gamification

TF CBT is one of the most studied and widespread methods of treating children and adolescents. This method turned out to be effective and efficient when working with Ukrainian children who were forced to move to Latvia as a result of the war. The goal of the work was to improve the accessibility and reduce the limitations of psychological assistance, the development of self-help skills using IT technologies with a large number of opportunities that go beyond the traditional format.

Since the beginning of the war in Ukraine, children's mental health has been saturated with intrusive memories. At the same time, children and parents massively avoid talking to each other about what happened to them, fearing to upset each other, creating the so-called "circle of silence". This type of avoidance supports post-traumatic stress and forms children's mistrust to adults, contributes to the emergence of distorted cognitions in relation to themselves and others. Storytelling helps children and parents put these intrusive memories into a format that already has a beginning and an end. During the compilation of the story, the child has the opportunity to process the traumatic experience from different levels: logic (what happened), emotions and bodily sensations (what he feels), time (this event is already over) and self-esteem (I survived this situation) (2, p.36)). Drawing stories in the format of comics allows the child to see all the planes in the plane at the same time, as if from the side.

Our team (Urus N., Kulyk S., Falko I.) started creating the StoryTileCraft application (2022): an interactive drawing tool for creating stories that can be located on the same plane and a gamifier of parts of the drawing, bringing the story to life. The narrative is formed according to the principle of a virtual chronicle, which the child creates step by step with the help of a tablet. It includes different scenarios (2), the complexity of drawing tools, the ability to save stories in a time sequence and return to them for comparison and analysis of experience. Such a historical archive helps to avoid many problems in the future, since the child has already learned to frame his experience in history and experience them, it will help parents learn to be a therapist for their child and themselves.

11

MDR RELATIONAL DYNAMIC MOSAIC: A new therapeutic and psychosocial investigative tool

Dr. Pierluigi Ceccalupo - Psychotherapist and Play Therapist

Relationships play a fundamental role in shaping our selves, so much so that all the relationships we have with others profoundly influence our identity, our beliefs, our emotions and our actions, thus, every aspect of our lives. The set of relationships built over time represent the ever-changing social networks that run through the individual and thus constitute his or her social world of reference, and his or her specific living environment. To know and examine one's social networks means, to think of oneself, conceive of oneself and experience oneself in "other" ways in different contexts. The book reviews the different psychological theories of interpersonal relationships but also the most relevant investigative tools used in the analysis of relational networks because it aims to present a new clinical assessment tool: the Relational Dynamic Mosaic (MDR). A tool, easy to administer, is useful for investigating in the psychotherapeutic field, with children, adolescents and adults, the broader relational network of the person, not only related to his or her family of origin, but also to the systems of belonging and social interaction, such as school/training, nuclear/parental family, work, friendship, love, sports and socializing aggregation. During the use of MDR the subject becomes the protagonist of the narrative by constructing his or her own mosaic by placing the characters in a way that is meaningful to him or her, in each relational area; at the same time he or she also becomes an observer of what has been created by increasing awareness of the quality of relationships. The dexterity and transposition of the internal world into the external world through the use of the colored, but neutral, characters encourages the projection of the significant figures involved in the relationship and also allows the subject to narrate himself in a playful way thus enabling the reduction of internal resistance. The use of the characters and the possibility of intentionally moving and positioning them in parts of the hexagon fosters immersive participation of the subject by granting him or her a protective psychological distance in accessing deeper content related to a specific relationship. From the administrations carried out with school-age children, preadolescents and adults, it has emerged that the use of MDR increases the ability to gather important information about the person, and about the primary networks anchored in the subject, a comprehensive mapping of significant relationships, relevant aspects of relationships with the figures described in the mosaic, the type of ties that exist, as well as the nodes and/or conflicts present and the emotional climate experienced. The person, in a new form, experiences self-narrative by shaping words by making a three-dimensional relational mosaic that he or she can observe from multiple sides, manipulate and further modify.

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