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Posttraumatic Play in Children: What Clinicians Need to Know by Eliana Gil.
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Preface

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Recent decades have seen profound advances in research into working with traumatized children (Ford & Courtois, 2013; Lanktree & Briere, 2017). Breakthroughs in neuroscience over the past 15 years have been particularly fruitful for practitioners (Perry, 2001; Perry & Szalavitz, 2006; Perry & Dobson, 2013). Consensus has been reached on the domains typically affected by trauma, specifically the areas of attachment, emotional and behavioral regulation, biology, dissociation, cognitive functioning, and identity. In addition, the National Child Traumatic Stress Network (NCTSN; *www.nctsn.org*) cites specific critical aspects of trauma-informed therapy: (1) safety, (2) self-regulation, (3) self-reflective information processing, (4) integration of traumatic experiences, (5) relational health, and (6) enhancement of positive affect. What remains in question are the specific interventions that might advance treatment goals and assist children's recovery process.

Diverse treatment approaches continue to vie for legitimacy, especially because some approaches (like play therapy) are more difficult to operationalize and research than others. Only a small percentage of the clinical community has the funding or the academic setting necessary to conduct research. Several evidence-based therapies are recommended, especially trauma-focused cognitive-behavioral therapy (TFCBT; Cohen, Mannarino, & Deblinger, 2006). Yet like every other treatment approach, TFCBT cannot be effective with every client, especially those who have expressive language deficits, are very young

and have linguistic or cognitive limitations, or have firmly entrenched avoidance. There is professional agreement that exposure techniques are necessary components of trauma-informed therapy. However, dissociation is particularly resistant to exposure techniques. More and more, the literature on traumatized children reports the necessity to incorporate play, art, or other expressive therapies in the assessment and treatment of young children, whether directive or nondirective techniques are used.

So while we recognize that several evidence-based programs have empirical support for positive treatment outcomes, other approaches are widely used and clinically useful, though not yet empirically supported.

My early work with posttraumatic play focused on its progression and the variables suggesting whether or not the play meets its intended goal. When posttraumatic play fails to provide children with mastery and to reduce anxiety, I suggest that it has become stagnant and potentially problematic—stagnant posttraumatic play may retraumatize children and make things worse for them rather than better. I first published a list of factors for clinical vigilance in 1998 (Gil, 1998). As a trainer who has provided educational programs on this topic to thousands of mental health professionals, I have found that many clinicians struggle with how to assess when posttraumatic play is helpful and when it is not, and how to intervene when necessary. Even when the play does not provide relief, it can supply valuable assessment information about children's posttraumatic stress.

Diagnosis of traumatized children who don't meet the full criteria for posttraumatic stress disorder (PTSD) as established in DSM-5 has always been challenging. The Zero to Three categorizations create opportunities to view posttraumatic responses in a different light, in a way that is perhaps more consistent with children's developmental changes. However, research has shown that most children have several of the symptoms associated with posttraumatic stress, and recent efforts have been directed at designing assessment instruments that are developmentally sensitive, particularly with very young children (Stover & Berkowitz, 2005).

In fact, based on current criteria for PTSD, it can be concluded that children manifest unique repetitive play that can signal the reexperiencing of trauma. Posttraumatic play clearly manifests literal

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elements of the traumatic event and, more importantly, can provide a self-reparative mechanism that is internally driven. Early findings on childhood trauma suggest that posttraumatic play is done in secret. However, I believe that children will exhibit posttraumatic play in the clinical setting when they view it as a warm and inviting setting, when there is a willing and receptive witness to the play, and when clinical interventions are permissive and allow the play to unfold until more directive interventions might be necessary.

I am convinced that we clinicians don't always know better. You can remain as informed as possible, prepare yourself continuously, and then, as Carl Jung (1928) said, "learn your theories as well as you can, but put them aside when you touch the miracle of the living soul. Not theories, but your own creative individuality alone must decide" (p. 361). The privilege of helping others comes with great responsibility and requires constant reevaluation of what we are doing. I believe that while we all tend to develop a certain level of comfort with our theories and approaches, we should always remain open to being surprised and inspired by the children with whom we work. They know best how to contribute to their own well-being. In other words, children can and will lead the way. We clinicians should therefore follow their lead unless it becomes necessary to supplement what they are doing in other important ways. This is the crux of *Posttraumatic Play in Children*.

It is my hope that this book supplements and amplifies the descriptive, anecdotal, and empirically based discussion of posttraumatic play to date and that it will be a useful resource for both play therapists and nonplay therapists who work with traumatized children.

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GRATITUDE

In this book I am eager to share what I have learned over the years on this amazingly pivotal topic. My professional career with clients is suspended at the moment with what may or may not be a permanent semi-retirement. It is with great pleasure that I now look back and organize my thoughts on a topic that is so important to me. Perhaps this will be my last book. If so, and if it reaches its intended audience

and contributes to clinical consideration and creative, flexible thinking, I will be immensely pleased.

I express my sincere gratitude to a small group of individuals who have sparked and shaped my interest, inspired my work, and helped me strive for excellence in my professional role with children and their families. My thanks to Spencer Eth, Robert Pynoos, Lenore Terr, Judith Herman, Katherine Nader, Lucy Berliner, Janine Shelby, Charles Schaefer, Bruce Perry, John Briere, Cheryl Lanktree, and Phyllis Booth. A special note of thanks to Bessel van der Kolk for spearheading a movement to introduce a new diagnostic category—developmental trauma disorder—into the DSM system and for always advocating for child and adult survivors of trauma. This diagnostic category is unequivocally the best way to evaluate the impact of trauma on young children and will hopefully make its way into a future version of the DSM.

Finally, what I learned from Garry Landreth, though not specific to trauma per se, provided an important context in all the work I did with children. It allowed me to prioritize *relationship* when working with children (and their families). My gratitude is endless.

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