CHAPTER

1

Introduction: Dimensions of Treatment for Traumatized Children

"It hurts inside,
it hurts inside,
it hurts inside so baaaad"

This was the sing-song refrain of Racquel, a seven-year-old little girl who had just survived a night sleeping on her front porch. She arrived at school that morning dressed in the same clothes she had worn the day before and complaining of being hungry. Her teacher reported that she was uncontrollable in the classroom, aggressively engaging her peers and disrupting the other students. She was sent to my office, where she sat down on the couch with her arms crossed over her chest and glared at me defiantly. She looked at me with hot tears held back by sheer willpower and said, "I don't want to talk about it." I explained that sometimes it was difficult to talk about feelings, but that they could get out through music or drawing. Racquel looked at me thoughtfully and then reached for the toy guitar and began to strum these words in a frenzied rhythm, repeating them over and over again until she reached a fever pitch. Then she sighed, put the guitar aside, and sat back down. The tears began to flow, and so did her tale. Mom had gone out prostituting herself in an attempt to keep the family afloat financially but had forgotten to leave a key under the mat.

The fact is that our traumatized children do hurt inside. Sometimes the hurt comes out in externalizing behavior problems. Sometimes the hurt is held close and causes a host of internalizing symptoms. Either way, child therapists become, in our use of self and the space, the strong containers who help to hold the hurt for the children we serve. This book highlights the many ways a therapist holds trauma content for a child, while navigating a developmentally sensitive, individualized course of treatment.

The Goals of This Text

The aim of this book is threefold. The first objective is to outline my approach to trauma treatment, what I have termed the flexibly sequential play therapy (FSPT) model of treatment for traumatized children. Although each child is unique, each case is different, and all require the finesse of a skilled clinician, a series of foundational treatment goals come up over and over again during a course of therapy for a traumatized child. They are:

1. Building a child's sense of safety and security within the playroom and in relation to the person of the therapist
2. Assessing and augmenting coping skills
3. Soothing the physiology
4. Using parents as partners: Ensuring that caregivers are facilitative partners in the therapy process and effective co-regulators of the child's affect
5. Increasing emotional literacy
6. Creating a coherent narrative of the trauma that integrates the linguistic narrative with somatosensory content
7. Addressing the thought life, including challenging faulty attributions and cognitive distortions while restructuring maladaptive cognitions and installing and practicing adaptive thoughts
8. Making positive meaning of the post-trauma self

In addition to these treatment goals, the rich environment of the playroom encourages two other processes that I have seen play out over and over again as children work through trauma. I have labeled the first of these the continuum of disclosure, which refers to the ways in which children self-titrate their exposure to trauma content. The second phenomenon is called

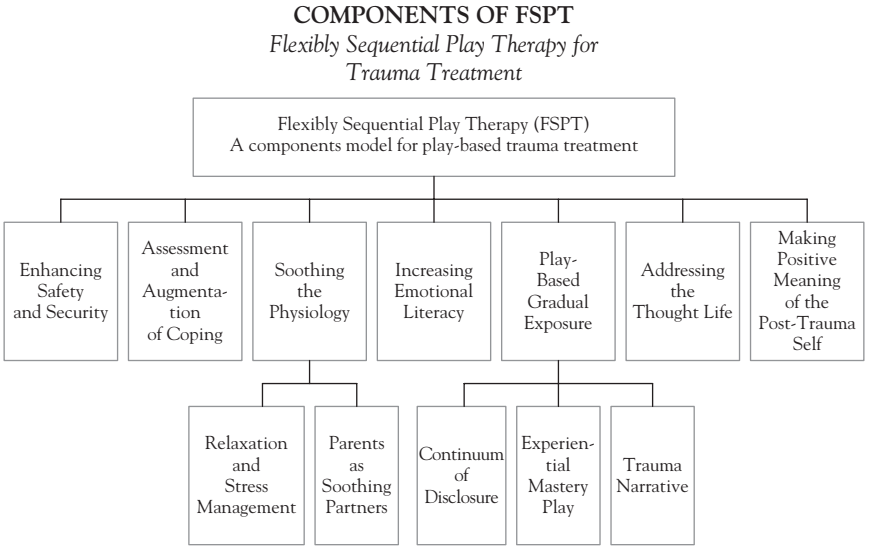

Figure 1.1 Components of FSPT

experiential mastery play (EMP) and refers to the myriad ways in which children use the play space and the tools of childhood to restore the sense of empowerment that posttraumatic children have often lost. These twin processes, grounded in play and expressive mediums and woven throughout the other skill-based work, are so pervasive with traumatized children that each is given its own chapter.

The FSPT model delineates specific treatment goals, delivered through a variety of specific play-based technologies and supported by an understanding of the facilitative powers of play and the therapist's use of self in the play space. The specific needs and symptom constellations of each child *require* a flexible, nuanced application of the model and also leave room for the integration of nondirective and directive approaches. The sequence is also flexible with respect to both chronological order and the length of time that is spent in the pursuit of each goal. The goals are laid down sequentially. This delineation may give the faulty impression that each goal can be fit neatly into a box and done in an ordered fashion with every client. The opposite is more likely to be true.

Although the skill sets may be introduced in a certain order, it is often the case that several goals are being pursued simultaneously. For example, although trauma narrative work is generally saved until the child has established a strong foundation of positive coping, relaxation strategies have been rehearsed, and parent support has been increased, children may begin to share trauma content

spontaneously. It is the therapist's job to become a container for this content, record it in some fashion as part of the narrative, and, if necessary, invite the child back into safer territory.

The flexible nature of FSPT also allows for steps in the sequence to be skipped if the child or family already seems to have a healthy grasp of the therapeutic content that would otherwise be covered. For example, a child who enters treatment after being involved in a serious car accident may not need to progress through every step of the therapy. He may already have some of the internalized abilities that would be provided through treatment. If he has a strong, contingently responsive caregiver, he is likely to already have internal capacities for self-soothing based on a history of being soothed by the parent. Additionally, if the parent is not mired in her own trauma reaction and is functioning as a healthy support to the child, the components of treatment related to soothing the physiology and maximizing the role of the caregiver may be minimal. Through careful assessment and clinical judgment, the most salient treatment goals from the model can be mapped out on a case-by-case basis.

The application of FSPT requires breadth of knowledge and finesse with a variety of treatment technologies. Goals such as coping, emotional literacy, and cognitive restructuring require an understanding of cognitive-behavior theory (Beck, 1975, 1979, 2005) and its derivative methodologies for children and adolescents (Asarnow, Tompson, & Berk, 2005; Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Deblinger, 2006), as well as cognitive-behavioral play therapy (Knell, 1993, 1998). Soothing the physiology requires an understanding of trauma theory and developmental traumatology (Briere & Scott, 2006; Cicchetti & Tucker, 1994; DeBellis et al., 1999; DeBellis & Putnam, 1994; Perry & Azad, 1999; Solomon & Siegel, 2003), physiological stress responses (Bremner et al., 2003; DeBellis & Thomas, 2003; Van der Kolk, 1994), and the theoretical underpinnings of somatic therapies (Rothschild, 2000) and mindfulness practices (Kabat-Zinn, 1990, 2005; Segal, Williams, & Teasdale, 2002).

Maximizing the role of parents as partners in a child's trauma treatment requires an understanding of family systems theory and attachment theory and familiarization with the latest dyadic interventions, including parent-child interaction therapy (Herschell & McNeil, 2007; Urquiza & McNeil, 1996), Theraplay (Jernberg & Booth, 2001; Martin, Snow, & Sullivan, 2008; Munns, 2009), filial therapy (Guerney, 1964; Guerney, Guerney, & Andronico, 1999; VanFleet, Ryan, & Smith, 2005), child-parent psychotherapy (Lieberman,

Van Horn, & Ippen, 2005, 2006), child–parent relationship therapy (Bratton, Landreth, Kellam, & Blackard, 2006; Landreth & Bratton, 2006), and the Circle of Security Project (Cooper, Hoffman, Powell, & Marvin, 2005; Hoffman, Marvin, Cooper, & Powell, 2006; Marvin, Cooper, Hoffman, & Powell, 2002; Powell, Cooper, Hoffman, & Marvin, 2007). Although it is not necessary to be proficient in every one of the models listed here, it is essential that the modern clinician's tool kit include sound dyadic interventions and psychoeducation components for the parent.

The developmental needs of children also require that clinicians have a healthy respect for the therapeutic uses of play (Landreth, 1991; Schaefer, 1993; Schaefer & Drewes, 2009) and the effectiveness of play therapy as a treatment modality (Bratton, Ray, Rhine, & Jones, 2005; Ray, Bratton, Rhine, & Jones, 2001). Overlaying all these areas of knowledge should be a great respect for a child's individuality and a deep belief in a child's ability to heal from trauma.

The second intention behind this book is to equip clinicians with creative, practical, easily replicable interventions that can be employed to accomplish each of the goals of the FSPT model. The most common concern I hear from practitioners is that techniques and theoretical information about trauma are easy to find, but the blending of solid theoretical groundwork with techniques is more difficult. The application of specific techniques or interventions, without the proper scaffolding of a comprehensive model of treatment in which to place them, may end up producing iatrogenic effects. To this end, an explication of prop-based intervention (PBI) is made. Additionally, all the goal-directed chapters include examples of specific, prop-based play interventions that can be employed in the pursuit of that goal.

The third aim of this book is to accurately convey the myriad ways in which children eloquently articulate and begin to resolve their experiences of traumatic events through play, art, and story. This book is not limited by the form that a particular trauma might take. Case examples include clients who have experienced physical abuse, sexual abuse, domestic violence, divorce, the death of a loved one, tragic accidents, chronic illnesses, and natural disasters.

The Need for Integration

In conference settings, I am often asked, "How should we conceptualize the underlying anxiety problem in posttraumatic children? From a neurophysiological perspective? From a psychodynamic perspective? From a behavioral

perspective? From a family systems perspective? From a cognitive perspective?" My answer is unabashedly, "Yes, yes, yes, yes, and yes." FSPT is both inclusive, in that it recognizes the valuable contributions of widely diverse paradigms to functional trauma treatment, and holistic, in the sense that all aspects of the child's life (developmental, social, cognitive, filial, neurobiological, etc.) must be considered when planning treatment.

An example may help to flesh out the complexities of treatment. Julie, a ten-year-old girl referred to treatment after witnessing her father violently attack her mother, is suffering from intense separation anxiety. In this case, it can be hypothesized that the avoidance of separation from mom is directly related to the trauma, because Julie had no difficulty separating from mom before the attack. Julie insists on staying in the same room with her mother, even when they are at home during the daytime. Mom is exhausted and bewildered by her daughter's behavior and vacillates between yelling at her daughter and accusing her of manipulating the situation and feeling guilty about the child's pain and enabling Julie's dependence on her. In this case, the child and parent need psychoeducation about the effects of trauma and anxiety and the best mechanisms through which to fight them. The mom needs specific training in strategies that will soothe her daughter while challenging her to push through the anxiety. The parent and child need to create a coherent narrative of the attack together and discharge the toxicity associated with that event. The child needs individualized play-based interventions that will augment her coping, equip her with relaxation strategies, and train her to "boss back" the anxiety and make strides in identifying and restructuring faulty cognitions. A process of graduated exposures will most likely have the greatest success if it is reinforced through behavioral rewards for the child. In addition to these pieces, the child may benefit from spontaneous reenactment of the trauma through the play materials in the room. Yes, yes, yes, yes, and yes.

The trend toward integration promoted by child clinicians from other professional fields is being trumpeted by play therapists as well (Gil, 2006; Kaduson, Cangelosi, & Schaefer, 1997; Shelby & Felix, 2005). Currently many theoretical orientations and working models fall within the scope of play therapy. Although each orientation has a valuable contribution to make, it is critical that clinicians select and tailor intervention models to the unique needs of each client, as opposed to championing one theoretical approach to the exclusion of others.

Clinicians have historically defined themselves in relation to their theoretical orientation. "I am a psychoanalytic therapist." "I am a cognitive-behavioral therapist." "I am a child-centered play therapist." "I am an attachment therapist." Each of these theoretical orientations birthed a host of technologies that allow for the practical application of each theory. These technologies may include a premeditated way of responding to clients, a series of intentionally designed questions aimed at exploring a particular area of a person's experience, a set of psychoeducational activities, or a succession of experiential exercises that support the model. Although all of these models have valuable contributions to make to the field of child therapy, no single therapy can claim to be the fix or the cure for every child who comes through our doors. In fact, when we as clinicians have too closely aligned ourselves with one particular mode of practice, we increase the likelihood that we will have clients whom we are unable to help. In these cases, we run the risk of eventually characterizing a clinical failure as one in which the child cannot be helped when what may be more accurate is that we have not yet found the most effective way of helping. With these dangers in mind, it is incumbent upon contemporary child therapists to be well versed in a variety of intervention models.

My own evolution as a trauma therapist may mirror the journey of many readers. I was originally trained in child-centered play therapy (CCPT) and its offshoot, filial therapy, both of which gave me a healthy respect for a nondirective approach and a child's ability to lead. There will be many examples throughout this text of the magic that can occur when a child is allowed to use play, the language of childhood, to work through her trauma experiences. I am constantly amazed at a child's ability to spontaneously go where she needs to go, eloquently describing her experiences through the play, art, and sand. I am, however, equally amazed at how a traumatic experience or maltreatment history can rob a child of this same spontaneity. Recognizing the limitations that an exclusively nondirective approach placed on my own practice, I went in search of additional tools.

Racquel, the seven-year-old girl who spent the night on the porch at the start of this chapter, moved from dysregulation to immobilization in the course of the morning. Her tightly crossed arms mirrored her tightly held control. She needed an invitation toward movement, and my offers of music, drawing, or sand play gave her options among which she could choose. The facilitative invitation, while directive in nature, opened the door for her

self-directed creation of the "It hurts inside" mantra. In this case, Racquel needed help getting started.

Other aspects of trauma treatment may also require more directive intervention from the therapist. Psychoeducation related to a child's specific traumatic events and skill building in target areas can both be accomplished through the medium of play but must be intentionally pursued. In addition, some children engage in trauma reenactment play that is repetitive and aimless, often separated from any meaningful thoughts, emotions, or energized movement. Gil (2006) terms this mired play pattern stagnant posttraumatic play. The therapist's response in these situations requires a range of purposeful invitations to help the child become unstuck.

Another aspect of trauma recovery relates to the restoration of disrupted attachment relationships with caregivers. In some cases a traumatic event has compromised the parent, the child, or both parties to such an extent that they need directive help in reestablishing a relationship of coregulation. In other cases, the depth of maltreatment requires a child to develop a relationship with an entirely new caregiver. In either case, a host of directive interventions exist that purposefully facilitate these connections. Keeping in mind the variety of these needs, the FSPT model embraces both nondirective and directive approaches to treatment, promoting the flexible application of each.

In sum, the FSPT model represents a systematic integration of theoretical constructs and tools drawn from these diverse schools of thought. Nondirective approaches are used in relation to specific goals. Building safety and security in the playroom is often a child-led process that is simply reinforced by the therapist. The broad processes that I term the continuum of disclosure and experiential mastery play and certain aspects of trauma narrative work tend to be child-directed. Directive approaches are implemented to concretize or augment the work done in these categories and are the primary portals through which skill building and psychoeducation occur, both for the children and their caregivers.

The Facilitative Power of Play in FSPT

FSPT relies heavily on the therapeutic and facilitative powers of play to deliver developmentally sensitive treatment. The facilitative power of play forms the foundation for the application of all evidence-based

methods delineated in the FSPT model. The integration of play into the delivery of other intervention models can maximize the developmental sensitivity of the model. For example, recent literature highlights challenges in the nuanced application of CBT for children and adolescents (Gravea & Blisset, 2004; Weisz, Southam-Gerow, & McCarty, 2001). Although CBT is the gold standard of evidence-based practice for the treatment of PTSD and depression in children and adolescents, recent concerns have been articulated related to the cognitive limitations of younger children. Children younger than eight may lack the sophisticated cognitive capabilities (processes such as metacognition) that impact the effectiveness of CBT (Holmbeck et al., 2003). According to two separate meta-analyses of CBT treatment with children and adolescents, older children benefited significantly more from treatment than younger children (Weisz, Weiss, Han, Granger, & Morton, 1995; Durlak, Fuhrman, & Lampman, 1991). The integration of play with the cognitive and behavioral information being conveyed may enhance the treatment's effectiveness. Some of the ways in which play functions as a mechanism for change in trauma treatment are listed next.

Play Counters Toxicity

Traumatic events have toxic effects on our children. Children naturally avoid exposure to noxious or overwhelming content. However, children are naturally drawn to play. Play is inherently fun and is as natural to children as breathing (Schaefer & Drewes, 2009). A child's natural inclination to play is activated in a fully equipped playroom and counters the felt toxicity of the trauma content being explored. In other words, play itself is a process that mitigates the felt potency of trauma material. Typically, children receive reinforcement through the simple pleasure of manipulating objects, creating things, using their imaginations, building relationships with others, and relieving stress.

The many therapeutic powers of play have been delineated in the literature (Schaefer, 1993, 1999; Schaefer & Drewes, 2009; Landreth, 1991, 1993). Two of these powers, the counterconditioning of negative affect and the reestablishment of a child's sense of power and control, work together to leach the toxicity out of disturbing material, affording the child a less perilous approach to the trauma content. The intrinsic enjoyment of the play

counters the toxicity of the trauma content while motivating the child to stay engaged in a process that can feel overwhelming or scary.

For example, an 8-year-old girl named Clara, who had been sexually molested by two male family members, came to treatment stuck in avoidance symptoms. She became overwhelmed whenever anyone approached the subject of her sexual abuse. One day she came into the playroom and began pouring glue onto a piece of paper. She squeezed out lots of glue and said, "I don't want to touch it." I reflected her desire to avoid tactile contact with the glue and then stated, "If and when you're ready to touch the sticky stuff, you'll know." Clara looked at me briefly and then began to smear the glue around with her fingers. Eventually, her hands were covered in the sticky substance. I asked what the sticky stuff made her think of and she immediately offered the names of her two perpetrators. I reassured her that in the playroom she was in control of the sticky stuff. She continued to smear the glue around the page as she talked about the men's ejaculations and the semen that she had been forced to touch. As she talked, she was having a self-directed in vivo exposure to a trauma reminder, which enabled her to begin the process of desensitization to the traumatic event. After a few minutes, she began to paint pictures with the glue, effectively recreating the meaning of the sticky stuff as an artistic tool fully under her control.

Play as Prelinguistic Communication

One theme that runs throughout this book is the function of play as nonverbal communication. From the moment that children begin to walk and talk, grownups repeat phrases like, "Use your words!" over and over again. However, words are not the primary language of children. Children primarily communicate through their behavior and secondarily through their play. Plato wrote, "You can discover more about a person in one hour of play than in a lifetime of conversation" (*The Republic*, 360 BC). This is particularly true of our child clients.

Moreover, many of the children we see in practice have experienced prelinguistic trauma, meaning that the trauma occurred prior to the development of language. There are no words that accurately capture their experience because there were no words at the time the trauma took place. In these cases, play therapy is an optimal modality, in that it allows the child to approach the trauma through nonverbal and sensory avenues.

Children may depict aspects of the trauma through manipulation of the toys. Because prelinguistic trauma is stored mainly in the body (Rothschild, 2000), child clients may have important sensory aspects of the trauma activated by being kinesthetically involved with the tools of the playroom. Play, a positive form of coping for children, runs a course parallel to the overwhelming implicit and explicit memories of the trauma. At the intersections of the play and the trauma, the play itself acts as a grounding device for the more difficult content that may materialize.

Play as Digestive Enzyme

In each of the play-based interventions described in this book, play becomes the digestive enzyme through which the child is fully able to ingest the therapeutic content that is being conveyed. Play ensures the most potent absorption of conceptual information for children. The FSPT model, in addition to holding the child's trauma experiences, includes a focus on skill building and psychoeducation. In the same way that the absorption of certain vitamins is aided by the accompaniment of other vitamins, the digestion of psychotherapeutic content with children is aided by the accompaniment of play.

The Power of Props as Anchors for Therapeutic Learning

My approach to working with traumatized children relies heavily on props. The fully equipped playroom is filled with a variety of props that are used in the service of the children's healing. A baby doll can become a child's self-object. As the therapist bandages the baby doll, the child receives a vicarious experience of caretaking. As the child nurtures the baby doll, the child may be empowered to take care of himself. A pair of handcuffs, simply by being made available to the child, can draw out a narrative of a parent being taken to jail. The dollhouse elicits a variety of play from traumatized children and is a prop rich with possibility for exploring family dynamics or for projecting fantasies of the hoped-for family. In addition to the spontaneous child-directed use of the playroom materials, I use props as the anchors for directive interventions I have created over the years (Goodyear-Brown, 2001, 2002, 2003a, 2003b, 2005). This series of techniques evolved as an attempt to meet the treatment goals of the FSPT model while being developmentally sensitive to the most effective mechanisms for teaching.

Literature in the areas of learning styles and forms of intelligence help inform our understanding of how people learn (Fleming & Mills, 1992; Gardner,1993). According to Fleming and Mills, people develop preferences for learning that fall into the categories of visual, auditory, reading/writing, or kinesthetic. Some people, when trying to absorb information from a speaker, need to sit on the front row and have an unfettered view of the presenter. These people are visual learners. Others would prefer to read the information in book form. Another subgroup of people can easily absorb the needed information simply by listening to a recorded version of the content. These people are auditory learners. A final group of people need to have hands-on application of the material and physically practice the skills presented before they feel that they have grasped the information. These people are kinesthetic learners.

What we know about children is that they are first of all kinesthetic learners. Piaget's cognitive development stages begin with the sensorimotor phase and progress into more complex cognitive processes during developmentally sensitive time frames (Piaget, 1954). Children may also be secondarily wired for either visual or auditory learning. It makes sense, then, that the most effective delivery of new information or alternate experiences would be through all three mediums. Using a prop as the centerpiece of an intervention allows the child to access all three modes of learning. Moreover the prop provides an anchor for the therapeutic content. Additionally, when the child is given a prop that can be taken home, he receives the added benefit of having the prop function as a transitional object, a connection between the safety of the playroom and play therapist to his home environment. A prop that can be used to help practice a new skill is especially useful as it anchors the therapeutic content, serves as a transitional object, and encourages the child to engage in therapeutic homework.

I use a three-step process to design these interventions. The first step is choosing a prop. As I scan the environment for props, I am looking for two things. I assess the potential metaphorical value of the prop and, equally important, how much it might appeal to a child. These are, of course, totally subjective criteria, but the prop must meet a certain fun quotient. The best prop is one that, as soon as you show it to the child, she grabs it, says "Cool," and begins to explore. I then think about the function of the prop. What was it created to do? Once I have defined the function of the prop, I parallel this function with a similar process in therapy. Magnifying the feel goods, for

example, is an intervention that I designed several years ago to help children boost self-esteem while silencing negative self-talk. One day I was walking through a toy store and I came across an elaborate set of magnifying glasses. It was just the sort of prop that would fascinate children. I then asked myself how the prop was designed to function. Obviously, a magnifying glass is meant to make something small appear to be bigger. What would I like to magnify in the children with whom I work? I would like to enhance their positive self-talk. This was the beginning of the intervention design.

These procedures for designing play-based activities, along with the theoretical constructs related to the usefulness of props (anchoring the child's learning, functioning as transitional objects, and encouraging the completion of therapeutic homework), comprise the treatment model that I have labeled prop-based intervention. PBI is the mechanism for creating the play-based technologies used in the fulfillment of each treatment goal delineated in the FSPT model.

Children are intrinsically rewarded by the manipulation of props. Attaching difficult therapeutic content to the manipulation of fun props greatly increases the child's tolerance for approaching the harder subject matter. A good example of this dynamic happened in a recent session with a ten-year-old girl. Her mother brought her in for issues related to anxiety. I asked her if she could tell me some of the thoughts that worry her. She said, "Well, when my papaw died last year, I got really scared that I might die too and I couldn't sleep. But I started reading at night, to distract myself, and now I can sleep. That's about all." This concise description of one specific problem area and its eventual resolution minimized the extent of this little girl's anxiety. Because mom had given other examples of the child's anxiety, I decided to offer her a game that would playfully invite more information while allowing a titrated approach to looking at the anxiety-provoking content.

I explained that I would hide Worry Worms around the room and that she would get to find them. She began to grin and seemed to experience immediate relief at the thought of doing something active, playful, and familiar. I also explained that for each Worry Worm she found, she would tell me one worried thought that she had. Through the game play, she was able to generate a series of twelve worried thoughts, many of which began with "What if." What if my mom dies in the night? What if my dad dies in the night? What if I drown while I'm swimming? This particular thought had assailed her all

summer. She would spend the day at the pool swimming and having fun, but once she laid down in bed, she would worry about drowning. She was able to tolerate sharing these uncomfortable thoughts out loud with me because she was motivated by the challenge, reward, and fun of finding the hidden props. Although the game looked like hide-and-seek to her, it was actually a titrated set of exposures to anxiety-producing content that she completed while remaining grounded in the safety of the prop. The addition of a playful prop exponentially increased the amount of therapeutic content shared in the session.

Empowerment through the Manipulation of Playthings

For a traumatized child, the externalization of trauma-related content takes concrete form in the playthings a child uses for reenactment. As the child manipulates the smaller, controllable symbols of the larger, uncontrollable trauma, a sense of power and control can be restored. One way that the externalization process may work is that a child who has been unable or unwilling to share any details of her trauma before coming to treatment agrees to draw a picture or reveal a piece of her story through the way she uses the toys. The content left in the playroom can later be revisited or manipulated in a variety of ways.

Perpetrator Symbols and Self-Objects

Another form of externalization is when a child chooses a perpetrator symbol or a self-object. A perpetrator symbol is any miniature, puppet, art creation, or other toy that the child may choose to represent the person or people who hurt him. A child may choose one perpetrator symbol and continue to use him throughout treatment. A child might vary the symbol for the perpetrator over time or may choose two or three different symbols that remain consistent throughout treatment but represent different aspects of the perpetrator. One of the symbols most used to represent perpetrators in my playroom is the character Two-Face from Batman. This figure, as well as my two-headed dinosaurs, seems to resonate with children who have been sexually or physically abused or have had parents with extreme mood swings. The symbols depict the dual nature that is possible within the same person. Two-Face is at times a charming gentleman and at other times a monster. Children who have experienced these two persons in one are drawn to these characters.

Once a perpetrator symbol has been selected, it can then be manipulated in any number of ways that allow the child a sense of empowerment in relation to a person by whom they were disempowered. A child may choose to draw a picture of the perpetrator, then crumple it, rip it, or burn it. The child may choose a miniature and insist that it be handcuffed and put in jail. The ways in which children may deal with their perpetrator symbols in the playroom are as diverse as the children themselves. Chapter 9, "Experiential Mastery Play," gives many examples of how children contain and manipulate perpetrator symbols as one process in their healing journeys.

Self-objects are the props that children choose to represent the self. A child may choose a superhero or a wizard puppet to be the self. In these cases, the child often needs the reassurance that comes from seeing himself as invincible. Other children may choose a baby doll or other toy that speaks of their vulnerability. Children who are not ready to receive nurture directly may be able to experience it vicariously through the therapist's nurture of the self-object.

Dimensions of the Therapist's Use of Self in the Play Space

Therapist as Container

Children often carry carefully suppressed sensory information, intrusive cognitions, and overwhelming emotions related to their traumatic events. Their developing bodies and minds were not meant to contain horrifying images, disgusting smells or tastes, overwhelming sounds, and tactile sensations that accompany trauma. Children who have endured gruesome experiences quickly recognize that the details of these experiences may be overwhelming to others. Children need their immediate caregivers to remain strong, stable, and available to them for care and comfort. Therefore, children are unlikely to take the risk of sharing the ugliest parts of their trauma experiences with their day-to-day caregivers. These children sense the precarious position in which they would find themselves if they flooded the parent with detailed trauma imagery and therefore perceive the laying bare of their worst experiences as a form of self-endangerment.

However, a terrible paradox is created for the child who desperately needs the care and comfort that adults can offer but cannot share the content that will better inform those adults as to how to soothe the child.

How does the child cope with the paradox? Often the child just keeps the content inside, pressed down and under tight control. The unshared images, smells, and sensations take on an internal life of their own, using up valuable developmental energy. A good child therapist becomes a holding tank for the child, communicating that she is strong enough, safe enough, and wise enough to carry whatever information or imagery a child needs to discharge.

Sometimes the containment takes a practical form. A child may arrive in the playroom with a number of intrusive thoughts or images. The therapist may help the child create a containment device such as a worry box or a sealable physical container into which the troublesome images and thoughts can be dumped. The externalized thoughts then remain locked in the playroom when the child leaves, relieving the child of the felt burden of returning home with them. Each image and thought is addressed together and handled on subsequent visits to the playroom.

At other times, the containment takes the form of the therapist evenly saying, "I see what you are showing me." As the child's trauma glimpses are met with equilibrium on the part of the therapist, the child is emboldened to show more of his internal life. The unique positioning of the therapist as container helps the child bridge the gap between the burdensome internal life and an externalization of the images, sensations, and stories that describe the child's trauma experiences. It begins to bring into question the previously unquestionable need to keep the content hidden. This gradual exposure process detoxifies the trauma content and allows the child to move toward integration.

Therapist as Partner in the Dance

There is a dance that children do in the midst of trauma work, a dance toward and then away from the trauma content. A wise therapist knows how to be a partner in this process. Children must have freedom in the playroom to break away from content that is becoming overwhelming for them. A sensitive therapist will understand these breaks as a necessary respite the child needs in order to get back to a state of internal equilibrium. I have had supervisees who, in the midst of describing a session, will say that the child had trouble staying on task and became easily distracted. Obviously, we all see children who manifest true deficits in attention. These children have short attention spans and little impulse control. However, I always explore further

when a clinician characterizes the child's behavior as distractible. When the identified child has a trauma history, what is perceived as distractibility may actually be a pattern of moving away from the trauma content in order to get back to a state of internal calm. Processing trauma content can cause upset and dysregulation in even the most well-adjusted adults. With this in mind, it seems prudent to titrate the doses of a child's exposure to trauma content.

Many times the child will instinctively back away from the trauma content by moving toward a fairly innocuous activity, such as bouncing a ball or running his fingers through the sand. The child moves to a prop that will not stimulate trauma processing. Beginning clinicians often make the mistake of trying to pull a child back into the processing at this point, to "keep him on task." It has been my experience that if you allow the break from the processing and genuinely move your interest and attention to the play material in which the child has become interested, it is easier to return to the trauma content at a later time.

The therapist's response to the child's dance toward and away from the trauma content can be viewed as another form of interactional synchrony. Examples of this dance are woven throughout the text. Interactional synchrony is a concept used to describe the contingently responsive relationship between an infant and her primary caregiver. A fascinating set of experiments using a maternal still-face paradigm (SFP) have looked at the dysregulation that occurs in infants when their mothers do not respond with expected affectual responses (Haley & Stansbury, 2003; Moore & Calkins, 2004; ; Tronick, Als, Adamson, Wise, & Brazelton, 1978; Tronick & Cohn, 1989).

In a similar set of conditions, mothers were asked to play with their infants. They found that as the mother and the infant played together, the infant would intermittently turn his head to stare at the wall. Some mothers waited patiently and attentively while their babies looked away and were ready to engage the infants again when they sought out the interaction. Other mothers worked hard to immediately recapture their infants' attention. The mothers who allowed the infant to turn away were seen as more attuned to their infants. The infant's need to stare at the wall is another manifestation of the infant's attempt to calm himself. Play with mother is exciting and sometimes overwhelming for a developing infant's autonomic nervous system. The infant's choice to look away from mom allows him to

unplug from the intensity of relationship, recalibrate his internal state, and then reengage with mom. A child's dance toward and away from trauma processing has a similar rhythm, and the therapist must not only recognize the dances away from the trauma but value them as a necessary part of the child's continual struggle to soothe himself while working through the trauma.

Therapist as Titration Agent

A first glance at the literature might give a false impression that a trauma narrative is something that can be explicated in a smooth, ordered way in the course of a couple of sessions. Certainly this is possible with some of the children we see, particularly if the child has experienced a single traumatic event and is living in an otherwise healthy and supportive environment. However, many of the children whom we see have a complex trauma history involving ongoing neglect or maltreatment. The narrative is never easy or uncomplicated for these children. The telling of the narrative is often sporadic and nonsequential. One part of the narrative may even seem to contradict other parts of the narrative. I have learned to take all this in stride. In fact, I have become so used to the erratic and patchy nature of the child's trauma disclosures that I have created a new way of recording the slices of narrative that they offer. I keep a variety of sticky note pads in various shapes and sizes in the office. Whenever a child verbalizes some new aspect of his trauma memory, I repeat it out loud while writing it down on a sticky note of the child's choosing. In most cases, I have previously helped the child create a rudimentary timeline. When new pieces of information are volunteered, I witness them, both verbally and in writing, and put the sticky note on their timeline. This allows for the child's experience to be contained and recorded. However, the sequencing of various pieces of information is usually left until later in treatment.

A Rationale for Flow of Goals (and Chapters) Outlined in FSPT

Having described the many foundational roles that play, play materials, and the play therapist fill in the application of the FSPT model, we now return to the flow of chapters as they reflect the flow of the FSPT model. To this end, the first goal covered in the text relates to building safety and security in the playroom and in the person of the play therapist. It is difficult to do any meaningful work related to a child's trauma experiences if the child has

not developed a sense of safety in the space where the work is done and a sense of security with the chosen clinician.

The playroom may provide the first atmosphere that is safe enough for the child to risk letting the internal life be glimpsed. The four walls of the playroom and all the tools within can become a place set apart, a place where anything is possible. Wish fulfillment through fantasy is a powerful tool in healing, and the playroom provides myriad opportunities for a child to fulfill her wishes through play. The therapist's ability to assess the child's developmental level and then meet the child in developmentally appropriate ways will increase the child's sense of safety in the playroom. The therapist must communicate acceptance of the child and delight in the child as a unique individual. The play therapist who allows a child to be fully himself in the playroom helps to build a foundation of safety upon which further interventions are scaffolded. Chapter 3, "Enhancing a Child's Sense of Safety" highlights specific examples of ways in which clinicians can use the child's metaphors for safety to create an atmosphere in which the previously untouchable content can be touched.

Once safety and security have been established, a host of goals open up as potential targets for treatment. Children are usually unequipped to tackle their trauma memories at the beginning of treatment. Because looking at trauma content is stressful, it is critical to assess how a child deals with stress before inviting him to enter into content that is likely to be stressful. Coping skills include the behavioral, cognitive, and somatic ways in which a child deals with exposure to stress. Therefore, a clinician's first job after providing safety and security is to assess the child's current coping skills with a view to augmenting the positive coping and extinguishing or at least minimizing the negative coping. Chapter 4, "Assessing and Augmenting Positive Coping Strategies," includes detailed information regarding assessment and intervention around this issue.

Stress management strategies are one critical component of adaptive coping. Physiological hyperarousal often accompanies a child's reaction to trauma, and specific techniques can aid a child in physiological de-escalation. Stress inoculation techniques include deep breathing exercises, centering exercises, progressive muscle tension and relaxation, guided imagery, and biofeedback. All these activities can be delivered through play-based intervention. The use of play as the medium through which these skills are communicated and practiced ensures that the learning will be better integrated than if the skills were

merely taught didactically. Chapter 5, "Soothing the Physiology," details these stress inoculation exercises.

Chapter 6, "Parents as Partners," follows directly after the chapter that focuses on the child's proficiency with self-soothing, in large part due to the fact that parents are often the initial soothing agents and coregulators of affect and arousal for their children. Sometimes the parent/child work revolves around restoring a healthy relationship of coregulation. Parent involvement can take many other forms as well. Parents often need psychoeducation about the effects of trauma on children and on the best parenting approaches for children in various stages of trauma recovery. Sometimes the focus of work is on positive enhancement of the parent/child relationship. In other cases, the therapist is fostering a healthy attachment bond between parent and child. In still other cases, the work is focused on building a coherent family narrative related to the traumatic events. Various forms of play-based intervention are described and augmented with case examples in this chapter.

One subset of positive coping involves the accurate identification and verbalization of one's feeling states. Chapter 7, "Emotional Literacy," deals with helping children understand, identify, and appropriately express their feelings. Another important subset of positive coping has to do with the successful use of social supports in both the peer and adult realms. Nonverbal play-based interventions as well as activities that promote kinesthetic engagement are covered in this chapter.

The next three chapters focus on the various ways in which children, through both nondirective and directive methods, begin to approach the trauma proper. Once children have the safety net woven from the intentional pursuit of the previous treatment goals, they often begin to tell their story in snippets. These processes are articulated in Chapter 8, "The Continuum of Disclosure." Children also face the trauma content in a more confrontational manner, allowing in vivo exposures while mastering the trauma material. Examples of this phenomenon are described in Chapter 9, "Experiential Mastery Play." Trauma often results in disjointed or episodic recollections of events. In PTSD reactions, it is posited that neurochemicals released during the body's reaction to the stress of a traumatic event may result in a blockage that keeps the linguistic narrative of events separate from important sensory information (Siegel, 2003). Until these two kinds

of information are synthesized, a myriad of trauma symptoms may trouble the child. Chapter 10, "Trauma Narrative Work," demonstrates a variety of ways in which a trauma narrative may take shape and gives more thought to the question of when and how to include parents in the creation of a child's narrative.

Addressing the thought life is another important treatment goal. Although I have placed it after the trauma narrative work, that placement has more to do with the need to be sure that faulty cognitions are restructured before termination than a denial of the fact that this work may begin earlier in treatment. It is likely that a child's first look at adaptive and maladaptive thoughts will occur as part of the assessment and augmentation of coping. However, it is often challenging to unearth a child's most troublesome traumagenic thoughts early in treatment. The difficulty with approaching a child's faulty attributions or cognitive distortions early in treatment is twofold. A child may not feel safe enough to share thoughts that engender deep feelings of shame or worthlessness during the initial phase of treatment. Moreover, the child may not even be aware of their most traumagenic cognitive distortions on the front end of treatment. In the synergistic process of establishing a trauma narrative, details related to the trauma emerge that often reveal a child's misplaced blame, magical thinking, cognitive distortions, and so on. In summary, although thought life issues may be addressed throughout treatment, it is critical that a final cognitive clean-up be done before graduating a child from treatment. Specific strategies for accomplishing this goal are covered in Chapter 11, "Addressing the Child's Thought Life."

Finally, after all these goals have been successfully navigated, the child and supportive adults should celebrate the child's healing journey. The trauma needs to be given a place within a personal narrative that allows the child to have a positive experience of the post-trauma self. In addition, a meaningful goodbye should be intentionally structured by the therapist. In some cases, the meaningful goodbye with the therapist may be the first meaningful goodbye a child has experienced and is therefore valuable in its own right. Examples of a client's self-directed use of space to achieve closure, as well as practical play-based interventions to aid the process of termination, are given in Chapter 12, "Making Positive Meaning of the Post-Trauma Self."

A Final Note

Throughout this text both masculine and feminine pronouns are used to represent clients in the third person. Case examples remain true to salient case content, and the names and other inconsequential details of cases have been changed to protect the confidentiality of the families who have graciously allowed me to use their healing journeys as teaching tools for the next generation of child therapists.