PARIS GOODYEAR-BROWN

Trauma and Play Therapy

HELPING CHILDREN HEAL

ROUTLEDGE

Trauma and Play Therapy

Trauma and Play Therapy synthesizes new developments in the study of children's trauma recovery to assist clinicians in combining play therapy with other powerful ways of addressing the needs of hurt children. The TraumaPlay™ model, formerly known as Flexibly Sequential Play Therapy, equips practitioners to manage and adapt aspects of the play therapy place and process in order to help children tell their stories while draining the emotional toxicity from traumatic experiences. Chapters explore the neurobiological and developmental foundations of play therapy as well as strategies for navigating children's trauma in relation to specific aspects of play therapy such as sensory integration, metaphor, and humor. Enriched by a tapestry of illustrative case examples and tools for therapists, this is a vital new book for clinicians working at the intersection of play and children's trauma.

Paris Goodyear-Brown, LCSW, RPT-S, is the founder and clinical director of Nurture House, a treatment center serving families in middle Tennessee, and the creator of TraumaPlay™, a flexibly sequential play therapy model targeted to help children heal from trauma. She is an internationally renowned speaker, an adjunct instructor of psychiatric mental health at Vanderbilt University, trains and consults for organizations around the world, and is the author of multiple books, chapters, and articles on child therapy, including the *Handbook of Child Sexual Abuse* and *Play Therapy with Traumatized Children: A Prescriptive Approach.*

Trauma and Play Therapy
Helping Children Heal

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Routledge
Taylor & Francis Group
NEW YORK AND LONDON

First published 2019
by Routledge
52 Vanderbilt Avenue, New York, NY 10017

and by Routledge
2 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

Routledge is an imprint of the Taylor & Francis Group, an informa business

Library of Congress Cataloging-in-Publication Data
Names: Goodyear-Brown, Paris, author.
Title: Trauma and play therapy : helping children heal / by Paris Goodyear-Brown.
Description: New York, NY : Routledge, 2019. | Includes bibliographical references and index.
Identifiers: LCCN 2018049756 (print) | LCCN 2018050324 (ebook) | ISBN 9781351216869 (eBook) | ISBN 9781138559936 (hardback) | ISBN 9781138559943 (pbk) | ISBN 9781351216869 (ebk)
Subjects: LCSH: Psychic trauma in children--Treatment. | Play therapy.
Classification: LCC RJ506.P66 (ebook) | LCC RJ506.P66 G663 2019 (print) | DDC 618.92/891653—dc23
LC record available at https://lccn.loc.gov/2018049756

ISBN: 978-1-138-55993-6 (hbk)
ISBN: 978-1-138-55994-3 (pbk)
ISBN: 978-1-351-21686-9 (ebk)

Typeset in Galliard
by Apex CoVantage, LLC

To my father, Glenn Johnson Goodyear, who would have delighted in his grandchildren.

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Foreword

Eliana Gil

From my point of view, some authors inspire us with academic theories and scientific facts while others guide us with practical, clinical applications that bring theories to life. Paris Goodyear-Brown is unique in her ability to do both: she presents a conceptual foundation for building a trauma-informed practice, and then she gives us specific examples that illustrate how theories inform (and anchor) the creation of developmentally appropriate, inviting, and innovative interventions. Thus, this book reflects a truly integrated model that both informs and inspires those of us for whom working with childhood trauma is our passion.

This book affirms that we've come a long way. In the early and mid-seventies, there were several courageous professionals working hard to bring attention to a number of different topics: child maltreatment, child sexual abuse, traumatic impact, attachment, and domestic violence, among others. We truly stand on the shoulders of greats. And in these early efforts, the topics emerged separately and reflected work that had been ongoing for years. But they were occurring discretely, without a lot of dialogue and information-sharing. We are fortunate indeed that these topics have emerged as shared interests. As professionals working with children and families, we have all gained a great deal by being exposed to these previously separate topics, as well as the field of neuroscience, which has provided us with yet another shared context.

This book is a snapshot of what trauma and attachment specialists hold dear at this moment in time. Goodyear-Brown challenges us to shift paradigms in favor of treating the client or family as uniquely individual. Her model is a motif, a palette, not a rigid protocol. She defies the idea of "either/or," inviting professionals to be more or less active, to lead and to follow, along a continuum. This requires more from clinicians. It requires them to make assessment an ongoing process and to be willing and able to shift approaches based on the child client's changing needs. There is an obvious privileging of play therapy as a treatment of choice; however, as a truly integrated model, it is flexible and respectful of other evidence- and practice-based interventions that promote trauma-focused goals. These other approaches fit easily into this model, finally setting aside the separatism that can exist among those who support one approach to the exclusion of others.

The model is user-friendly; it proposes that the child leads the way and clinicians follow the child's needs at all times. It provides easily applied "components" that respond to specific trauma-related symptoms or concerns. It is guided by the healing power of relationships and safety. It incorporates prevention, anticipating children's needs, and being prepared to help with a range of behavioral, social, psychological, and relational concerns.

Goodyear-Brown walks the walk and talks the talk. She has built a child and family treatment center, Nurture House, and it is an incredible example of how we can incorporate what we know into consistent, warm, and empathic practice. This book describes how she puts her knowledge into practice, both in program development and in the practice of child and family therapy. There is ample evidence of all her greatest current influences, including Theraplay, polyvagal theory, neurosequential treatment, Circle of Security, and, of course, trauma-focused play.

I congratulate Paris for pulling together all the threads of knowledge, for adding her own creativity and conceptual genius, and for leading with the heart. The interactions she demonstrates with her child clients include respectful touch, co-regulating relational opportunities, respect and dignity, necessary structure and limit-setting, coherent narrative building, and kindness. This is a must-read for anyone hoping to be of true service to others.

Coincidentally, I reviewed this book during the same time frame that the US government had a policy of separating (immigrant) children from their families at the southern border. The news coverage has been appropriately focused on this unprecedented policy, and many child welfare and health professionals have made clear and consistent statements about the potential traumatic impact of these separations on young children and their parents. Reading this exquisitely thoughtful and sensitive book at this time made the author's voice even more compelling, more relevant, and more necessary.

Preface

As I reflect on the words of Eliana Gil's Foreword, I am humbled, challenged, and inspired. I feel this particular combination of emotions more and more frequently these days as I watch our field maturing, as I watch our professional community grappling with the numerous disheartening aspects of our world, and as I watch the warrior spirits of my colleagues as they hold the hard stories of traumatized children while simultaneously holding out hope for healing.

The complexity of tiny humans who have somatically, emotionally, cognitively, and relationally encoded trauma responses requires mental health professionals who work with children to be lifelong learners. I have been taking a deep dive into what it means to titrate a child's approach to trauma content, to appreciate the myriad ways children invite us into their play and their pain, and the power of the one to heal the other. This volume marks the debut of TraumaPlay™, the simplified name of what has been formerly called Flexibly Sequential Play Therapy (FSPT). The evolution from FSPT to TraumaPlay™ mirrors the evolution in my own thinking, my deepening delight in the unlikely power of pairing play with trauma to leach the emotional toxicity out of hard things. These two words paired so closely together are likely to give pause to those who have not yet seen the magic and the mystery that happen as play mitigates the child's approach to trauma content. Just as trauma comes in a bewildering number of forms, so does play. This text will offer a new tool—the Play Therapist's Palette—that articulates in graphic form many of these modes of play in an easily accessible format. Chapters will expand on the nuance of applying these tools to trauma work with children and families. Join me as we explore the power of play together.

Acknowledgments

A huge thank you, Eliana, for your pioneering work in articulating posttraumatic play. I remember the first time I heard you speak 20-some years ago: your heart, knowledge, and passion painted a path for my growth. Your voice has continued to be the most influential in my conceptualization of trauma work with children and families, and I am honored to have you add your voice to this book.

I am indebted to so many others who have influenced my thinking and shaped my approach. These influences include Charlie Schaefer, Garry Landreth, Sue Bratton, Heidi Kaduson, David Crenshaw, Phyllis Booth, Evangeline Munns, Joyce Mills, Linda Homeyer, Rise van Fleet, Athena Drewes, and Rick Gaskill, to name a few. As the field of interpersonal neurobiology has expanded, I have gained depth of understanding and augmented articulation from the work of Dan Siegel, Bruce Perry, Bessel van der Kolk, Alan Schore, Stephen Porges, Bonnie Badenoch and Theresa Kestly.

Thanks to my play therapy tribe. There are too many to name, but you know who you are! A special thanks to my play therapy women's writing retreat group—Clair, Sueann, Jess, Angie, and Holly—for carving out time and space for writing and laughing.

Thanks to the team that has helped me build Nurture House—Linnea, Kristen, Eleah, Elizabeth, Amy, Eric, Jenny, Kate, Jess, Shelby, Bethany, and Stacey, to name a few. They have grown with me, encouraged me, and held down the fort when I am off gallivanting.

Lastly, my deepest gratitude for my best friend and partner in all things, Forrest. Thank you for taking up the slack again and again with grace and strength—as a parent and as tech support—and for being the love of my life and my biggest encourager. Thank you, Sam, Madison, and Nicholas, my sweet ones, for bringing me hugs, snacks, silly songs, encouraging notes, and for giving me belly laugh breaks from the writing.

1 Titration in Trauma Work
Using the Play Therapist's Palette

This project evolved as a response to repeated requests from clinicians who are familiar with the Flexibly Sequential Play Therapy (FSPT) trauma model, outlined in *Play Therapy with Traumatized Children* (Goodyear-Brown, 2010), to more fully explore the nuance of how we help children move toward and away from trauma content to create the story of what happened. The overarching goal of the work is to leach the emotional toxicity out of the child's experience so that it can be integrated into a healthy sense of self. This model, formerly known as FSPT, has been renamed TraumaPlay™ in order to give more clarity to clinicians and clients alike. TraumaPlay™ is components-based and allows for a variety of interventions to be placed along a continuum of treatment, depending on which treatment goal is actively being addressed. Goals in the early phases of treatment include building safety and security, addressing and augmenting coping, soothing the physiology, enhancing emotional literacy, and helping parents be better partners in regulation while offering additional caregiver support to help them hold the hard stories of the children in their care. The middle phases of treatment provide some form of play-based gradual exposure that may include the continuum of disclosure, experiential mastery play, and/or trauma narrative work. The final phase of treatment is helping the child and family make positive meaning of the post trauma self.

When to invite children to go deeper, when to respect their defenses, when to acknowledge their retreat, when to celebrate that they have come to the end of what they can approach right now, and how to support their exposure work are questions with which both beginning and seasoned clinicians wrestle. An attuned trauma therapist is deciding, sometimes on a moment-to-moment basis, when to invite children out of stuck places, when and how much to push up against avoidance symptoms, when to witness their posttraumatic play (Gil, 2017), and when to support the need to simply rest. This volume is meant to expand significantly on the nuance of these questions while offering a new tool for thinking about the mitigators of a client's approach to hard things.

If you work with traumatized children regularly, my guess is that you have already found yourself in a playroom environment with a child where you have been unsure when to offer invitations to further explore the traumatic event and when to allow the play to do its own healing work. As I train people

both here and abroad, the struggle I hear clinicians wrestling with revolves around the question of when, how often, and how directly do I invite children to explore the trauma content in order to bring more coherence and when do I create a space of respite, mindfulness, and the simple and powerfully healing enjoyment of play? If we neglect the avoidance symptoms of posttraumatic reactions, we inadvertently collude with the trauma itself, communicating to the child that it is indeed too big and scary to be approached. If we push a child too hard or too fast, we can cause iatrogenic effects, flood them with anxiety, and shut down their healing process.

Another way this question gets put to me in training sessions is, when do you lead and when do you follow? The question is critically important and always excites me because the clinician asking is wanting to follow the child's need rather than becoming dogmatic about either following the child's lead or directing the therapeutic interactions in the room. A third way this question is asked is as follows: when does the therapist invite the child/family into new kinds of interaction and when does the therapist wait to be invited? Moreover, how do we extend moments of therapeutic work or help open and close circles of communication? Sometimes this question is not specific to the traumatic event but may be asked in relation to other goals of treatment, ones that would be considered symptomatic of the trauma itself, such as self-regulation abilities, hyperarousal symptoms, and a child's ability to connect with others.

My response to this question of when to lead and when to follow, when to be more or less directive, is unpopular in our current protocolized culture: it depends. Beginning clinicians really do not like this answer, as the clearly defined steps of a protocol are soothing to them. As we grow, we become more comfortable with ambiguity and with trusting the process, but it remains important, even for seasoned clinicians, to ask this same question of when to lead and when to follow in a present-minded way in each and every session. One of my goals in supervision is to help clinicians become more comfortable with not having a definitive answer for what is needed per protocol so they can hone their ability to follow the child's need from moment to moment. My goal is to help clinicians nurture the nuance in trauma work with children and families.

Nurturing the Nuance

Nuance is necessary—arguably in all forms of therapy and most certainly when using play therapy—with traumatized children and families. I have learned this lesson by going too slowly with a client system—not offering enough invitation to change or not providing enough strengthening of the muscles that hold hard things. I have also failed in the opposite extreme by attempting to take a child too quickly toward hard things. My concern about treatment becoming "cookie cutter-ish" applies to my model as much as to any other model of treatment. The flow of the treatment goals codified in TraumaPlay™ is pictured in Figure 1.1).

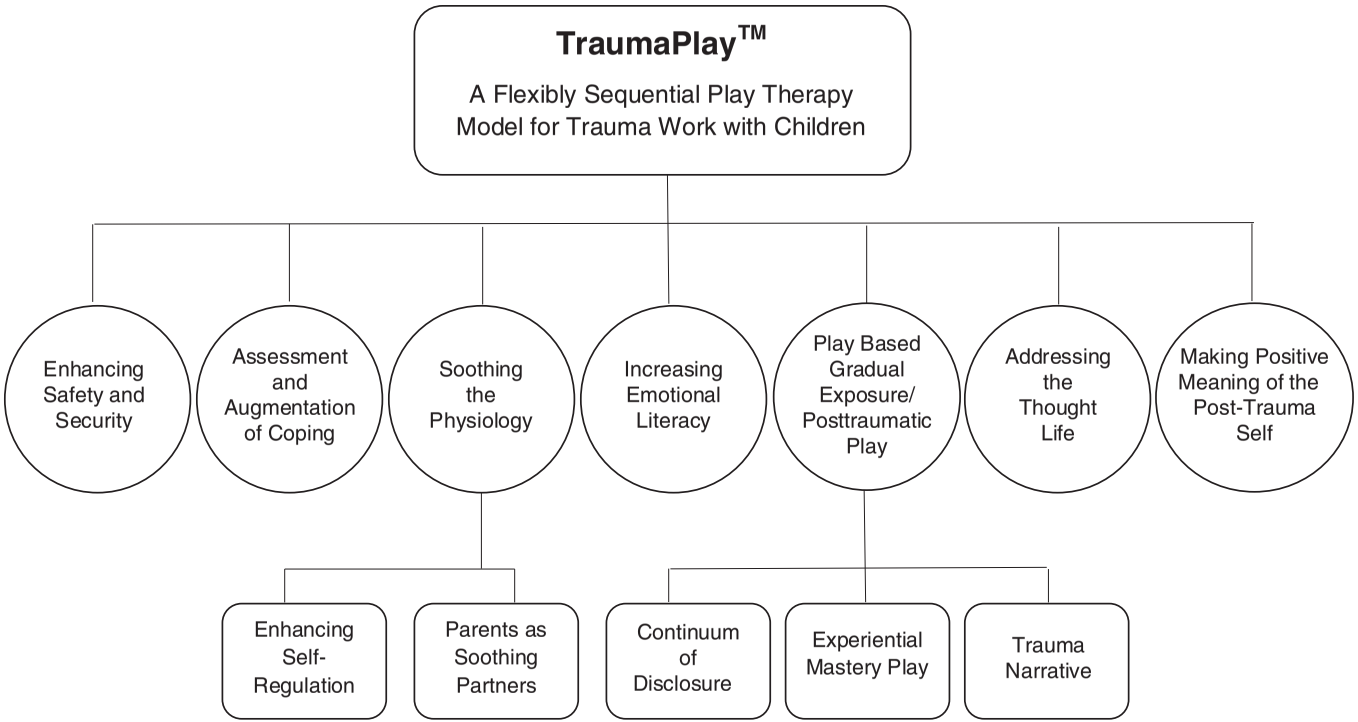

Figure 1.1 Flowchart of TraumaPlay™, Formerly Known as FSPT

As clinicians have used the model, they have brought back questions and insights that have informed this deeper delineation of factors that I am offering here. As clinicians move through the components of TraumaPlay™, each individual goal of the model requires a nuanced titration of the clinician's therapeutic self to see positive movement in the system. What we have found over and over again in supervision is that nuance is necessary every step of the way. In other words, the questions of "how much?" and "in what dose?" become constant reflections, helping clinicians hone this approach in ways that meet the individual needs of the client in front of them. Along the way, we are constantly aware of the titration of many aspects of engagement with the child and/or caregivers. The first goal of the model, establishing safety and security, may take minutes or months depending on the unique dynamics of the case and the interaction of these with the unique dynamics of the therapist's presence and play space.

A continuum of directiveness exists within the field of play therapy, and the consensus is growing that there are times when a nondirective approach may be most beneficial and other times when a directive approach may lead to greater therapeutic growth. It is an exciting time in the field of play therapy. Several forms of play therapy have just been added to the SAMHSA list of evidence-based treatments. These include child-centered play therapy, filial therapy, and CPRT (all less directive in nature) and Theraplay and Adlerian play therapy (both more directive in nature).

With the addition of certain forms of play therapy to various evidence-based treatment lists, play therapy is becoming more recognized and respected in the larger therapy world. Although more research is needed in the area of play therapy, a vast amount of experimental research exists that proves the efficacy of many different forms of this therapy. Many of these studies were essential in the attainment of evidence-based therapy status. For example, numerous studies spanning over seven decades show the efficacy of using CCPT for children with various presenting problems and of differing ages (Bratton et al., 2013; Cochran, Nordling, & Cochran, 2010). Additionally, several meta-analyses show the general effectiveness of various types of play therapy interventions for children and adolescents (Bratton, Ray, Rhine, & Jones, 2005; Bratton & Ray, 2000; Leblanc & Ritchie, 2001). Beyond showing the effectiveness of play therapy, many studies also proved the effectiveness of additional clinical factors that most play therapists intrinsically incorporate into their practice. These additional factors, length of treatment and parental involvement, also impact the effectiveness of play therapy. Though research does show that play therapy is effective in short-term instances, it also demonstrates that the effectiveness of play therapy increases with the number of sessions provided. Numerous studies also show that when a parent is fully immersed in therapy and has ample opportunity to practice new skills, the chances for therapeutic success are increased (Bratton et al., 2005).

Unlike studies performed on adult populations, which usually exhibit similar results, play therapy research provisionally shows that some forms of play

therapy are more effective with certain populations than others (Bratton et al., 2005). As mentioned in this chapter, play therapy exists on a continuum, and at times a client needs both directive and nondirective approaches in the same session. This recent research adds even more importance to the clinical task of assessing our client's needs and responding in an effective manner.

Core Agents of Change in Play Therapy

Those of you who are familiar with Charlie Schaefer's *The Therapeutic Powers of Play* (Schaefer & Drewes, 2014) will embrace the idea that play provides therapeutic value of its own, that play can be the bridge to attachment enhancement, and that play can lead to increased solutioning abilities, foster useful exploration of roles (that may later be embraced or discarded) through a judgment-free role play environment, etc. These therapeutic powers of play are referenced here and broken down into broader categories of therapeutic goals (see Figure 1.2).

If you are new to play therapy as an overarching approach, it is worth familiarizing yourself with these, as these "powers" are foundational to the process,

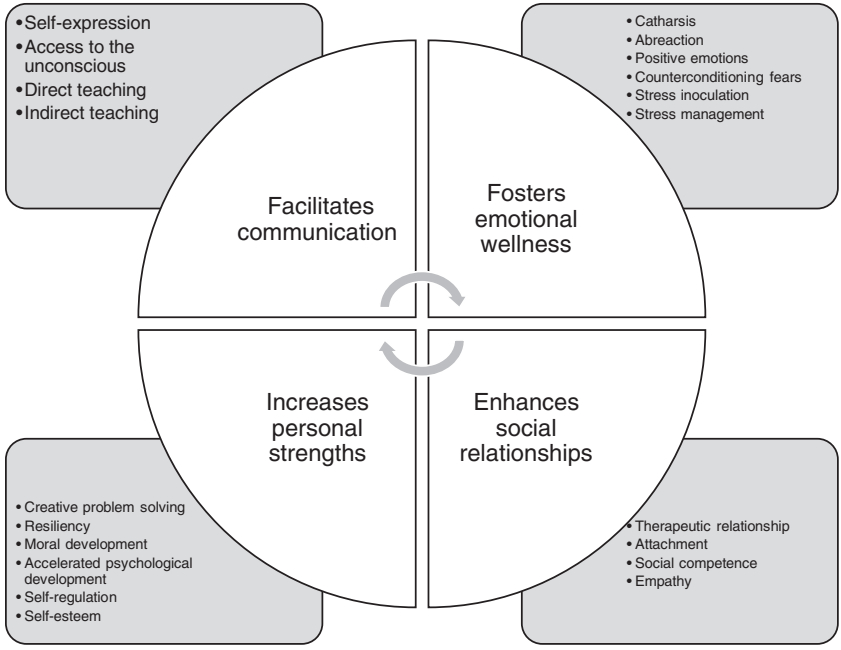

Figure 1.2 A Graphic Representation of the 20 Core Therapeutic Powers of Play

Parson, J. (2017). Puppet Play Therapy-Integrating Theory, Evidence and Action (ITEA) presented at International Play Therapy Study Group. Champneys at Forest Mere, England. June 18. Adapted from Schaefer, C. E., & Drewes, A. A. (2014). *The therapeutic powers of play: 20 core agents of change* (2nd ed.). Hoboken, NJ: Wiley Publishing.

and only in a play therapy environment where these powers have been given freedom to work can clinicians begin to ask themselves these questions of nuance. Charlie has quoted Gordon Paul's question to me many times over the years: "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?" (Paul, 1967, p. 111). Gordon Paul talked about the set of change mechanisms as "active ingredients," and Schaefer and Drewes (2014) talk about them as "core change agents."

Developing a treatment plan for a traumatized child requires us to identify the areas in which a child's window of tolerance for the stress involved in basic life tasks has been compromised. In which area is the child's window of tolerance most compromised? Is the child's window of tolerance for acknowledging or holding big feelings the most compromised? Is the child's window of tolerance for imperfection or mess the most compromised? Is the child's ability to tolerate unknowns compromised? If so, which approach will help to expand the child's window of tolerance in a baby-stepping way that does not create iatrogenic effects by tripping the child's neurophysiology abruptly into hyperarousal or hypoarousal/collapse? This set of concerns is always in the background as I am working with a family. Once I have chosen the approach that I think is most helpful in this moment of work, I then move to my mitigators. I have found that these mitigators protect therapists—particularly new clinicians—from holding too tightly to a dogmatic implementation of the TraumaPlay™ model, or any other model, for that matter. The mantra at Nurture House is to prepare for a session thoroughly, have a plan going into the session, and then let it go and be in the present moment with the child or family. The whole array of potential mitigators is "tucked in their pocket" and gives them options for continuing to dance with the client when things get hard in session.

During the assessment phase of TraumaPlay™, clinicians are looking for clues about which aspects of growth-promoting interaction have been impeded by trauma. Clients feel uncomfortable or awkward when attempting these kinds of interactions. We call this the scary stuff for the child, the dyad, and/or the family system, and we begin targeting these growth areas long before we engage in trauma narrative work. I recently had a first session with parents in which the mother was unable to make direct eye contact with me at any point during our time together. This experience taught me that connection on this particular relational level was outside her window of tolerance; it was uncomfortable—even foreign—for her and was therefore, on some level, scary stuff. Which relational risks are uncomfortable for the traumatized child or family and which mitigators (named on the Play Therapist's Palette, which will be explored later) of playful approach are most inherently attractive to that same child or family are two curiosities that are always held by clinicians during the assessment phase of TraumaPlay™.

Titration is a weird word. With its origins in hard science, the definition took me a while to absorb. But now that I have, I think it serves as a powerful

way of framing the work we do with traumatized children and their families. Titration has to do with taking a beginning solution (a mixture of things) and adding bits of something else—sometimes called the change agent—in different amounts until you arrive at a new solution. A simplified version of titration happens when my children are making a Shirley Temple for a fancy event. They begin with a generous portion of ginger ale and then titrate the dose of grenadine by slowly adding drops of the bright red liquid until they have achieved the perfect sparkly, pinkish red color they are looking for. Add too much and you end up with a beverage that is too sweet to drink; add too little and it doesn't seem very different from regular ginger ale. If the verb *titrate* refers to continually measuring and adjusting the balance of something, then I would suggest that play therapists are constantly engaged in titration whenever we are interacting therapeutically with a traumatized child and their caregivers.

For traumatized children, the beginning solution they bring to play therapy includes their unique set of experiences and resiliencies; their early relational ruptures, neglect, and maltreatment experiences; whatever traumas have occurred in their young lives and the way these may be manifested in their bodies by episodes of hyperarousal or hypoarousal; their beliefs about themselves; their "go to" emotions; and the ways they have learned to cope. Their beginning solution also includes their beliefs about how to navigate the world and how they negotiate getting their needs met in daily interactions. In order for change to occur, these children often need new experiences—doses of various aspects of therapeutic interaction—to help rewire the brain and body for healthier interactions with the world. In trauma work, the play therapist is the change agent: what we add and how much of it we add matters.

Although the concept of titration has long been understood and applied in the medical community—even among psychiatrists who work to titrate psychotropic medications to their most beneficial dose—there is little application of this term to behavioral health. The discussions that have occurred thus far seem to have more to do with optimal overall time frames for the implementation of treatment protocols—i.e., is 14 weeks enough time to see the change being hoped for, or is 18 weeks needed? The conversation can be much deeper than this. One benefit of the evidence-based practice (EBP) movement is that interventions have become more honed and targeted for specific populations; another is that therapists are being held to a higher level of accountability to be able to defend why they are doing what they are doing in therapy. With wide dissemination of this practice approach, adherence has become a constant topic for reflection, and literature abounds regarding fidelity to the protocol. Fidelity can be defined as "the degree to which a program is implemented following the program model, i.e. a set of well-defined procedures for such intervention" (da Silva, Fernandes, Lovisi, & Conover, 2014). Many of the new clinicians I help train come into this field already anxious about their performance—anxious about "getting therapy right"—and trainees may cling to a stepped protocol like it is a life vest.

The fidelity checklists provided in some of these protocols can shift our focus from a child-centric view to a self-centric view. The questions can move from "what does the child in front of me need right now?" to "am I implementing this part of the protocol well right now?" The "Am I?" questions lead to a therapist-centered orientation. It is a slippery slope for a clinician, moving from asking clinical questions that are child-responsive to asking questions that are focused on the performance of the therapist. There is a danger that we may become overly rigid in implementation of a protocol (regardless of which specific protocol you are using), promoting the mandates of the protocol above the needs of the unique child in front of us. A core value embraced by the TraumaPlay™ model is that we are following the child's need at all times, and although all treatment goals are evidence-informed and arranged in a clinically sound sequence, the time spent in pursuit of each goal and the various models and mitigators that will be implemented along the way may shift based on the needs manifested in the attachment relationship on a moment-to-moment basis. This requires bringing as much of your fully grounded, curious, and compassionate self to each session as possible, making a plan, and then being willing to let that plan go if it does not serve the needs of the attachment relationship and ultimately the need of the child in the moment.

This text is meant to offer a paradigm shift for therapists, enabling them to begin to see themselves as human titrators equipped to offer varying doses of varying kinds of therapeutic interaction to change the experience of the client system they are working in. This idea of titration is an outgrowth of my ever-growing respect for the unique clinical presentation that each client brings us based on all the experiences that have shaped them thus far, each client's window of tolerance for stress, and the idea of optimal arousal zones for therapeutic work.

When we apply the idea of titration to our moment-to-moment interactions with children in the playroom, we open up a world of possibilities. When we explore titration as it applies to the use of various aspects of the self in the play therapy relationship, a rich conversation begins. Our tone of voice; our proxemics; our decision to reflect verbally, remain silent, or offer interpretation or suggestion; whether or not we use touch in any given therapeutic interaction; and how our choice meets the need of the client in front of us are all dimensions of titration worthy of our focus. How we titrate the use of various forms of play with the child needs to be based on our growing clinical understanding of where the child is—developmentally, kinesthetically, emotionally, socially, and cognitively. How we titrate the use of the play materials and the play space to further optimal change at a pace and in a way that are best for each client requires an approach nuanced to the needs of the moment. In the implementation of TraumaPlay™, *fidelity to the model is defined as fidelity to the child*—to the need being expressed and the most appropriate way for you to meet it at each moment within the session, with a secondary goal revolving around expanding their window of tolerance for whatever is hard to face.

So what are we titrating? Put simply, we are titrating the approach to the "scary stuff"—whatever that may be for a particular child at a particular time. It may be that trusting a grown-up to meet needs is the scary stuff for some clients; deciding between the choices offered by a caregiver may be the scary stuff, receiving nurture from a grown-up may be the scary stuff, eye contact may be the scary stuff, positive self-talk may be the scary stuff, and certainly aspects of the trauma itself may be the scary stuff. In earlier writings, I have talked about titration mainly in relation to how children and their caregivers navigate the creation of more coherent narratives of the trauma content itself. The dance toward and away from trauma content that occurs between children, parents, and counselors is certainly a part of this. Many times this shows up as posttraumatic play (Gil, 2012; Gil, 2017; Goodyear-Brown, 2010) or repetitive symbolic play (Campbell & Knoetze, 2010), and case examples of this kind of self-titrated exposure will be given in the chapter entitled Holding the Hard Story: Narrative Nuance.

However, the need to titrate various aspects of therapeutic interaction extends far beyond the trauma story itself. Many other moments in treatment are different expressions of the encoded trauma: a foundational attachment wound that has created an intense challenge to a child's ability to trust, an overtly observable pattern of using too much physical force on their physical environment, or a need for continual reassurance that there is food available. Each of these markers is a different "showing or telling" of the trauma and requires just as much finesse in titration as the moments that are specific to narrative processing. Something as seemingly simple as eye contact may need to be nuanced with great intentionality, maintaining an awareness at all times of the child's current window of tolerance for stress and their zone of proximal development.

Why would a traumatized child have difficulty with eye contact? Some children, while not having words for this discomfort, may feel unmasked by allowing another to "see" them. There is a traditional Zulu greeting in which the greeter says, "I am here to be seen," and the one being greeted says, "I see you." This greeting begins with the two people looking deep into each other's eyes. Whether you are an African bushman or a 12-year-old girl living in urban America, this kind of greeting requires that both parties wish to be seen and are willing to open themselves up to being vulnerable in this way. This is no small task for the children in our care. These children carry such a deep perception of being damaged and of having this damage reflected and amplified in the eyes of another that they avoid eye contact at all costs. These children may also have core beliefs surrounding their "badness" and carry great shame related to their abuse. Eyes are indeed the window to the soul, and these children fear in their deepest selves that holding the gaze of another will result in a being seen that ends in rejection or a validation of their worst fear—that they truly are damaged goods. Other children have experienced such extreme neglect that they simply have had no practice holding the gaze of another, a skill that evolves as a foundational part of the healthy relational exchange between

infants and parents in good enough family systems. The neural pathways that train the brain to seek out the nurturing presence of another through eye contact and the neurochemical release that often occurs as a result of a nurturing eye gaze are missing from some children's experiences.

Still other children may have a neurobiologically wired warning system that says eye contact equals danger and perhaps wisely tells them not to make eye contact with grown-ups. Some of my clients were taken out of environments where terrifyingly dysregulated parents would insist, "Look at me when I'm talking to you!" However, as soon as eye contact was made, these children were smacked, pushed, or frozen in place while an enraged parent screamed in their face. In other cases, children had been raised in environments where an alpha dog mentality was modeled by an aggressive parent. In these situations, direct eye contact was interpreted by the aggressive parent as a challenge and always ended in some sort of minimizing, shaming interaction for others. Put in a neurobiological framework, the experience of making eye contact with caregivers did not produce a neuroception of safety. In fact, for many of my clients, direct eye contact with their first caregivers was punitive, scary, and neurologically overwhelming. Instead of supporting the social engagement system, the threatening gaze—often paired with violent words or actions—would spark the immobilization or mobilization system (Porges, 2001).

I have seen all of these presentations in my playroom, and in each of these, the eventual risk the child took to meet my gaze, then hold my gaze, and ultimately the risk taken in allowing me to show the child their preciousness and my delight in them (expressed through my gaze) were part of the set of new experiences that was healing for this child. Healing—but not easy. Respecting the child's window of tolerance for eye contact (how much, how often, and with what mediators) requires us to hold several challenges in mind. The stress experienced by becoming vulnerable and risking eye contact in the first place, the nervous system response as the interpersonal neurobiological process of shared eye contact begins, and the stress of the somatic excitation that is part of this simple action are all critical parts of deciding how you titrate the dose in this instance. Something as fundamental as eye gaze seems like it should come easily, but assuming ease inhibits our ability to respect the dance and ask the most helpful questions.

Nurturing the nuance in this titration starts with asking, "Which play therapy approach best titrates the dose of exposure to extended eye gaze most sensitively and effectively at this point in treatment?" This question is not asked once but is constantly before us as we see how the child/family responds to the approach we have chosen. For example, one child might benefit from diving right in with a course of Theraplay® that extends—very intentionally—the moments of connected eye contact as a form of engagement. For another child, beginning with child-centered play therapy might be most appropriate, as it would allow the child to choose the moments of connection, discovering how it feels to connect with the eyes of the therapist through brief moments of connection, mitigated by kinesthetic engagement with other self-chosen play

materials. For a teenager with limited eye gaze, beginning work in the sandtray may offer the safest approach, as therapist and client can together focus joint attention on a separately defined space. The answer regarding which approach is best may be this, this, and this at different points in treatment (I have often ended up utilizing multiple approaches in the course of my work with a traumatized child), but when and how I order them can depend on a variety of factors, not least of which is this guiding question. I conceptualize the initial question as a decision point, a term borrowed from the play therapy dimensions model (Gardner & Yasenik, 2012).

Mitigators

A respect for the process of titration led me naturally to ask the question, "How can we mitigate the child's approach to the hard thing?" My answer to this became the Play Therapist's Palette. The idea evolved out of lots of supervision sessions in which clinicians were actively engaged in a course of TraumaPlay™ and would say they "hit a wall" or felt stuck with a child or family. Sometimes a therapist will say about a client, "He has gone as far as he can go." In some cases, this may be true, and a season of rest and celebration can be embraced. In other cases, the stuckness may have more to do with a lack of clarity about the scary stuff that needs to be held. A movement from less directive to more directive can simply mean having the therapist share what they know about the scary thing. Sometimes the therapist's fear or hesitation to bring up the scary thing that happened can be contributing to the lack of traction in the work. New clinicians can feel that the words surrounding trauma—suicide, murder, rape—will be too much for the child to hold. It can help to understand that the child is already holding (often somatically and potentially through the unspoken, but still communicated, stories of those around him) the hard thing. Naming their somatically known experience can often bring relief and should not be withheld because of our discomfort. Naming *it*, whatever it is, matter-of-factly can bring permission for deeper work. Therefore, an ongoing part of TraumaPlay™ supervision is helping grow our abilities to contain and name in a safe, grounded way what children need us to hold and name.

Other times the movement to get out of a stuck place may need to occur away from an agenda or direction of any kind. When a child has developed a need to control all aspects of his environment as a response to trauma, the therapist's agenda for checking the next treatment box is likely to cause distance and division. Helping clinicians return to simply being with the child, without an agenda, is often the most powerful use of supervision. In yet other cases, what may be needed to help a client process the trauma is the offering of a different medium. Since so much of our posttraumatic encoding occurs in the right hemisphere, using expressive therapies can open up new pathways for exploration and integration. Inviting a child who feels stuck in a visual art process to move to a sandtray process—or having a client who has been working

with sand move to clay—can offer new and deeper expression through working with the trauma from different angles. The same can be true in metaphor work: a child who is not embracing a metaphor for change—say the life cycle of the butterfly—might resonate instead with a metaphor of superheroes and their alter egos. In many cases, it may be true that the client has gone as far as they can go (in a certain direction) on their own. The wonderful hope that emerged from Vygotsky's work and his concept of the zone of proximal development (Vygotsky, 1987) is that the client can do more with the aid of a bigger, stronger, wiser, kind grown-up than they can by themselves. This phrase, *bigger, stronger, wiser, kind*, offered by the creators of the Circle of Security (Hoffman, Cooper, Powell, & Benton, 2017), has become a standard mantra at Nurture House, both for our clinicians and for the parents we are coaching.

When a supervisee feels stuck with a client, I often ask them this question: "Which mitigators would make this client's approach to the scary stuff easier?" Some children have very little difficulty giving the top-level, linguistic narrative surrounding a traumatic event—they just do it in a way that is removed from affective components and somatic experience, leaving little room for processing it in relationship with another; the narrative can be delivered almost as a book report. These children may be aided by mitigators that allow for deeper emotional expression through attuned exploration and reflection (the attachment relationship) or by deeper somatic experiencing (Payne, Levine, & Crane-Godreau, 2015), often aided by interaction with nature or kinesthetic grounding.

The Play Therapist's Palette

The most recent evolution in my thoughts about how to make these mitigators accessible to others is imagining them on an artist's palette. The palette reflects my experience of the play therapy process as a creative process in which the traumatized child, the caregivers, and the therapist paint a canvas of connection and healing together while respecting best practice treatment goals in trauma treatment (Briere & Scott, 2006; Cloitre et al., 2011). Out of the need to quantify our offerings to help clinicians make quick decisions, I have developed a palette of nine potential mitigators in a child's approach to trauma. Each chapter in the book expands on the offerings represented on the palette, and each expands on one or more of these mitigators, citing the theoretical underpinnings and giving many case examples to inform the practical application of the Play Therapist's Palette. You will notice, as you look at the icon below, that the central offering on the palette is the attachment relationship. Implicit in the seminal role of the attachment relationship is that we are providing delight in the child at all times, especially when holding hard things or setting boundaries. We become both a secure base and a safe haven in the playroom. Arranged in no particular order around the attachment relationship are the following mitigators: metaphor, nature, kinesthetic grounding, need meeting, humor, containment, novelty, and touch (see Figure 1.3).

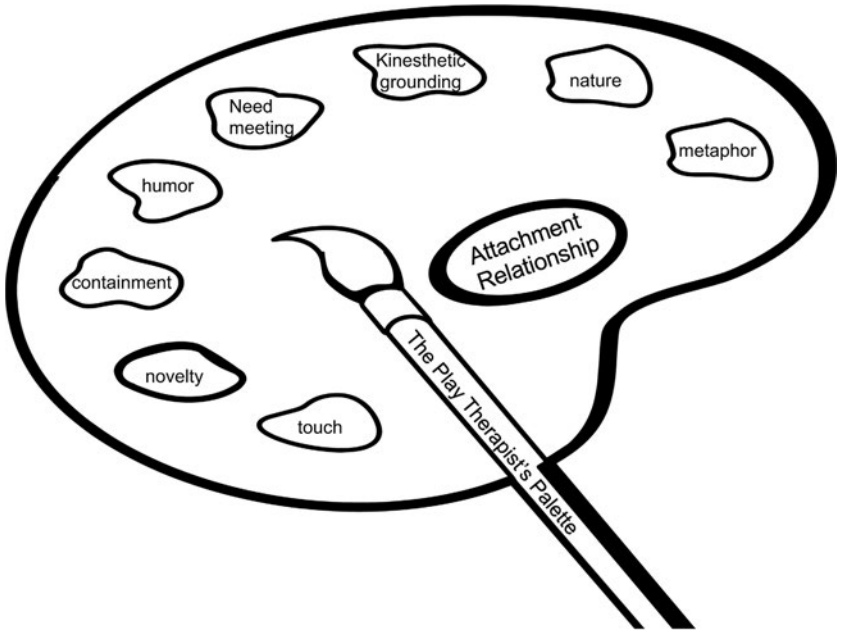

Figure 1.3 The Play Therapist's Palette

My artist friends have described to me the excitement that comes with a freshly filled palette and a blank canvas. As they approach a blank canvas, they feel that anything is possible. I feel similarly about each new family I meet. How will the trauma recovery process be navigated? How will we expand the window of tolerance? What will I offer to help co-regulate their approach to the hard stuff? No two children are alike and no two trauma recovery processes are the same. There may be parts of the palette that do not get used at all in one clinical relationship and others that may be mixed together or used in large amounts. Either way, the clinician can hold all the possibilities and all the potential avenues for navigation close enough to have them at the ready.

The deeper I have dug into this idea, the more convinced I am that nuanced titration of therapeutic interaction has vast application to therapeutic work. For an integrative play therapist, the foundation of work includes (1) the belief that play is the natural language of children and (2) a respect for the power of play to enhance attachments, heal trauma, create new solutions, build new skills, and help develop new understandings of oneself and the world. We begin by creating a fully equipped play space; developing a safe, nurturing relationship with the child; reflecting their thoughts/feelings/behaviors during the play content; and creating a holding environment for difficult content. From there we can choose from our palette of mitigators.

As we are understanding more and more about how trauma gets stored in our bodies (Ogden, Minton, & Pain, 2006; Rothschild, 2000; van der Kolk, 2015) and expressed in our relationships, the range of mitigators in the approach to trauma content has grown. Who will create the change and how much mitigation is needed are foundational questions in this work, as is the question, how do you know when you've reached the resting place? And how do you avoid adding too much? Scientists begin very slowly, adding higher concentrations of the new substance as they go. I suggest that play therapists can use a similar approach.

Each mitigator can be understood as a powerful ally in the work, offering categories of interaction that promote the neuroception of safety and enhance feelings of competence. Each of these therapeutic allies serves the function of mediating a child's (or parent's) approach to a hard thing. The offerings on the palette are meant to provide a menu of possible ways to go when a therapist hits a relational risk point with a client. These risk points arise when clients begin to move outside their window of tolerance, have gone as far as they believe they can on their own, and are looking to the therapist to help them regulate. Co-regulation may mean that the therapist acknowledges that the client is ready to rest and joins them in doing so or that the therapist acknowledges the client's need for additional support and provides an experience of competence, connection, or plain old fun.

It was in my first painting class that I learned how to hold a palette correctly. I kept dropping it and finally just set it down beside me. When a classmate took pity on me and showed me how to hold it, I could not help but hear the parallel for how a secure base is created through my attachment relationship with the child in my care. The classmate asked me if I wanted to sit or stand to work on my painting, and I chose to stand. She was pleased and said that standing while balancing the palette gives you the most flexibility and mobility, both in creating the work of art and in observing it from multiple angles during the creative process. Then she said, "Use your forearm as a base for the palette and insert your thumb through the hole to help anchor the palette. Then wrap your fingers gently around the other side or let the palette gently rest on your fingers." The first time I tried it, I was concerned about dropping it, so I had a death grip on the palette. She laughed and said, "Relax. You will get cramps in your fingers if you hold on too tight." I relaxed my grip, and she said, "Good. Just remember, you may need to provide a little more support when you put your brush in the paint." It was a constant balancing act between providing enough support and not breaking the palette or my fingers, but I found that resting the palette on my fingers was more comfortable than gripping it tightly.

I feel the same way about these mitigating tools in trauma work. I offer the palette of expressive choices and mitigators for the approach to hard things, but I offer them lightly, supporting the child's choice of all the options available to them. Each time we choose a path together, I have to reassess how much support is needed for the child to explore. My hope is that this text

will bring a new awareness of all the pathways available to us when helping children expand their expressive vocabulary. In an art studio, an art student has the freedom to create anything they can imagine, as long as the materials offered are extensive enough to support the work. "I saw the angel in the marble and I carved until I set him free." I reflect on this quote and hear the parallel to play therapy and trauma recovery: if we offer a wide enough range of expression and mitigators for the approach to hard things, we can find the real child inside the hard shell of trauma. I want children to have all the resources we can give them for the journey toward healing. My hope is that, whatever model of play therapy you are using, you will finish this text feeling more deeply equipped with a palette of powerful mitigators that can help you approach the hard moments in your work with traumatized children and families.

A TraumaPlay™ practitioner is operating on multiple levels of awareness simultaneously. The clinician must be aware of where they are on the continuum of treatment, how fully treatment goals have been met, and which goals may need to be returned to, all while remaining as present as possible to discern the child's current window of tolerance for stress. In supervision, I am often helping therapists recognize which parts of the play therapy experience are bringing joy and regulation to the child and how the therapist's use of self is scaffolding a child's approach to the hard things.

Therapeutic Use of Self

Therapeutic Use of Self in TraumaPlay™ requires the clinician to be comfortable with and always growing in three roles: the role of the witness, the role of the nurturer, and the role of the safe boss. When I am training others in TraumaPlay™, we will map out the therapeutic use of self at various points in a session around a triangle. Each point of the triangle represents one of the roles we may fill in a TraumaPlay™ session: witness, nurturer, safe boss. In the center of the triangle is the child, and all movements by the clinician around this triangle are in direct response to the needs of the child at the current time. Each child in our care requires a unique titration of each role. Some may need more of the witness (seeing) than the safe boss (structuring), whereas others may need large doses of delight from the nurturer before any trauma content is approached (see Figure 1.4).

The Witness

Being a witness to a child's play therapy process involves hearing, seeing, and holding the child's communications, both verbal and nonverbal. We hold without judgment and, with as much presence as possible, practice staying with the child from moment to moment. Being a witness means communicating through our words, actions, and neurobiological presence that "I see what you are showing me, and you can show me more." We communicate

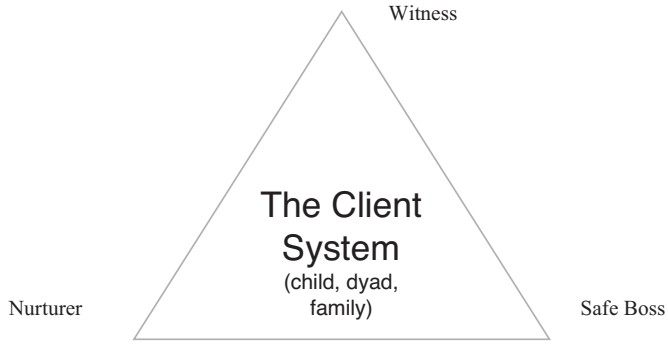

Figure 1.4 The Triangle of Therapist Roles in TraumaPlay™

this in big and small ways throughout sessions. When a three-year-old puts on a puppet play in which the police officer puppet says, "Put the handcuffs on, you fucker" (as happened in one of my recent sessions), we need to be able to reflect this language without backing up from it. Avoiding the reflection of the word *fucker* can communicate loudly that we are uncomfortable with this language, compromising the child's ability to use us as container and reflector.

All children learn how to stay close to their attachment figures by reading their cues. As soon as we enter a therapeutic relationship with a child, we become a potential attachment figure. In order to provide a corrective emotional experience for the child as an attachment figure, we, as therapists, must stretch ourselves to become large enough containers for whatever hard stuff the child or family system needs us to hold. I must be able to contain difficult images, words, stories, and somatic expressions and reflect them without allowing any personal discomfort to keep me from these roles. When a child's play behavior makes the therapist uncomfortable, it then makes the child uncomfortable. In some cases, the child will curb or even remove the uncomfortable play pattern from their play in order to protect the therapist and maintain the relationship. The three-year-old may understand that the word *fucker* makes *us* feel uncomfortable and so won't play in that way again. In effect, they are being told by us to mask part of their experience from us.

The idea that miscuing begins when a child's feeling or behavior "makes us uncomfortable" was conceived by the creators of the Circle of Security Project to describe the pattern in which children become what they need to be to stay close to their caregiver. So, if we want to get the most authentic version of the child's self in the playroom, we only have to make sure that nothing makes us uncomfortable. Do you hear the laughter stemming from the obvious impossibility of such an ask? In reality, remaining a bigger, stronger, wiser, kind container for our clients means continually working on our own triggers, aggressively pursuing an understanding of countertransference issues as they arise, and intentionally growing our ability to be filled with

difficult things and then emptied again. This begs the question, "Where do we put all that we hold?"

Another important aspect of TraumaPlay™ supervision is supporting clinicians in doing their own self-care work, acknowledging compassion fatigue, and transforming heaviness into letting go of what can be let go while holding with gratitude whatever relational gifts or new nuggets of wisdom or insight have been gained. In this way, TraumaPlay™ supervision often becomes a parallel process for the work being done in the client system. From the moment we begin establishing safety and security—the first goal of TraumaPlay™—the child may begin to give us trauma content. The number of times children have created a viscerally disturbing image or engaged in a play pattern that seems to be immediately recreating the situations or experiences in which they have been unsafe supports the idea that we must be ready to embrace our role as witness at any point along the way. The witness communicates, "I see what you are showing me, and you can show me more."

The Nurturer

Many of the families I see in the wake of trauma are having difficulty with either the giving or the receiving of nurture. Some of our clients come from lonely beginnings. They did not receive nurturing touch to help wire their brains toward connection and regulation. They did not have a continuous stream of reciprocal exchanges of delight with a caregiver. They did not have anyone telling them they are amazing and deserve to exist simply because they were created. These children did not have someone trumpeting their ability to become whatever they chose to become. So, for many of these children, a more direct recapitulation of parent/child interactions may be needed, with attention given to meeting earlier developmental needs that may be hiding inside chronologically well-developed bodies. Delight can be communicated in many ways by TraumaPlay™ practitioners and often includes meeting basic needs, offering nurturing touch, and appreciating a child's sparkling eyes or sense of humor.

The Safe Boss

The therapist as safe boss provides structure while sharing power with the child. Many of the children we see, as well as many of the parents who care for them, have not had safe boss behavior modeled for them. One of the most rewarding parts of my work is helping parents and teachers breathe in this phrase and grow into safer bosses for the children in their care. I am constantly engaging in parallel process work, and as I model safe boss behavior, the parent begins to internalize this model themselves. As the parent begins to believe their new self-talk, i.e., "I am the safe boss," it changes the way they approach parenting. Safe bosses are people in authority and under authority. A *boss* is the person in charge, the person who has the power to effect change, the person who makes final decisions and holds your future in their hands. If you

have been around children for any length of time, you have probably heard one say, "You are not the boss of me." Little ones often fantasize about being the boss, but they are not equipped, and when they have more authority than their parents or teachers—when they actually get to feel like the boss—they end up feeling unsafe.

Children do not have the capacity to be fully in charge. They first have authority over their own mind, will, and emotions, and their growing edge is to bring these more and more under their own control. Theoretically, a safe boss knows more about whatever they are the boss of than the people they are leading and will use this knowledge to equip, encourage, and grow others. Safe bosses do not shame those under their authority. They also set safe boundaries, quickly and efficiently reshape harmful interactions, and maintain appreciation for the person they are leading at all times. Safe boss behavior may involve setting limits, giving explanations, or even doing didactic teaching or skill building.

The safe boss role is one that respects the parallel process dynamics of the therapeutic relationship. The therapist models the dimensions of healthy leadership that can become part of the family system's way of relating. The picture below, taken at Camp Nurture, shows one of our young campers at a time when her body let us know she needed to rest. One of her buddies offered a pillow and lap for the little one to rest on. The child's back-up-buddy got behind the holder and began to braid her hair, providing nurture to the one providing nurture to the child. It was not until long after Camp Nurture was over that I found the picture below (see Figure 1.5). I find it a beautiful representation of the parallel process dynamics we have been exploring. As we, as therapists, hold the holder, the traumatized child is also held.

Figure 1.5 Holding the Holder

We talk a lot at Nurture House about opening and closing circles of communication. Any opening and closing of a circle of communication between therapist and child is an opportunity to titrate a dose of something therapeutic. Something as simple as saying, "See you later alligator," and the child responding, "In a while crocodile," can be considered an opened and closed circle of communication (Purvis, Cross, & Sunshine, 2007). Any time a child verbally interacts with us and we respond in a way that is reflective of their language, a communication loop has been opened and closed. Even in the more difficult moments of therapy, when a limit has to be set, completing the circle of communication is critical. If a child has thrown something at you, immediate feedback of some kind—whether it is Landreth's ACT limit-setting model, i.e., "The block is not for throwing at me; you can throw it into the block bin or onto the cushy chair," or "Whoa! That made a loud noise when it hit the floor!" or "My stomach clenched when you threw that, as I was worried it might break"—is necessary. There are multiple options for response, depending on your model of intervention, but the circle of communication, opened by the child when he threw the object, must be responded to in order for the circle of communication to be closed and therefore to provide meaningful feedback for the child.

It is important to talk briefly here about how children learn, particularly children who have compromised neurophysiology due to complex trauma. Behaviorally based therapy approaches generally support the ignoring of most negative behaviors. I believe that ignoring these negative behaviors when they begin is the beginning of the end, in the sense that the behaviors will generally continue to ramp up. The child's body language, facial expressions, physical actions, and expressed words (even if the words are curse words) are giving us valuable information about the current regulation of the child—and their underlying needs. When we see negative behavior is when we need to pay more attention, not less. Traumatized children need caregivers who stay very close to them—close enough to sense the changes in reptilian brain stem regulation that matter—and respond quickly, providing valuable feedback that can aid in regulation.

Conclusion

It is my deep desire that this discussion of titration will expand your sense of freedom in dancing toward and away from the trauma content while at the same time trusting the process and the relationship with the client. It is also my hope that by offering this new tool, the Play Therapist's Palette, the many options available to play therapists (as mitigators in the dance) will feel easily accessible. When I think about the phrase *taming the trauma*, what sometimes comes to mind first is a wild animal and a wild animal tamer wielding a whip as they steer the animal into a cage. The idea of caging the trauma is shortsighted, as it compartmentalizes the trauma within boundaries it will most likely outgrow. In addition, the tamer may one day forget to lock the cage, only to have the trauma come bounding out, more resentful than ever

and on the attack. Taming, in the context of this book, has to do with using the process of titration and the Play Therapist's Palette to help clients enhance felt safety, get needs met more effectively, and leach the emotional toxicity out of the trauma in a way that brings greater internal coherence to the trauma survivor.

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2 The Neurobiology of Trauma and Play

Understanding the Playroom as a Neurochemical Boxing Ring

Any discussion of how the Play Therapist's Palette helps mitigate the approach to trauma content must begin with unpacking the neurobiology of trauma and the neurobiology of play. As it turns out, play pretty powerfully meets our neurobiological needs for trauma recovery (Badenoch, 2008; Gaskill & Perry, 2012; Gaskill & Perry, 2014; Hong & Mason, 2016; Kestly, 2015; Stewart, Field, & Echterling, 2016). Clinicians who treat traumatized children must familiarize themselves with brain structure, function, growth pathways, and potential injuries to the developing brain. Additionally, clinicians who develop a healthy respect for the neurochemical boxing match that often occurs between stress-related neurochemicals and those released through pleasurable, competency-building experiences in play have the best chance of confidently helping children dance toward and away from the trauma content, trusting the process. We are marvelously made and are meant to be able to co-regulate one another. The more respect we develop for both the power and the limits of neurobiological resonance, the more adept we will be at intentionally crafting experiences and playful interactions that will offer a path toward healing.

It is well understood now that experience shapes the brain and that neural circuitry is use-dependent (Kay, 2009; Siegel, 2001, 2012). The adage "neurons that fire together wire together" (Hebb, 1949) gives scientific explanation to the ways in which interpersonal patterns of relating are shaped. I share this idea with parents by having them imagine that the brain is like a field of tall grass. If you walk a path once, the grass will bounce back, but as you walk the path over and over again, the grass gets pressed down, the path becomes clear, and it becomes easier to get from point A to point B. This laying down of neural pathways can provide a clear path through the weeds and incredible resilience in our development—or the path can become riddled with muddy ruts that are difficult to get out of, even when we are desperate to find another way to interact with the world. If you have a caregiver who comes to soothe you every time you are upset, your brain develops connections that begin to anticipate soothing, and eventually you learn to self-soothe. If you have a caregiver who is continually frustrated and short-tempered with you, your mirror neurons become activated in similar ways, and neural pathways are shaped to

more and more quickly override higher brain regions with lower brain reactivity. In other words, you may become short-tempered.

Most of the traumatized children we treat have dysregulation of the brain stem and require co-regulation work and the expansion of their windows of tolerance for stress. Play provides a natural medium for the occurrence of up- and downregulation, and as such is an important component of holistic, healthy development in children (Erickson, 1963; Ray, 2011). Neglected and maltreated children have usually been raised in environments where they have been deprived of play and its natural benefits in shaping our nervous systems. Stuart Brown, founder of the National Institute for Play, unpacks the many benefits that play provides, both in the animal world and in humans. These include opening up our creative potential, providing social training in things like empathy and cooperation, allowing us to try on roles without any long-term consequences, building strength and mastery, and experiencing pleasure. He also discusses the ways in which play deprivation can lead to deficits in connecting with others. These deficits run the gamut from a lack of empathy and ability to problem-solve with others to extreme sociopathy and outcomes such as rape and murder (Brown, 2009).

When a developing mind is subjected to prolonged or overwhelming stressors, use-dependent neural systems can be altered (Perry, 2000). We understand now the multiple ways in which in utero threats, such as alcohol or drug use, malnutrition, and excessive cortisol reactions in the mother's body, can derail healthy brain development. We understand now how neglect, maltreatment, and chronic trauma can negatively impact a child's window of tolerance, creating states of both hypoarousal and hyperarousal (Ogden, Minton, & Pain, 2006). Children who did not have a supportive attachment figure to help mitigate stress for them early in life tend to move outside their optimal arousal window much more frequently than those who had thousands of repetitions of nurturing care early in life.

The groundbreaking work around the Adverse Childhood Experiences (ACEs) study has led to an understanding that early traumatic events have long-term consequences on everything from physical health to addictive behaviors to the kinds of intimate relationships you will have as an adult. This longitudinal study began as a collaboration between Kaiser's Health Appraisal Center and the Centers for Disease Control and Prevention. After visits to the Health Appraisal Center, surveys with detailed questions regarding a host of adverse childhood experiences were mailed out. Three categories were abuse-related (emotional, physical, and sexual), and the other seven were related to household dysfunction (parental separation/divorce, domestic violence, substance abuse, crime, and mental illness). In one phase of the study, researchers looked at the relationship between exposure to ACEs and lifelong exposure to drug use. They found that each ACE increased the risk of drug use earlier in life two- to fourfold (Dube et al., 2003). This study also examined four successive birth cohorts dating back to 1900 and found that the relationship between ACE scores and early onset of drug use crossed

all four cohorts. People who have more than four ACEs are twice as likely to be smokers, seven times as likely to be alcoholics, twice as likely to have heart disease or cancer, six times as likely to be sexually active before age 15, and—the most disturbing statistic—12 times as likely to attempt suicide. ACEs predict the ten leading causes of adult death and disabilities. ACES also increase our likelihood of being obese and having impaired cognitive capacities—and therefore school and work performance—often leading to higher rates of poverty (Felitti et al., 1998; Anda et al., 2006). In addition, ACEs increase the likelihood of psychotropic drug use as an adult and are predictive of mental illness (Anda et al., 2007). It is now understood that untreated ACEs can lead to changes at a cellular level, in essence creating intergenerational trauma as genetic code is passed down to one's children and one's children's children.

Developmental Trauma Disorder

Out of our understanding of the pervasive neurophysiological differences found in people who experience trauma has come an appreciation for the devastation that trauma can wreak in every area of a child's development (D'Andrea, Ford, Stolboach, Spinazzola, & van der Kolk, 2012). Bessel van der Kolk's body of work and his offering of developmental trauma disorder as a more holistic conceptualization of the clinical picture of children with complex trauma histories have shaped our field. He completed a study that compared adult survivors of childhood trauma with adults with acute trauma and adults with domestic violence in their adult histories, and he found that there was a very different presentation of symptoms for adults who had experienced chronic trauma as children than for adults who had experienced a single traumatic event equipped with the resources of adulthood.

The three main areas that van der Kolk identifies as being impacted by developmental trauma are attentional abilities, affect regulation, and how the individual navigates relationships. People who experience chronic trauma in childhood are not able to attend deeply to tasks for long periods of time and are easily distracted by things, unable to filter out extraneous information in order to focus on what matters at the moment. They are also less able than others to regulate their affect, becoming too reactive and too intense and having too high highs and too low lows. He makes the point that as this clinical presentation gets treated for affective arousal, these children are often diagnosed with bipolar disorder and given antipsychotic medication that shuts down the dopamine system, which is important for engagement and motivation. In our generation, more and more children are being treated with psychotropics that numb the excitation response. This numbing (arguably dissociative response) does not allow children to do the work of expanding their windows of tolerance for distress, as distress may not be authentically felt and therefore has no hope of eventually being tolerated.

Neuroplasticity, Hope, and Balance

Neuroplasticity, the lifelong potential for neural change (Mundkur, 2005; Neumeister, Henry, & Krystal, 2007), supports the idea of a growing edge for both caregivers and children in learning new response patterns and implementing them. We know that synaptic strengthening is experience-dependent, and since play is inherently fun, it is rich soil for the planting of new interactions between parents and kids. Foster and adopted children get an opportunity to create new neural pathways in relationship to their caregivers as new interactional patterns are practiced. In these ways, models such as filial therapy, child-parent relationship therapy (CPRT) (Bratton, Landreth, Kellam, & Blackard, 2006), and Theraplay (Booth, & Jernberg, 2010) are in vivo methods for helping dyads practice new ways of interacting. As parents and children play together, new cognitions and emotional perceptions of earlier events can occur (Siegel, 2012).

I find that one of the hardest balances to strike in providing trauma-informed care for families is unpacking for parents the potential injuries to their child's neural development while continuing to wave the banner of neuroplasticity and hope for change. The brain is a marvelous, magical guidance system, and to diminish the lifelong capacity for the growth of new synapses based on new experiences would be a disservice to our clients. Alternatively, asking a child to do something they simply are not able to do yet (and might not be able to do at all) based on their current brain development would be wildly unfair. Helping parents set the bar appropriately for their traumatized children in each area of development is an important part of our job.

I was speaking recently at a conference for foster parents, adoptive parents, and kinship care providers. An adoptive mother came up to me afterward and explained, "I have a nine-year-old child adopted from Uganda. She has significant cognitive delays, temper tantrums, and isn't learning our rules. I am just wondering if I should keep believing she can change, or if I should accept her limitations and resign myself to the fact that this may be "as good as it gets." My answer was, "Which one will help you remain most regulated, kind, and connected with her?" This was, of course, just a jumping off point for much more detailed conversations she might have with her local therapist around which developmental arenas (including the attachment bond and ultimate growth in social relatedness) can be impacted and which behaviors/symptoms/ways of relating to the world may need to be accepted as the child's current best self.

I could see that my question as response to her question was unexpected, but it seemed what this mom most needed—time to reflect on which stance helps her be the most grounded mother she can be and to help her understand her power as a potentially different relator than anyone else in this child's world. I asked her to list the top two behaviors that are hard for her to tolerate, and after some processing, she was able to separate them. For the relational behavior, we came up with some strategies for reengaging her daughter. For the

other behavior, which we agreed had a sensory defensive source, she ended up saying, "You know, I'm really not sure she can help that—and if I just admit that, I'll stop fighting with her about it." Yes!!! I see parents who overestimate the speed with which a symptom "should be" extinguished and set a bar that is higher than the child can successfully reach, creating resentments in both the parent and the child and widening the gulf between them. I also see parents who believe that the damage is done and have disengaged. In these cases, I am often attempting to reopen the caregiver's compassion well so they will continue to open and close circles of communication with their child toward the growth of new neural circuits.

Lev Vygotsky's zone of proximal development has been a key concept in shaping my thoughts about the Play Therapist's Palette. In fact, the intersection of Vygotksy's work on how children learn and Perry's neurosequential model of therapeutics (Perry, 2006; Perry & Dobson, 2013) has sparked a new question that can aid us in treatment planning with traumatized children: "What is this child's neural growing edge?" We talk often in supervision about the "growing edge" for our clients. The growing edge is the boundary between what a child can do on his or her own and what a child can do with the help of a safe boss. Asking this question as we begin treatment planning helps us avoid a scenario in which we are pushing child clients beyond their current capacities. Children who have underdeveloped brain regions (the reptilian brain stem, diencephalon, and limbic system being ones that often take a hit) benefit from targeted interventions that pair the presence of a safe boss with an enriched environment that will stimulate new growth in those underdeveloped areas. The neurosequential model of therapeutics has informed an appreciation for targeting interventions to the specific areas of the brain that are lacking in optimal development. Targeting intervention to the neurophysiological needs of the child informs my choice of which mitigators from the Play Therapist's Palette to use with each child.

The Brain and the Other

Play therapists have long understood the attachment relationship between the therapist and the child to be the most critical part of the understood change mechanisms in play therapy (Axline, 1947; Landreth, 2012). Pioneers in the field of interpersonal neurobiology (IPNB), such as Dan Siegel and Bruce Perry, have given us a new language, grounded in neuroscience, to support the importance of interpersonal regulation and growth. Perry and Pate (1994) write, "Simply using cognitive and verbal interventions will not alter the parts of the brain mediating trauma . . . the changing element of therapy is the 'relationship,' . . . not the words of therapy." Play remains one of the most powerful and palatable ways to help a child grow in regulation with a co-regulating grown-up, and it offers these experiences without the necessity of linguistic involvement. The nine dimensions of neural integration offered through IPNB (consciousness, bilateral, vertical, memory, narrative, state,

interpersonal, temporal, and transpirational, or identity integration) can be positively impacted by play therapy (Wheeler & Dillman Taylor, 2016). The consciousness dimension is often tackled by play therapists almost intuitively as we become more mindfully present in the playroom and offers a reflective presence for children to become more aware of themselves. In the bilateral dimension, as we give words to the feelings we see children expressing, we are facilitating communication between hemispheres (Badenoch, 2008). Play therapists need to understand the unique role that play holds in accessing and remapping lower brain regions. Play therapy may be not only a helpful medium but also the most effective medium for inviting certain areas of brain development.

Bottom-Up Brain Development

Put simply, the brain develops from the bottom up, and that hierarchical development must be respected if we are to heal from trauma. The hierarchical and systematic development of the brain begins in utero. The brain develops first through genetic scaffolding and very quickly is influenced by environmental factors, including in utero threats to development. The idea of bottom-up brain development was first posited by Jackson (1958). The brain of an infant starts out with a consuming preoccupation with survival. The reptilian brain stem is in charge, and whenever that baby is hungry, cold, wet, etc., a lot of noise is made in order to get the help of a safe boss to bring the infant back to a state of regulation—satiation, warmth, dryness. However, as infants in a satisfactory caregiving system grow and get thousands of repetitions of this co-regulation by parents, their reptilian brain stem begins to pay less attention to moment-to-moment basic need meeting, and more time is spent in relationship-building and learning. If you think of the energies spent by the brain as a pyramid, with the most energy spent at the bottom and the least at the top, the pyramid looks inverted for a typical brain that has had lots of experiences in which safety was a given. The typical brain has only the tip of the pyramid given over to survival responses, the next layer given to regulation, the next to social and emotional involvement, and the largest part of the pyramid, the base, to cognition.

When a brain has experienced trauma, and particularly if the trauma has been chronic, the pyramid is reversed. The base of the pyramid, the largest part by far, is consumed with survival, and the next largest is concerned with regulation. Very little room is left for social and emotional engagement, and only the smallest tip of the pyramid remains given over to cognition. Once we understand this, the paradigm shift is easy. Historically, our treatments for trauma have revolved around cognitively geared therapies. Van der Kolk (2015) makes the argument that somatically regulating interventions, such as mindfulness, trauma-informed yoga, and interaction with nature, is significantly more effective in reducing trauma symptoms than cognitively geared treatments.

When helping caregivers shift their paradigms, I usually begin with parents by showing them the elegantly simple depiction of MacLean's triune brain, consisting of the reptilian brain stem, the limbic brain, and the neocortex, or thinking brain (MacLean, 1990). There is a beautiful spiral staircase made of stone on Vanderbilt's campus. Whenever I see it, I am reminded about the sequential bottom-up nature of the brain's development. I have taken a picture of the spiraling stairs and will sometimes give parents a copy that we label with the functions of each part of the triune brain (from respiration to cognition, etc.). During parent support sessions, I ask them to put an asterisk next to which parts of the child's brain the parent was targeting during a moment of co-regulation or discipline from the week prior.

I often share Dan Siegel's hand model of the brain (Siegel, 2010) with parents early on and talk about how stressful experiences can cause us to flip our lids (Siegel, 2011). My favorite practical application of the triune brain comes from Becky Bailey's conscious discipline model (Bailey, 2001, 2015), in which she attaches guiding questions to each part of the triune brain to make it even more accessible to caregivers. I explain each brain region's "job" and pair it with Bailey's questions. I explain the functions of the reptilian brain stem in regulating heart rate, respiration, body temperature, and sleep (Perry, 2006). While the brain stem must be active for an infant to survive, it continues to grow through the repetition of regulating interactions with caregivers over the first year of life (Perry, 2006). This most foundational level of the brain is always asking the question: am I safe? The limbic brain is represented by the palm of the hand, and the enfolded thumb represents the amygdala. Emotional responses and the fight, flight, and freeze responses originate in this midbrain region. The limbic brain is responsible for emotional regulation and is always asking the question: am I loved? The cortex, or the thinking brain, is represented by the fingers wrapped over the thumb enfolded in the palm of the hand. Various fingers and knuckles represent specific regions of the cortex, but as a whole, the cortex is responsible for executive functioning, goal-driven behavior, and cognition and is always asking the question, what can I learn from this? I talk about it as the journey from regulation to reason. I share the bottom-up language of brain development with them. I help them understand that until that child's brain has answered the questions "am I safe?" and "am I loved?" with a resounding yes, the neocortex is not empowered to ask questions related to learning. It is helpful also to have an understanding of the evolution and anatomy of emotion and emotional circuits in the brain (LeDoux, 1996; Panksepp & Biven, 2012; Panksepp, 1998) in understanding both bottom-up implications for the brain's interpretation of the environment and the potential for top-down regulatory control.

When I present this information to 30-year veteran day care owners and school teachers in the inner city, they usually say something like, "Amen, sister!" Many of these dedicated professionals, who have been in the trenches for years, have their life experiences validated by this expanded language of bottom-up brain development. In less than 15 minutes, they are given

permission and perhaps even a mandate to provide regulation and nurture (connection) before trying to teach ABCs and 123s. I was training school teachers in a highly violent urban area of Nashville recently. At the break, a teacher approached me and explained that two kindergartners in her class had come to school the day before saying they had stepped over blood on the sidewalk on the way to school. For these two kindergartners, the answer to the question of whether they are safe may be "absolutely not" or "only for a few hours." Many teachers who work in the inner city have communicated to me the sense that they are starting over at ground zero each morning, and by the time they have rebuilt a child's sense of safety and connection, the final bell of the school day is ringing. How can these children learn if we cannot help their limbic brains to calm and their lower brain regions to regulate their bodies properly? More and more schools that serve at-risk children are moving to trauma-informed models of teaching that spend time with connection and regulation in the classroom before attempting to teach children their ABCs and 123s. The research is showing that when these underlying needs for regulation and connection are met, learning proceeds more spontaneously and more quickly (Walkley & Cox, 2013; Perry & Daniels, 2016).

The Amygdala Alarm

The amygdala is, among other things, the seat of somatosensory memory as it relates to heightened emotional experience (Davies, 2002; Goleman, 2006; Hughes & Baylin, 2012; Panksepp & Biven, 2012). That's kind of a mouthful, but it basically means that your most joyful memories—the day you got married, the moment your newborn was placed in your arms, the day you graduated from your graduate program—may have a crystal clear sense memory attached to them, i.e., the taste of the wedding cake, the smell of your baby's head, the contrast of the black graduation cap against the blue sky. If that is true of our joyful memories, it is doubly true of the things that terrify us. We are wired to encode danger signals from the environment very deeply and to respond to them very quickly in order to survive. If a fist is coming at you and it punches you, the next time a fist comes at you, you hope to move out of the way, right?

The thing is, the amygdala is a pretty sloppy processor and can have functional impairments related to the anxiety that is being carried (Strawn et al., 2014). Its associative function pairs sights, sounds, and smells with the traumatic experience and is meant to be an early warning system, but sometimes it generalizes too broadly (Goleman, 2006). The way I normally unpack this for the families in my practice is by bringing out an extra-large military figure and telling a story. I say, "Let's pretend this guy is in Iraq, and his job over there is to take care of the tanks. So he gets up in the morning and is washing the windshield of the tank, when all of a sudden he hears gunshots—bang, bang! He drops to the ground, his heart is racing, his body is shaking, but he is safe. After a few minutes, the gunshots subside. He slowly gets up, checks himself

out, and he's not hurt. His heart rate and breathing go back to normal, and he goes back to his job. The next day, he and a buddy are getting the mud off the big treads of the tank tires, and again there are gunshots—bang, bang! He drops to the ground, and so does his buddy, although his buddy doesn't drop quite as fast and gets a little bit hurt (he just needs a Band-Aid), but our guy is safe. This happens day after day in Iraq until our guy's tour of duty is over. He is back in the states, he's been home for maybe five months, and he is at the mall doing some Christmas shopping. He is laden down with packages, and as he's walking out to his car, he hears a car door slam—bang! What's he going to do? He's going to drop to the ground."

Kids as young as five will tell me the guy is going to drop to the ground, and while we don't say to children, "Your brain becomes habituated to the trauma trigger," this story illustrates the idiosyncratic, quirky ways we respond to trauma. In fact, one of my favorite definitions of *trauma* is the normal reactions of normal people to events that for them are unusual or abnormal (Parkinson, 1993). This explanation de-pathologizes our response to trauma and gives permission for children to use the playroom in any way needed to express and heal from the trauma.

Implicit and Explicit Memory

Another way to talk about how trauma gets stored is by describing explicit and implicit memory systems (Siegel & Hartzell, 2003). Explicit memories require autobiographical memory to be available to us. Autobiographical memory relies on the hippocampus, which is highly underdeveloped in infants and young children. In utero injuries and early trauma are stored in implicit memory, which is basically associative memory. As infants, we have thousands of interactions with our primary caregiver, and while we do not consciously remember each of these, we make associations between the smell of mom's hair or her motherese and pleasurable feelings of satiation. If mom was nurturing, these smells and sounds will trigger a full body sense of wellness. If the smell of alcohol on dad's breath was associated with yelling, throwing things, or mom being hurt, the smell of alcohol may trigger a felt sense of danger even if you have no conscious memory of a negative event. The most insidious thing about implicit memories is that you do not have a sense of remembering something, as you are taken over with the physical embodiment of a somatic memory.

When I am training others, I often give this example: imagine you are a nine-month-old baby, and for the first nine months of your life, you were colicky, difficult to soothe, and had a mother who was struggling with postpartum depression. She would leave you in your crib for long periods of time, but when she got to the point where she could not stand your screaming anymore, she would storm into the room, pick you up, and with clenched teeth scream, "Stop crying!!!" The good news is when you reached nine months of age your mother went to see her doctor and got the help she needed to regulate. Since autobiographical memory does not usually develop until around age two, from the time you can remember, she was a terrific mother, providing delight

and regulation and meeting your needs from that point forward. Fast-forward 40 years, and you are married, and it is your job to put out the trash on Tuesday mornings. Your wife comes home and says in frustration, with her teeth clenched, "Why didn't you take out the trash?" You are awash in fear and feel as if you have been attacked. You may have no awareness that what you are experiencing is an implicit memory, but it is impacting your relationship in the here and now. I encourage both children and their parents to pay attention to any moments in daily life when they tend to significantly overreact or greatly underreact to a situation happening in real time, as these can give us hints to unintegrated implicit memories that may need exploration. Preverbal implicit memories can be restored and consolidated through play (Badenoch & Kestly, 2015). I have had fascinating cases in which I sit with a tearful mother who tells me in great detail about the traumatic experience of her child's birth. She verifies that she has never told the child the story in the graphic detail she just told it to me, but the child then comes into the playroom and acts out almost identically in play what the mother had described, seeming to be playing out for me the somatic encoding of their birth experience.

Another example of a child communicating his implicit memories of abuse through posttraumatic play was given to me by Danny. Danny was four years old at the time he came to therapy. He had been sexually abused by his mother's boyfriend. When he first entered my playroom, he went directly over to the brand new, extra-large dinosaur I had recently added to my collection. The dinosaur was made in two pieces, and he unscrewed the front of the dinosaur from his tail. The creature now had a gaping hole in his backside. Danny went over to the play kitchen and got the eggbeaters and began to shove them rhythmically into the hole in the backside of the dinosaur, making sexual grunting noises as he did so. I do not believe this behavior was a conscious telling, but rather an implicit reenactment. During a subsequent session, he began to scribble on a large sheet of paper. I asked him to tell me about his drawing. He said, "This is what Daddy did," and he began to jam the marker into the paper, making grunting noises again. Both of these expressions were examples of penetration play, the first an expression of implicit memory and the second a more conscious attempt to communicate the hurtful acts to me.

Nurture House: An Unexpected Neurochemical Boxing Ring

Everything about Nurture House is based on our most current understanding of the intersection of the neurobiology of trauma and the neurobiology of play. From the way the space is designed to the tools of play offered within to the play therapist's ways of relating, all aspects of the environment are crafted to increase the release of healing neurochemicals in doses that will be effective for individual children who are recovering from trauma. At any given time, as you come into Nurture House, you will hear laughter and see high fives, and you will see children eating, drinking, jumping, and playing—playing for their lives. The secret drama unfolding beneath all of this is an epic neurochemical

boxing match in which stress hormones and feel good hormones are vying for primacy, and play gives the joy hormones a leg up. I would encourage you to visit www.nurturehouse.org and watch the introductory video or spend some time with the gallery of images. Chapters 3 and 4 will give you a sense of the trauma-informed choices for the design of the physical space and how the offerings at Nurture House answer those lower brain region questions "am I safe?" and "am I loved?" with resounding yeses.

The hypothalamic-pituitary-adrenal (HPA) axis is intimately involved in the stress response and is a mediating pathway for the release of the stress hormone cortisol. People who have experienced persistent or overwhelming trauma have large amounts of cortisol coursing through their bloodstreams. Cortisol is the stress hormone that in small amounts might motivate us to get out of bed to get to a meeting on time, but when an overwhelmingly terrifying event occurs, it is released in massive amounts and becomes toxic to our bodies and minds. The hippocampus, a brain structure important in memory and emotion, reads cortisol levels and can help modulate them (Gilkerson, 1998). The real problem is that continually high levels of cortisol can lead to cell death and are implicated in hippocampal volume loss in traumatized children and adults (Schmidt, 2007). Cortisol is hard to miss: it looks like the figure pictured below (see Figure 2.1).

This child (OK, he is my son) has just experienced a massive cortisol dump due to this shiny, freaky hat that someone (OK, me) put on his head, thinking it would make for an adorable Halloween costume. The hat was short-lived, but during the time it was on his head, his normal bright-eyed, inquisitive, playful nature was shut down. Cortisol dumps shut down our play system lightning fast. We all experience occasional cortisol dumps, but in children who live under ongoing conditions of threat, cortisol is released daily in almost inverse proportions to the typical population. Most of us wake up with our cortisol at the highest levels it will be all day. This helps us get out of bed, motivates us to face whatever is ahead of us, and slowly lessens throughout the day. Cortisol is at its lowest concentration for most people in the evening, making it easier for us to slip off into sleep. For children who have experienced significant maltreatment or neglect, their cortisol is lowest in the mornings (making it difficult for them to wake up and get motivated for the day) and highest at night (making for knock-down, drag-out bedtime battles in which the child is insisting they are not tired because on one level they are the most alert—or, arguably, hyperaroused—they have been all day). We know that excessive cortisol suppresses our immune system, is implicated in all sorts of gut issues, and can further cause dysfunction of the hippocampus (McEwen & Magarinos, 2004; Shin et al., 2004).

If the above picture represents cortisol, then Figure 2.2 represents its antidote, oxytocin, often called the bonding or calming chemical (Uvnäs-Moberg & Francis, 2003) (see Figure 2.2).

Antidote may be too strong a word, but it makes for an easy way for parents to keep priorities ordered when co-regulating an upset child. Oxytocin is released in the brains of both mom and baby during nursing in order to knit

Figure 2.1 Cortisol Dump

Figure 2.2 Oxytocin Antidote

them closer together. We want as much of it as we can get on board while we are healing from trauma. Fortunately, nursing is not the only way to get it. This same neurochemical can be stimulated through humor. It can also be released through other forms of nurturing touch. In fact, touch in the form of infant massage has led to clear decreases in infant cortisol (Acolet et al., 1993). Finally, oxytocin can be released through play.

When we are in a state of play, engaged in spontaneous, joyful interaction, dopamine, sometimes called the "joy" chemical, is also released in our brains, so play helps us combat terror with joy. Playing comes naturally to most children, and therefore most feel competent as players and receive dopamine releases when they have a mastery experience in play, e.g., getting a ball through a hoop, painting a pleasing picture, climbing to the top of the monkey bars. When the competency experience (dopamine release) is witnessed and delighted in by an important attachment figure (oxytocin release), an opioid effect is provided for the traumatized child.

Play serves many functions, but in terms of expanding our window of tolerance, it may hold powerful keys. Stuart Brown argues in his book *Play: How It Shapes the Brain, Opens the Imagination, and Invigorates the Soul* that play uniquely positions us to be able to handle the unexpected. The unexpected is always accompanied by stress, so if we can use play to expand our ability to tolerate the unexpected, is it not likely that play in a larger sense helps us

expand our window of tolerance for stress? For many children who have experienced neglect or maltreatment, their sympathetic and parasympathetic nervous systems are often strangers to one another, meaning they tend to move quickly out of an optimal arousal window (Ogden et al., 2006) into either hyperarousal or hypoarousal. They may spin wildly out of control, punching, hitting, screaming, and kicking, or collapse in on themselves, turtling up and becoming withdrawn, dissociative, or even catatonic. We see these reactions play out in the playroom often in children who engage in mighty sword fights with me, die, and, after a period of time experiencing what that feels like, come back to life and seem to be processing, through their play, what Stephen Porges would call the mobilization and immobilization responses of the vagus nerve. I sometimes see myself as a greeter for the dysregulated child, helping the sympathetic and parasympathetic responses say hello to each other and learn to live together in more harmony.

Play and the Social Engagement System

Many trauma survivors, including the children we serve, carry great shame at what they perceive to be their body's betrayal when a trauma reaction is triggered. It can help children to understand, in developmentally appropriate terms, that our trauma reactions are based on the evolution of our autonomic nervous system. Our nervous system is constantly assessing risk, and a *neuroception of safety*, a phrase coined by Stephen Porges, the creator of polyvagal theory, must be present in order for our social engagement system to do its job. Porges' term *neuroception* was a nod toward honoring the involuntary nature of our responses in the face of threat. It is neither conscious awareness nor cognitive perception, but rather a viscerally felt sense of safety. Understanding that this felt safety is the foundational neuro-scaffolding for change supports the enhancement of safety and security as the first and continual goal of TraumaPlay™. Panksepp and Biven (2012) offer a similar idea around the spontaneous activation of the play circuit that occurs when a child is experiencing safety. Understanding that when this felt sense of safety is missing we may respond in highly specialized and self-protective ways can give our clients permission to accept the polarity of responses they may have experienced when danger signals were present. Porges compares our nervous system to a TSA agent doing a body scan of every person who comes near. This process by which we viscerally assess risk and assure ourselves that we are safe enough to engage socially becomes the primary goal when beginning work with a traumatized child or family system.

Porges' theory is based on research tracking evolutionary shifts in the vertebrate autonomic nervous system (ANS). He explains that as vertebrates evolved into social groups, the aggressive and defensive subsystems of our ANS needed to be downregulated in order for spontaneous social behavior to evolve. One form of spontaneous social behavior is the subject of this book: play. Porges talks about the dueling processes of excitation and inhibition that

are always ready to play their part and can be honed in large part through the social environment. The social environment of choice for play therapists is, of course, play. Porges endorses play as a neural exercise that shifts affective states within a safe context (Devereaux, 2017). There are many moments of play that are exciting, and as children become excited, we offer them reflection, matching, and modulation—all supported by the attachment relationship. Collapse, or death-feigning, is a phenomenon that all seasoned therapists has seen played out at different times in the playroom. In play therapy, players (either the therapist or client) literally collapse in defeat or death and withdraw into immobilization as they hide in stillness inside a play tent or puppet theater or use a turtle or snail puppet to play out complete withdrawal from those around them.

Porges' study of the phylogeny of the vagus nerve resulted in the identification of three phylogenetically distinct systems: the social engagement system (a uniquely mammalian system) and two defense systems that hearken back to our vertebrate days—the mobilization system and the immobilization system. The three circuits are organized hierarchically, and when we are in a state of felt safety (including a state of play), our myelinated mammalian vagal pathway is in charge, regulating and keeping our heart beating in a more steady rhythm, modulating the HPA axis, minimizing our fight or flight response, and generally bringing us a sense of wellness and literally allowing our bodies to heal by inhibiting our immune reactions (Porges, 2009).

The most fascinating aspect of polyvagal theory, for those of us who place a core value on the attachment relationship and the co-regulation functions humans provide for one another, is that this mammalian myelinated vagus is intimately connected to the muscles of the face and inner ear. What have we always done intuitively to create safety and connection with our little ones? A soft, loving eye gaze, a delighted facial expression, and prosody that includes a nurturing tone of voice become powerful ways in which to bring another person back to a state of calm. Conversely, an overly intense eye gaze, a disapproving facial expression, or a harsh tone of voice can inadvertently cause a "takeover" of the older vertebrate fight or flight (mobilization) system or the death-feigning (immobilization) system. Misusing our tone, eye contact, or facial expression can cause these defense systems to become activated. In play therapy, an attuned reflection of anger or anxiety can build the child's sense of feeling felt, where as expressing these emotions in a way that seems to genuinely emanate from the therapist may actually move that client further into a state of dysregulation. Co-regulation by play therapists does not mean embodying the anger, anxiety, etc., of the child but modulating it by holding the space and understanding our role in keeping the social engagement system activated, consequently keeping the client within his window of tolerance for continued work.

We see then that excitatory pathways and inhibitory pathways are both available to us, and when the children in our care become dysregulated, we can read their physical cues more effectively and provide the right kind and

amount of co-regulation more intentionally. This content is a critical part of the paradigm shift that often needs to occur in the parents and teachers of dysregulated children. When I am working with children who have their mobilization system activated frequently, I will work with caregivers on more preventative measures, exploring the conditions that help this child remain in their optimal arousal zone and remain socially engaged. For many children who come from hard places, their sensory systems have been compromised in ways that wire them to be sensory seeking or sensory defensive, so one of the primary treatment goals for these children becomes helping them learn to regulate their own physiology, their own autonomic responses, helping them develop an internal capacity to create a sense of being safe. We will return to this concept in the chapter on need meeting and sensory integration.

It is critical at these times, when children may be moving from a state of hyperarousal to a state of hypoarousal or collapse, for the play therapist to continue to have a duality of being, remaining an anchor and a secure base as the child explores these polarities. The play therapist remains a holding presence, an anchor, and a reflector in a way that is always providing feedback and helping shape the traumatized child's ANS toward the middle of this arousal continuum. Skilled play therapists are able to enter into role play with children in a way that helps them feel felt and that matches their intensity with a duality that maintains a readiness to modulate the child's arousal level as needed.

Implications for Play Therapy With Traumatized Children

Much research exists to promote the idea that the most effective way to regulate a child's arousal system, particularly when limbic calming is needed, is within their safe relationship with a regulating adult (Perry, 2009; Schore, 2001; Siegel, 2012; Sroufe, Coffino, & Carlson, 2010).

Porges proposes that the vagus nerve offers unconscious mediation of our autonomic nervous system through our social engagement system. The good news is that we can become co-regulators for one another and use our own powerful presence, accessing the social engagement system, to co-regulate the child, parent, or dyad who is with us. Polyvagal theory becomes a powerful argument for the foundational importance of the play therapist as the main agent of change in the room—we literally co-regulate the child in our care through our tone, gestures, and limbic resonance. As such, there is great hope in the use of the play therapist's self to create a feeling of safety. Our presence and the way we use it become the most powerful predictors of state change in the child in our care.

Porges' definition of play is very much in line with that of play therapists. For it to be useful in terms of practicing neuroregulation, play requires reciprocal and synchronous interactions using the social engagement system as a "regulator" of mobilization behavior (e.g., fight/flight). This definition of play may differ from the world in which play is used to describe interactions between an individual with a toy or computer. "Play with a toy or computer

lacks face-to-face interaction and will not 'exercise' the social engagement system as a regulator of the neural circuits that foster fight/flight behaviors" (Porges, 2015, p. 5). Porges states in an earlier work that over time, "a face-heart connection evolved with emergent properties of a social engagement system that would enable social interactions to regulate visceral states" (2009, p. 1). What this means is that each of us is at all times a powerful influence on those around us.

Feeling Felt and Countertransference

The groundbreaking discovery of mirror neurons informs our understanding that increased neurobiological resonance between a client and a TraumaPlay™ therapist is possible. TraumaPlay™ therapists reflect in an attuned way the feelings and emotional expressions we observe in the child. The keys here are attunement and reflection of what we are perceiving in real time. This allows for clients to feel felt and can lead to powerful corrective experiences for the people in our care. However, TraumaPlay™ therapists always keep the awareness of our own countertransference—that is, all the thoughts, feelings, behaviors, and experience (and its somatic encoding), side by side with our attuned responses. Perfect neurobiological resonance is impossible and believing that we can achieve it would be dangerous. It leaves no room for reflection on the anxiety that may be pervasive for a beginning clinician and could easily be misconstrued as the child's anxiety. The clinician could be perceiving anger as emanating from the child in the playroom when the anger being experienced by the therapist may be a carryover from the fight with a family member the night before. Intrapersonal influences of a therapist's moment-to-moment experience of the child in the playroom may even include the simple visceral overload of having had bad pizza before the session. In a system of belief that our neurobiological presence can be thoroughly felt by another, these dimensions have no room. An amplification of a child's dysregulated presence in the playroom by the therapist who believes they are matching the child may leave the child feeling there is no anchor in the room. All of our interactions must be based on a working hypothesis that we gently test out, while always remaining grounded in an understanding that we may have gotten it wrong and will need to switch gears therapeutically.

Conclusion

Every time I enter a session with a traumatized child, it helps me to remember the neurochemical boxing match that is happening at all times. This visual imagery takes the very complex ideas surrounding the neurobiology of trauma and the neurobiology of play back to the very simple understanding that my internal calm, my attunement, my smiles, my delight, my offerings of ways out, my containment of hard content, and my continual reading of the client's somatic cues help me lower cortisol and increase oxytocin. As I use all

of myself as a safe boss, I become the kind of brain-to-brain regulator Schore (1996) talked about—and so can you.

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3 Need Meeting to Enhance Regulation

Feeding, Touch, and Sensory Integration

Our case conceptualizations for traumatized children need to begin with a respect for the importance of meeting basic needs and an understanding of dysregulation as an outgrowth of brain and body trauma storage. Dynamics specific to the trauma content—the story of what happened—cannot be addressed until the physiology has been soothed and the family has learned some tools for regulation. Fundamental forms of regulation embodied in hydration, nutrition, and sensory input (Purvis, Cross, & Sunshine, 2007) are sometimes ignored or minimized, when these forms of need meeting can be powerful vehicles for building trust in nurturing caregivers. This chapter will explore how externalizing symptoms of trauma, including behaviors that caregivers find difficult to manage, can be indicators of unmet needs, and that attempting to "give yes" to these unmet needs is a critical part of enhancing felt safety. We will focus on the ways in which meeting children's physical needs builds felt safety.

Reading cues appropriately and finding nurturing, playful ways to meet these needs throughout trauma work can lead to faster resolution of symptoms. When a traumatized child seems resistant to being cared for directly, they will often choose a self-object of some sort and then watch very carefully how the therapist cares for the self-object. For example, Cindy, a five-year-old girl who has deep attachment injuries from years of neglect, chose a baby doll and gave voice to it, saying, "Wah!!! I'm hungry!!! My tummy hurts!!" Cindy looked at me, waiting for my response. If we zoom out from this interaction for a moment, we realize that the play therapist has choices here. One choice would be to simply reflect the content of her play and validate the baby's voice: "The baby's tummy hurts because he's hungry." Another choice would be to enter the pretend scenario with the baby doll, saying, "Oh no, baby! I'm sorry your tummy hurts! Let me get you a bottle, and we can feed you." A third option would be to say to Cindy, "I'm worried about this baby. I wonder if it would be OK for me to feed her." Cindy might then let me know how she would like me to handle this baby's expressed need. This child may be waiting to see if the therapist will meet the expressed need of the baby doll. As a child watches the therapist nurture the self-object, trust is put in the tank that this grown-up is a safe boss.

Titration of nurturing care experiences respects the child's previous experiences while building trust in the therapeutic relationship. As the child watches how the clinician cares for the identified self-objects or vulnerable creatures in the play, they develop expectations of nurturing care from the therapist. Sometimes, in the midst of providing care for self-objects, a child is able to share a new glimpse of their trauma history with us. Miles is a good example of this. Miles was 11 at the time he came to see me. He had spent the first five years of his life in neglect and maltreatment, enduring sexual abuse by several men who paraded through his mom's home. One day, after he had been seeing me for about three months, Miles came into the playroom and said, "I want to wash the babies." This was a brand new request, as he had never expressed interest in the baby dolls before, so I knew it was important for him.

I got down the tub, which he filled with warm water and dish soap. He got a baby doll for each of us, instructed me to undress my baby doll as he undressed his, and then began to wash the head of his baby doll. I imitated his play, washing the head of the baby doll in my arms. As he washed the head of his baby doll, and while his eyes were focused intently on the circular movements of his hands as he washed his baby's head, he said, "My momma used to shove my face in my baby brother's shit diaper." His eyes remained trained on his baby, and he continued to wash its head. I said, "That sounds like a really important part of your story. Thank you for sharing it with me." I believe so strongly in the glimpses and snapshots that children gift us with along the way—and in the power of holding the glimpse together for a moment—that I keep sticky note pads all around the office. I pulled out a sticky note pad and began to write slowly while I spoke slowly out loud: "My momma used to stick . . ." Miles interrupted me: "Shove!" I looked up from the writing/speaking and said, "Oh, buddy, thank you for correcting me. Shove is different than stick." In all the times I have used this approach to extend the moment of holding the story together, I have never had a child cover their ears and not want to hear it repeated. They all come around behind me and watch over my shoulder as I write. They want to make sure I get it right. This exercise extends the moment of holding just a little, and I am careful not to stick with it beyond the child's window of tolerance for looking at it. It becomes a slightly prolonged moment of exposure work. The communication becomes, "I see what you're showing me, and we can stick together in it as you show me." I firmly believe that Miles was only able to tell me about this terribly humiliating, shaming experience because he was actively washing the self-object. Just the act of taking care in play can mitigate the approach to difficult content.

When a child has experienced early neglect, in utero threats, or early trauma, the brain stem may become dysregulated in ways that manifest later as elevated heart rate, difficulty with prolonged attention, sensory integration issues (sometimes sensory seeking or sensory defensive or a combination of the two) (Kranowitz, 2005), or abnormalities in appetite (Neigh, Gillespie, & Nemeroff, 2009; Perry, 2006; van der Kolk, 2015. The importance of providing integrative sensory experiences for children with differences in their needs

for proprioceptive and vestibular input will also be described here and will set the stage for some of the practical interventions discussed in the next chapter.

Need Meeting: It's Never Too Late for Nurture

The need for nurture never diminishes, although the easily discernible signs that a young person needs nurture may diminish as they grow. Teenagers exist in a very uncomfortable space where their bodies are often more adult than their brains, and even healthy teens can miscue parents that they are independent and not in need of nurture. When teenagers have experienced trauma, it can be even more difficult to recognize their underlying needs for nurture and connection, as they will often respond with a bid for independence that in many teens would be age appropriate but may keep the traumatized teen in a place of isolation and fear. That is why, at Nurture House, we place a high value on being able to use your words to ask for what you need. Even if it is not asked for, I will often offer nurture, assuming it will be received. If it is not received, I will have learned something about the teen in my care. In my experience, when it is received, I see my nurturing engagement open the door to that teenager's real connection with me—and often to underlying vulnerabilities that can be held.

Regulating Body Temperature

If I am meeting with families at Nurture House and another nurturer has turned up the air conditioning, I will begin to find the cold painfully distracting. Sometimes I use these moments to model being attuned to my somatic experience and say, "I'm feeling really cold, and it is keeping me from being able to concentrate on you. I think I need a blanket." I will grab one (we have two in every room of Nurture House) and wrap it around myself. Then I will inquire as to whether the other person or people are chilly and in need of a blanket. This offers just a moment, a titrated stillness of somatic focus, to check in with themselves about whether they are having an uncomfortable experience of being cold. Providing warmth to someone who is cold has always been an expression of need meeting.

Since one of the systems regulated by the brain stem is body temperature, children who had in utero threats to their developing brain stem (drugs, alcohol, excessive cortisol releases) may have impairments in their ability to regulate their temperature and may have an overactive or underactive feedback loop regarding body temperature. These are the children who are running on the playground, red-faced and sweaty, on a hot, humid summer day and are not being signaled by their brains that they need to cool off. These children may also keep their coats on in a warm room until they are invited to take them off because their bodies are not giving them signals that their body temperature is rising. I will sometimes take stones that look almost identical, place one in the refrigerator and one in the sun outside, and then have the client

experiment by holding each of the stones and noticing what communication their hand is sending their brain about the stones.

Nadine, a 16-year-old young woman, was referred to me after years of managing an eating disorder. She had run the gamut of services: residential treatment out West, intensive outpatient programs locally, dietitians, nutritionists, therapists. She had also tried acupuncture and yoga but continued to feel disconnected from the world and to have great difficulty coexisting with family members. When she came to me, she was therapy weary (and wary) and knew all the lingo. She came up to the loft of Nurture House with me, sat down, and began to recite her diagnoses and treatment history. The feeling I had was that she had distanced herself from her own experience—she could play the game of therapy and talk the talk, but she kept the real child locked up tight inside the teenage persona.

At one point, while she was giving a litany of her previous treatment, she shivered absentmindedly. I immediately said, "Oh, your body just let me know you might be cold. Let me get you a blanket." I leapt up fast enough that she had very little time to react, and I grabbed an extra soft cream-colored throw, wrapped it around her, and—as I was leaning in to tuck in the edges—noticed her really cool hair color. I commented on it with delight and briefly touched the edges of her hair, wondering out loud if that hair color might work for me. You would have thought I switched on a lamp. From that moment on, that moment of caretaking, of meeting a basic physical need, one that she most likely would not have mentioned or asked for help in rectifying, she was like a different child. I use the word *child*, as opposed to referring to the beautiful 16-year-old she was chronologically, because in meeting those basic needs for her, I ended up meeting the younger version of her, the "self" buried under all the diagnoses and interventions. I liked what I saw—and eventually so did she.

We are never too old for nurture. Robby taught me this lesson when I was just beginning my work in disaster relief settings. Robby was 16 years old when his family was displaced from their home in the wake of Hurricane Katrina. I was three years out from my graduate training and had been to my first Theraplay training. I was using the model regularly in my work with children in the therapeutic preschool where I worked. I had been through disaster relief training for mental health professionals with the Red Cross a year earlier, and I was called when masses of displaced families arrived in Nashville for emergency services. They asked me if I would come and run a group for the children in the temporary housing shelter. Although I was unsure what to expect, I said yes, and when I showed up in the large parking lot taken over with triage tents and asked where I was to run the group, they pointed me toward the abandoned office building that was to serve as a temporary housing shelter for these families. On the second floor, I set up my supplies as children began to straggle in. Their parents were busy filling out FEMA forms, and I was the only adult available. I ended up with a group of about 13 children ranging in age from three to 16 years old. Robby, at 16, was the oldest youth there and already had the stature and muscles of a grown man. We made introductions,

played connecting and regulating games, and generally had a good time. At the end of the group meeting, I introduced the rock-the-blanket exercise, a game I had learned during my Theraplay training. To do this exercise, you simply put a blanket on the ground and have a child lie in the middle of it, and then two people pick up the ends of the blanket and rock the child back and forth while singing. I always sing a song to the tune of Frere Jacques that goes like this: "You are safe here, you are safe here, yes you are, yes you are."

I laid out the blanket, and while I was laying it out, Robby saw the predicament I was in: there was no other equally strong person to hold the other side. He jumped up and said, "I can help!" I was admittedly relieved. Disaster work is particularly challenging because you never know what you are going to get. Best practice standards for group work would discourage the idea of a group this large being run by one adult only. In a clinic setting, we might also frown on a group covering such a wide age range. The phrase from the book series Pinkalicious always guides me in times and places where I am trying to provide clinical care but may not have a best practice environment: "You get what you get and you don't get upset."

We began the rocking game with a little three-year-old named Trina. We rocked her in the blanket while singing, "You are safe here, you are safe here . . ." We made our way up the age chain from three-year-olds to eight-year-olds and finally to the 14-year-old girl, and rocked all of them in the blanket. When we had rocked the last of them, I went to lay down the edges of the blanket on my end. While Robby was laying down the edges of his side of the blanket, he said very quietly, "Can I have a turn?" I caught his eyes and said, "Absolutely. We will make that happen." I finished group with the other children and asked Robby to stay for a moment. I went and got another staff person, and we rocked Robby in the blanket. We are never too old to need rocking, to need holding. Thank you, Robby, for teaching me this profound truth.

Conversations About Care: *What Do They Need?*

Inviting conversations about caretaking of others can serve two purposes with clients: I can begin to get a sense of the child's core beliefs—do they believe that children, animals, and baby plants should have specialized care? What are the child's *shoulds*? Should vulnerable, young, or small living things be taken care of differently than big things? If so, do they deserve to be taken care of in those ways? These conversations can be difficult, and play therapy can help. Creating environments for miniatures or Beanie Babies—simply offering a child a large shoebox, asking them to choose a Beanie Baby from among several choices, and then asking them to create an environment from lots of creative supplies that will give that creature the environment it needs to thrive—can playfully mitigate an approach to this content. I was first exposed to this intervention while training in Trust-Based Relational Intervention (TBRI) (Purvis, Cross, Dansereau, & Parris, 2013) and used it individually

with lots of children but had the most powerful results during Camp Nurture. I brought in a large amount of wet clay and several miniatures from the sandtray room: horses, puppies, dragons, and dolphins. Campers paired up, chose a miniature, and then created the environment that creature needed to grow. The horses needed lots of room but also fences to keep them safe. Out of this came some powerful conversations about boundary setting and safe bosses. The dolphins needed the open ocean, but also other dolphins, in order to thrive. Out of this came powerful conversations about our need for community, friends, and others who understand what we need.

I love to use a version of this intervention in self-care work with our team. I ask each clinician to create a symbol for an anxiety that he or she is carrying. We place all the anxieties into a container, and then each clinician chooses one symbol (not their own) to work with. That clinician creates an environment of soothing for the symbol. It is only after this has been done that the creator of the environment pairs up with the person who created the symbol. Clinicians are deeply touched simply having someone "take care" of their anxiety, and the cross-hemispheric intervention often opens up new possibilities for managing the anxiety in new and soothing ways that the original symbol maker may not have been able to access alone.

Potted plants and healing gardens can open up similar conversations about what these living things need to grow. At Christmas this year, I had a client bring me an indoor bulb planting set. It sat on the kitchen counter for a couple of days, and then Jake, a seven-year-old client who had been adopted at birth but dealt with lots of anxiety and sensory processing issues, asked, "Why do you have a bucket of dirt?" Our conversation is below:

ME: Well, it's supposed to grow a plant, but I haven't opened it yet.

JAKE: Can we open it?

ME: Sure. I've never done one of these, but I think you plant the bulb in the bucket and it grows inside.

JAKE: Not outside? At school we learned plants need soil, water, and sun. How will it get all that inside?

ME: Good question. The directions say to fill the pot three-quarters of the way full with dirt.

JAKE: There has to be some in the bottom. [*He began filling the pot with dirt.*] There's more dirt than I thought [*when he got the level right*].

ME: There is a lot in there. It's like a bed so that there's a place for the roots to grow.

JAKE: Well, it's bigger than I thought [*picking up the big bulb*]. No wonder it needs so much dirt. It needs more room.

I felt like here we began talking on two levels, although we kept the conversation all about the plant.

ME: Yes, sometimes the bulb has to rest there for a while before the roots even begin to grow.

JAKE: Well, do we just lay it in there [*getting back to the task at hand*]?

ME: Place it on the dirt and loosely cover it with the moss [*reading aloud, quoting the directions*].

Jake carefully placed the bulb on the dirt, picked up the moss, and began placing it on top. In truth, it looked to both of us like there was not enough moss to really cover it. When we had placed all the moss, Jake said, "Where's the rest of it?"

ME: It looks like there should be more, but that's all there is.

JAKE: Well, how will it grow? It is not covered.

ME: Yes, it does feel like it's kind of exposed, but we've followed the directions and used everything that came with the plant. The directions say to add water now.

JAKE: It won't be hidden.

ME: Seems like you are worried about it being uncovered.

JAKE: Well, plants push up, right? This one won't have anything to push through, so maybe it'll grow faster.

The parallel between this statement and some of his current struggles was profound. His fear of whether his family would keep him even if he didn't perform well often led him to cover up the "real child" in lots of big behaviors or to retreat into himself, hiding his big feelings from everyone. He would ping-pong back and forth in a way that often led to big behaviors and dysregulated meltdowns. The realization that the plant might be able to grow faster with less struggle, as it had fewer layers of covering, represented a potentially profound shift in his ability to come out of hiding and struggle less in his environment. We watered the plant together.

JAKE: What's next?

ME: The directions say to put it in indirect sunlight.

JAKE: What does that mean?

ME: I think it means not in bright, hot sunlight but kind of off to the side so it can absorb light without the light being too intense for it.

JAKE: I know where. [*He put his hand in the shaft of light coming through the kitchen window.*] That's too hot. I'll put it just over here.

I was a little anxious about whether the plant would grow, but a green stalk began to appear within a couple of days. When Jake returned for his next appointment, the plant had grown up, surprising both of us with how much it had grown in such a short period of time. He said, "See? I knew it would grow faster 'cause it didn't have so much stuff on top of it" (see Figure 3.1).

Sensory Savvy Safe Bosses

Children with chronic trauma in their history often have sensory differences that must be respected, and needs arising from these differences must be met for trust to be adequately built with their caregivers. While the differences in the way these children experience the world are more clearly understood than ever, our behavioral science traditions continue to inform how these children

Figure 3.1 The Plant in Full Bloom

get treated in families and classrooms until a different way is learned. Helping parents and teachers understand the sensory seeking or sensory defensive leanings of their children and helping them meet the needs that arise from these leanings is foundational for the rest of our trauma work at Nurture House. In American culture, we have been taught to see smaller amounts of dysregulation—a child who is tapping their pencil repeatedly, a child who is

rocking back and forth in their chair or jiggling their leg up and down—as behaviors to be ignored, the idea being that as you ignore the behavior it moves to extinction. However, for many of the traumatized children we see at Nurture House, their bodies are actually trying to give the child and their caregivers valuable information about what they need. When children come in with sensory dysregulation, the therapist joins the parents and child in being detectives, attempting, with deep curiosity, to figure out what the child's body is saying it needs. You will hear the phrase, "Your body is letting us know that . . ." many times a day at Nurture House.

Billy is a good example of how much connection and shift can occur when a client's bodily needs are being met. He was internationally adopted at age three and diagnosed with autism spectrum disorder by age four. I met him when he had just been asked to leave a public school environment because of "acting out behavior." The teacher in question had been trying to give individualized attention to Billy for most of the year and was exhausted and resentful at the amount of time his needs required. She saw him as defiant and unteachable. When I asked Billy's mom what she thought had been the final straw, she explained that on his final day of school, the teacher had told everyone to line up for recess. However, instead of lining up, Billy hid underneath his desk. The teacher asked him to come out, and Billy shrank further under his desk. She spoke sharply to him, saying that if he did not come out from underneath the desk *right now* he would lose his trip to the library that week. Now, Billy was having such a miserable time at school that the only activity that brought him solace was library time, as he could delve into a book for half an hour and not have to interact with others. The teacher's withholding of this privilege at a time when his amygdala was already armed caused him to upset the desk and run out of the room.

What would have happened if, instead of perceiving the behavior as defiant, the teacher had seen it as a valuable indicator of what his body needed right then? What if she had been able to say, "Oh, buddy, your body is letting me know you need a small, quiet space right now. How clever of you to know what you need." I have recently worked with an amazing principal in town who understood the sensory needs of children like Billy so well that she had cleared out one of the built-in cabinets in her office specifically so that escalated children could curl up in there and regroup before she tried to engage them, regulating the reptilian brain stem before attempting to engage in any cognitive exchange.

One day early on in our sessions together, Billy and his mom were in the kitchen with me. When I had greeted them in the lobby, I had offered Billy a variety of snacks, and he had chosen Cheetos. He had chomped through all his Cheetos, licked his fingers, and begun chewing on his shirt and hands. Billy's mom was sharing a story with me around a recent moment in which she and Billy had had a playful, connected mother-son date. She interrupted herself several times to gently touch his hand and say, "Stop putting your hands in your mouth, Billy." She was pleasant and kind in her tone, and Billy

would take his hands out for a moment, but they would migrate back to his mouth quickly. The third time his mom stopped to correct him, I intervened, saying, "I too am noticing that Billy is putting his fingers in his mouth over and over again." I made eye contact with Billy and said, "Buddy, it looks like your body is saying, 'I need to chew on something—I need something in my mouth!' Is that what your body is saying?" Billy moved his eyes over to his mom but nodded. I said, "Well, here at Nurture House we love it when kids know what their bodies need and can show us. I have three options for you: you can suck on a lollipop, you can chew on a gumball, or you can have one of my pieces of chewelry." I proceeded to open a drawer in the kitchen and show his mom several kinds of chewelry. He chose the lollipop. Once he had unwrapped it and put it in his mouth, I said, "Now, since your mouth is busy with what it needs, the rest of your brain can stick with us." Billy's mom laughed out loud and said, "Oh my goodness, I can't tell you the number of times I have asked him to stop putting things in his mouth, but you're saying that maybe he needs to?" I explained what I believed to be some of Billy's sensory seeking behaviors, including his need for almost continual oral gratification. I thought it would be helpful for the family to create stress engines together.

The Alert Program (Williams & Shellenberger, 1996), a tool developed by an occupational therapist, teaches children how to become more attuned to their bodies, equating the child's current state of regulation with how slow or fast their engine is running. A personalized stress engine is created with the child and becomes a concrete tool for reflection on internal states. If you are in the blue zone, your engine is running too slow (this might occur during times of hypoarousal, and children are likely to be sluggish, grumpy, and slow to respond to prompting). The green zone is the just right zone, where you feel regulated and alert for new learning. When you are in the red zone, your engine is revving too fast. I asked Billy if his need to put stuff in his mouth felt more urgent when his engine was running too fast or too slow. His response was *both*, and we talked about how that was probably true for him. So we dug deeper, Billy, his mom, and I, wondering out loud what sorts of oral gratification needs he had when his engine was running too slow. He was able to discern that crunchy or sour things would be helpful in upregulating him at those times. He also began to see that sucking on something or chewing gum could be calming for his central nervous system when he was running too fast. This activity invites children and their parents to investigate what helps in each of the somatic states (see Figure 3.2). On the very first morning of Camp Nurture, we made stress engines for each child. Every two hours we checked in with the whole group about how their engines were running. It was through this repetition of mindful internal focus that the children began verbalizing when they needed to go to Crash and Bump and use their bodies and when they needed quiet, and even when they needed weight to be added to help them regulate (each child had their own weighted blanket, and weighted lap pads, ankle/wrist weights, and weighted vests were also available). Halfway

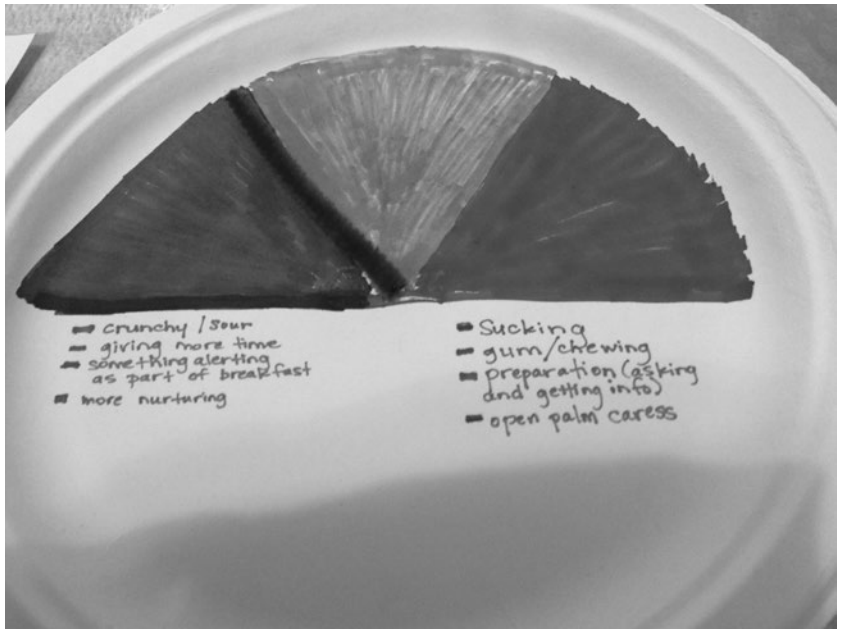

Figure 3.2 An Example Stress Engine With Articulated Strategies

through the session, Billy's mom joked that she could use one of these for herself, so we made one for her as well. I think we could all use one.

As we began to understand what Billy's body was telling us and began "giving yes" to the underlying needs, he became more connected and was able to take more risks in therapy. He was making great gains in his social relationships but was still having difficulty receiving nurture from his mom. We thought some work around the adoption would be helpful, but Billy became very shut down whenever we began work around this. One day toward the end of a session, in which he had had lots of child-led play, I brought out a book of one-page descriptions of amazing people who were adopted. He said, "I don't want to read it!" I replied, "I hear you. You don't like that book. You can choose what we play." He immediately began stacking three Big Joe chairs with nylon covers that slip around on each other. When stacked on top of one another, they reach a height of at least four feet. After he stacked them, he then scrambled up on top, somehow arranging himself so that he was able to maintain his equilibrium. As soon as he was settled on top, I said, "Wow! You are doing it. You are staying on top!" He grinned really big and said, "OK, give me the book." I gave it to him, and he sat on top and read a whole page out loud. Below is the picture he requested I take while he was reading the book perched on top of his pillow mountain (see Figure 3.3).

So what happened? What helped? I believe the intense exertion needed to wrestle those pillows into place and then scramble up on top of them and the

Figure 3.3 Kinesthetic Competence

continued engagement of Billy's core that was required to remain balanced up there gave him neurochemical competency surges—pleasurable experiences of mastery that mitigated his approach to the harder content related to adoption. While he was feeling strong, powerful, and in control of his created (if precariously balanced) world, he could choose to delve into content that made him uncomfortable. This is an example of expanding the child's window of tolerance for looking at hard things through mitigation. In this case, the mitigator is somatic mastery, or kinesthetic competence.

Sensory Static

We had several children at Camp Nurture who had never been able to successfully play with other children without hurting the other children or themselves.

When we met them, these children were isolated and socially impoverished. Each child was assigned a buddy and a "backup buddy," and as these buddies met needs, provided structure and nurture, and gave constant feedback (which required staying within three feet of the child at all times), the children began to change. The inward focus that is required by states of hyperarousal and collapse creates a kind of static that gets between the hurt child and the rest of the world, including potential friendships. When we are in a state of hyperarousal or collapse, we are unable to learn from our experiences.

The first level of feedback always had to do with what their bodies needed to remain regulated. On the first morning of camp, each child was given a backpack and went around the room to stations that each provided a regulation tool. Each child got chewelry, bubble gum, and lollipops. As we know that sucking can provide soothing to our reptilian brain stem, they also received a specific kind of water bottle that requires a stronger suck than others. It seemed that these children had so much sensory static they could not see clearly through it to be curious about the people around them. Peers were not seen as relational resources. As we met underlying needs and used ourselves as the external modem for each child, the static began to clear. We also diffused essential oils at camp. At Nurture House, we value the use of scents as a sensory portal for providing upregulation or downregulation. The olfactory bulb is the only part of the central nervous system that is exposed to the elements, so it is the fastest way in for a change of state. We brew coffee for parents who need both the smell and the caffeine to upregulate, and we keep diffusers in most of the rooms of Nurture House and diffuse essential oils (Johnson, 2015) Setzer, 2009) based on the regulation needs of individual children—and sometimes the regulation needs of a therapist. I tend to hit a downregulated slump in the middle of the afternoon and often diffuse lemongrass oil at that time in order to help upregulate myself so I can remain as fully present and engaged with my clients as possible for the rest of the afternoon. We often make "regulation lollipops" with children as we are helping them appreciate their own up- and downregulation needs. We begin with cotton balls and popsicle sticks and cover the cotton balls with small squares of fabric. Then we invite the client to explore all of our oils and choose the one that is most stimulating to them and the one that is most calming for them. We put drops of each on the lollipops, seal them in separate Ziploc baggies, and have the family practice using them as different regulation needs arise.

On the third morning of camp, Scott, one of our most dysregulated kiddos, asked for one of the "body socks" that had been made by one of our gifted buddies and completely enclosed himself in it. He wrestled around on the floor within a foot or two of his primary buddy for an extended period of time. Eventually, he pulled apart the Velcro sealing the two sides of the sack together at the top, and then spent considerable time and energy wiggling out of the sack. He did not ask for help, would not allow help, and spent great focused and sustained bursts of energy trying to free himself from the sack. His buddy described it to me as a live demonstration of a caterpillar coming

out of a chrysalis. It was after this point that he began asking another little boy to play with him. It was as if he noticed the other little boy for the very first time, as if a complete metamorphosis had to occur for him to become aware of the "other." The large, intentional, and constant doses of need meeting by the buddies had to become internalized and reshaped into an ability to connect with others. One of my life mantras is "you can only give what you have received." This little boy had to have enough nurture and need meeting offered to him in high enough doses to allow him to begin to look around. The buddies of both Scott and the little boy he asked to play were still both highly engaged and within three feet of the two boys at all times. There were multiple helps in interactions and multiple redos and compromises needed for the boys to begin socializing, but it was as if the awareness of the "other" was not even initially possible because first one had to cut through all the kinetic static of unmet early needs that circled around Scott.

The ability to develop a friendship requires a capacity for "other-centeredness," which arises from the development of a sense of self as separate from but connected to the "other." It also requires that one have assurance that basic needs will be met. I am reminded of Maslow's classic hierarchy of needs whenever I watch the evolution of children who have experienced attachment trauma. His iconic pyramid of needs placed physiological need meeting as the seminally important foundation for any further growth, followed by security, and then belonging. I believe that capacity for other-centeredness can be grown and involves being able to have a sense of self as secure and cared for.

In many cases, traumatized children do not have basic needs met consistently or are harmed by those who are supposed to care for them. Even when these children wind up with a caregiver who is meeting all their basic physical needs, they may still have the terrifying core question, will I have enough? This is why, at Camp Nurture, we always provided *more than enough*. Because a child's perception that the need has been met is critical to quieting the reptilian brain stem and regulating the limbic brain, having just enough of the needed item is often not sufficient—having backups and backups of backups is sometimes necessary. The fear of not having enough is experienced as an ongoing threat to survival and results in a preoccupation with the self. When they first come to treatment, adoptive parents are often bewildered about why their child "melts down" every time they "don't get their way." We validate and appropriately hold the parents' frustration, begin to offer appropriate psychoeducation, and gently support a shift in paradigm. Parents often use words like "manipulative," "selfish," "spoiled," or "demanding" when they first come to Nurture House and are attempting to paint the picture of their daily lives with their children. It is difficult to meet any need effectively when you feel you are being manipulated or believe what is being demanded is "too much" or unreasonable.

When I am supporting parents, I will explain that the neurophysiology of a traumatized child is such that anxiety, excitement, and aggression all balance on the head of a pin. In the blink of an eye, and through the neural confusion

of excitement and anxiety, a want becomes a need. Parents will often feel like they cannot win for losing. If they offer the potential of a trip to the toy store or the friendly possibility of a trip to the park, they may initially be rewarded by the flush of pleasure on their child's face but end up feeling held hostage to the child's demand for the thing or held captive by the child's anxiety about when, where, and how quickly they will get it. These children often need to be taught, with great patience and reflection by a safe boss, the difference between a want and a need. This teaching does not happen with words—or certainly not by words alone—but through the titrated experience of having needs met and exceeded. During the initial titrations of having needs met and exceeded, the parental presence is intentionally paired with the need meeting. We are attempting here to recapitulate the healthy attachment dance in which basic needs are lovingly paired with a safe boss. The relationship between a nursing infant and mother is the most powerful example of this natural association between physical need meeting and the nurturing connection with the "other." The baby's body is snuggled warmly against the mother, often accompanied by a loving eye gaze and playful interaction, while the physical hunger is satiated. Bottle feeding, too, is usually done in such a way that the baby is nestled in the crook of the mom or dad's arm while being fed. As the baby grows and starts eating solid foods, sweet circles of communication surrounding the eating evolve: the baby opens the mouth wide again after swallowing a bite, and the parent, picking up on the nonverbal cue and perhaps even giving voice to it—"you are letting me know you're ready for some more"—gives the baby another spoonful of food, rewarding both of them. When the baby is super hungry, it may be hard to wait, and the baby's window of tolerance is expanded while waiting for mom to spoon out more mashed bananas.

Satiation, or the sense of being truly full, is another way to characterize the neuroception of safety. In the natural feeding cycle of caregivers and infants, satiation, or fullness, is delivered through the relationship with the attachment figure, and eventually the food or the connection in the relationship fills them. I have been repeatedly struck by the profound nature of the trust established in these early feeding routines and the distrust established when a child did not get them. At Nurture House, we use a dyadic assessment that is partially informed by the Marschak Interaction Method (the assessment tool used in Theraplay) (Booth & Jernberg, 2010). One of the tasks directs the adult and child to feed each other. Watching the way adults and children navigate this task is fascinating. In families where a secure attachment exists between parent and child, they will often put food directly into one another's mouths. The parent sometimes finds great joy in this and replicates a game, such as airplane, that used to be played during feeding time during the child's first year. Other parents will elaborate on the task. On numerous occasions, I have watched a parent choose multi-flavored gummies and invite the child to play a game of "guess the flavor." This requires a great deal of trust, as the child closes his eyes, opens his mouth, and allows the parent to place a gummy inside. When

the task is navigated in this way, it often makes a powerful statement around the neuroception of safety shared between the parent and child.

In other dyads, and in many of the adoptive families I see, children will begin to make demands almost as soon as the task has been shared out loud. They may simply say, "I want to feed myself!" or they may grab the bag of crackers from the parent or play their own version of the game in which they get close to putting the food in the parent's mouth and then either jerk it away at the last minute or aggressively insert it. These ways of coping with the stress induced by a task that calls for intimacy and vulnerability can tell us a lot about the child's earlier experience and lack of trust that basic needs will be met. On the other hand, it is sometimes the parent who is unable to feed the child. The parent may cope with a task that calls for intimacy that exceeds the parent's current comfort level by encouraging the child to hold the bag themselves, buffering the potentially intimate eye contact that can occur during feeding by "noticing" something else in the room at the same time the feeding is occurring, precluding the extra layer of intimacy felt through eye contact, or by saying, "You don't want to be fed, you're a big boy now!" This idea that the older you are the less likely you are to be comfortable with this intimacy is not supported in my observations of healthy dyads. Many teens, when faced with this feeding task, will laugh and acknowledge the weirdness but then move right along and feed and be fed. Really attuned parents of teens will raise the challenge level for this task by having them toss food into each other's mouths from a distance. Regardless of how they navigate it, securely attached teens and their parents have fun with the task (there is usually a lot of giggling or joking) and do not find it difficult or frightening. An insecure attachment pattern, however, is often evidenced by the parent and child not being able to feed each other with ease and connection.

What starts as excitement about the potential for a new toy or a chosen food or a chosen activity can quickly morph into anxiety around whether they will get to have it. The discomfort of having an out-of-reach potential can trigger the wanting/needing response. This want/need pattern scratches at the thin layer of new neural experiences of safety—their tenuously developing neuroception of safety—as if it were a scab. If we extend the metaphor, what happens when the scab of safety is scratched? The core fear oozes up. In these cases, the question asked by the fear-infused core self is, will there be enough for me? The sandtray you see below was created as a first world by a ten-year-old girl who had been adopted from a very poor country where she had lived in one of the least resourced orphanages. I simply asked her to create a world in the sand (see Figure 3.4).

Notice that the tray is full to its edges with plates, bowls, and cups, and all of them are filled. None of them are empty. This overcompensation for the previous lack of resources is something we see frequently when children are beginning to try to answer the question of "will there be enough for me?" with new answers. Another example of the irrational perception of needing more, even when we have plenty in front of us, may aid our understanding. My fingers are hovering over the keys to delete the word "irrationality" as

Figure 3.4 Overflowing

I write it because it sounds "judgy," but it only sounds judgy because we, as a society, have judged rationality to be the ultimate goal of experience and have not fully understood and embraced the truth about how the triune brain functions. Within at least the recent American psychological tradition, the subjugation of needs, drives, emotions, and somatic experiencing to the neocortex and the executive functioning system has been, at the minimum, the implied goal of many evidence-based treatments. Respect for the work of lower brain regions and an appreciation for the importance of meeting the needs of lower brain regions are growing in trauma work. Perhaps it remains the overarching goal of mental health to have the lower brain regions deliver input to be interpreted by the higher brain regions, but in order for this to occur, we must agree that irrationality is not a dirty word. In fact, irrationality must be heard, must be explored, must be given a voice in order for regulation to occur. What if instead we reframed *irrationality* as *really good and important information about what our bodies are needing for physical/sensory regulation* (reptilian brain stem/diencephalon) and what our feeling brain needs for emotional balance in order to clear a path to our executive functioning potential.

Whenever I begin to wonder if meeting (and exceeding) the need serves any valuable purpose, I always think of Tasha. Tasha was a five-year-old who had been adopted from India at the age of two. Her orphanage experience was one in which she often had to scramble for rice that was dropped in a heap on the floor in the midst of a circle of hungry children. Her parents had to help

her learn how to use utensils when she came home. However, as her buddy and backup buddy met her needs in excess in repetition after repetition, she began to shift.

During the camp day, she was hyperkinetic, sometimes aggressive with other peers, and sometimes territorial. We included several snack times in the schedule at Camp Nurture, and children were always given a yes to getting food or drink between snack times if they simply used their good words to ask their buddies for what they needed. Each child had their own basket of approved snacks (because of allergy constraints), but each basket was heaped with food, and the whole basket was presented at snack time. The only exception to this was if we had learned that it was harder for the client to choose between offered snacks (in which case a narrower field of snacks that was not so overwhelming was offered). One morning, I decided to have a snack with Tasha and her two buddies. Tasha and her two buddies moved over to her snack spot, and her buddy picked up the snack basket and set it down on the floor (snack time was always a picnic affair). Tasha immediately demanded, "More Pirate's Booty!" I got down on both knees in front of her so that I was eye level with her and said, "You want more Pirate's Booty? Sounds like you feel like you *need* more Pirate's Booty." She locked eyes with me and nodded vigorously. I said, "You can ask me for anything, and I will listen." She said, "Can I have more Pirate's Booty?" I replied, "Absolutely!" and went and got two more mini bags of Pirate's Booty. I placed them on top of the one bag of Pirate's Booty that was already displayed on top of her basket of food, and she eyed the basket. Apparently, she decided it was "enough" now and sat down. She opened a bag and had two pieces of the cheesy snack, then gave one bag to her primary buddy and another to her backup buddy and offered me the rest of her bag. It was not about the food. The underlying need was not related to physical hunger. The need was to answer the question, "will there be enough?" with a resounding YES. As soon as she had her loud enough answer, the static cleared and she refocused on relationship, actually sharing the treasure with those who had been nurturing her most closely.

The picture below (see Figure 3.5) includes our offerings of water bottles, juice boxes, and snacks. Children can increase negative behavior when they are dehydrated. Some children's bodies may not communicate well to them that they are thirsty. Therefore, hydration is a core regulation need that we are always supporting at Nurture House. Offering choices of beverages, choices of snacks, and even a choice of which color gumball clients would like sets up opportunities for clients to practice using their voice and having it honored. These choices are also a way for us to share power with clients almost as soon as they enter the building.

We have recently added a third hydration option—a large water dispenser with a giant inverted water jug. I was delighted, just the other day, when I entered the lobby with my empty water bottle to refill it. There was a six-year-old child in the lobby, and he eagerly approached me and asked, "Are you going to fill that up?" I said, "Well, yes I am!" matching his enthusiasm. There is some coordination involved in positioning the bottle correctly to catch the stream of water, but once I had done that and pressed the lever,

Figure 3.5 Meeting Basic Needs: The Empowerment Principles

this six-year-old stood grinning ear to ear and staring at the giant bottle as it glugged and shot bubbles through the surface of the water. I caught his eye, and he started making the glugging noise the bottle was making out loud, matching the cadence of the actual glug. I joined in for the fun of it, and he and I had a moment of shared experience and connection, simply through his enjoyment of the rhythmic sounds of the water dispenser. I did not know this kid from Adam, but he taught me a new way to enjoy the lobby.

The Gum Guy

Joey was three years old when I met him. He teetered into the playroom on unbalanced legs with his "milk" backpack on his back. One of his first statements to me was "I do not eat by mouth." Joey has a very rare genetic disorder that combined with anxiety issues, spectrum symptoms, and encephalopathy results in a child who is often dysregulated and then very worried about how this affects those around him. He is fed by a tube and has had multiple life-threatening moments in his short life. His parents have wondered just how deeply the inability to eat affects him. At the very least, it seems like it has contributed to the heightening of all his other senses. If the neuroception of safety could only be attained through physical satiation, Joey would never feel safe because he never feels "full." Over the years, his parents have learned how to make accommodations for him and give him partial "yeses" around food. When he goes out to a restaurant with his parents, he licks a lemon, and he can pour salt into his hand and taste that also.

The very first day he came to see me, he asked for a gumball on his way out. His mom and I helped him get one for himself, and then he requested one for his mom. He understood that he would not be able to eat it, but he took a couple of licks of the gumball and then held it in his hand all the way home in the car. At the end of the next session, we went through this same routine. On his eighth visit, the gumball supply was lower than normal. He became very anxious about this, but having learned that if he uses his words to tell me what he needs, we will really try to make it happen, he walked right into the kitchen (now at the ripe old age of four) and told my intern (who I guess he thought was in charge of the gum) that he needed to buy more gumballs please. For Joey to use his words instead of his body to express a need and to trust that someone would be listening was huge progress. To help give Joey more than enough assurance that we would handle the gumball crisis, I got out a piece of paper and had Joey dictate a note to my office manager, asking her to buy more gumballs. I let him write the letters of his name, and we put the note in "a special place" where Miss Linnea would see it. During our team meeting that week, I noticed that she had the paper on her lap. I said, "Oh yes, that's for Joey. The gumballs are really important to him. Even though he can't eat them, he needs to have them." I was profoundly reminded again of how deep our perceived need can go and how powerfully an attempt to give yes can soothe.

Joey's heightened development of his other senses became clear to me again during a recent session. I walked out to the lobby to get him, and he introduced me to "Cubba," his bunny, who also has a feeding tube. As he was showing it to me, he held it out and said, "Smell it!" I did so, and it smelled like fabric softener to me, and I said, "You wanted me to smell it." Then he pulled Cubba close, inhaled deeply, and said, "He smells like snuggles." I was struck by the profoundly simple statement. His olfactory sense is highly developed, and the smell of Cubba has paired with the physical sensations of snuggling with both his mother and the bunny. The snuggle soup of mom

and bunny is enhanced by the release of oxytocin and dopamine and further enhances his neuroception of safety. Cubba, then, can serve as a transitional object and olfactory source of soothing even during times of separation from mom (see Figure 3.6).

Figure 3.6 Smell the Snuggles

Touch as Need Meeting

Despite a debate over the use of touch in counseling, many play therapists have come to believe that, when counseling children, touch is essential for various reasons. When mediating factors concerning touch, such as the gender, age, cultural background, and diagnosis of the child, are taken into consideration, touch can be both ethical and beneficial in the therapeutic relationship (Courtney, 2017). Sometimes touch is the simplest and most powerful way to help a child regulate. I want to make it clear that we are not endorsing any punitive uses of touch; however, touch can convey delight. It can provide gentle containment, it can provide sensory input that a client needs, and it can let them know that we are with them, that we are connected in relationship. Touch can be grounding, and touch can be playful. It is concerning to me that so many school systems are disallowing touch, one of the natural pathways for providing care and nurture for children. Kara and the Camp Nurture group are good examples of the power of touch in need meeting.

Kara was a child internationally adopted when she was two. As I was using Theraplay with Kara and her mom, it became clear that this child had some sensory seeking tendencies. One day they were snuggling together in my big cushy chair, and Kara's mom was talking to me while she was unconsciously running her fingers up and down Kara's arm. It was clear to me that this gesture was meant to be nurturing, and I recognized from my own Theraplay work with the mom that she preferred this light touch herself. However, Kara started to twitch. I interrupted her mom and called attention to the interaction. I said, "Hey, mom, I'm sorry to interrupt, but I see something happening that I'm really curious about. Kara, as your mom is stroking your arm, your eyes are twitching." I demonstrated, and she giggled. "It's like your body is saying, 'That feels weird.'" She looked up at her mom shyly, and her mom, a pro at giving Kara voice, said, "It's OK to tell me, honey. I want to help." Kara said, "Well, it feels kind of tickly." We went on to experiment with deeper and deeper caresses of her arm, and when we got to the kind of touch that felt "quite right," it was much deeper than what her mom would have preferred for herself. This new understanding helped Kara's mom be a better sensory co-regulator for her daughter.

The group of children who made up Camp Nurture were so dysregulated, so covered up in static for the first few days of camp, that although we had Nurture Groups, Crash and Bump, and art therapy groups, we did not attempt to read to them, as this would require more of their executive functioning skills, and we felt like we had not really provided enough regulation to the lower brain regions yet. On the morning that I decided to try reading to them, I was still expecting to get three short pages in and then have to say, "Your bodies are letting me know that we need . . ." Then I would offer a regulation tool to extend their window of tolerance and reengage them. It was not necessary. I got through the whole book and was pleasantly surprised. It was not until much later, when I was reviewing the pictures from the day,

that I understood why it had been doable. Look at the picture below. What do you notice is happening with each child who is attending to the story? Yes! They each have an anchoring touch from their buddy. At no point did I train everyone to put hands on their camper's back, but they had each attuned to the needs of the camper in their care, and the anchoring touch was need meeting for all of them (see Figure 3.7).

I recently saw a remarkable series of snow globes recently at a local art gallery. Humpty Dumpty was perched precariously on top of the wall, but he was looking down at several broken eggs on the ground in front of him. His predicament struck me as a parallel to the tenuous neurophysiological balancing act that is happening cyclically inside the children we serve. Children with early trauma and consequent compromises to the regulatory functions of the brain stem often have difficulty processing their body's signals. In these children, I often see excitement, aggression, and anxiety all balancing on the head of a neurophysiological pin. These children can benefit from repetition upon repetition of gross motor involvement. They can also benefit from cycles of upregulating and downregulating. Since the excitation of their neuronal systems—even if the excitement comes from the anticipation of a trip to the circus—can often move over into anxiety or aggression, they benefit from expanding their window of tolerance for excitation in play. In play sessions, I will sometimes blast music and dance with a child until we are both out of breath and then move to a downregulating activity such as deep breathing or balancing a peacock feather.

Figure 3.7 Touch Anchors

Mindfulness

As shown throughout this chapter, children who have endured early trauma or neglect lack the basic body awareness that is essential for regulation. Many of the case narratives show an integration of mindfulness techniques (lollipop) that meet the child's sensory needs while inviting them into a state of awareness. Mindfulness, which is defined by Kabat-Zinn as "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally," begins the work of meeting the child's basic needs so that they are more fully present to participate in deeper clinical work (2003, p. 4). Usually mindfulness work is most successful when it is connected to the child's somatic experience (Burdick, 2014). Whether mindfulness is practiced through movement, sight, smell, or taste, becoming aware of one's body is the foundation of health.

Although mindfulness practices have been widely incorporated into treatment with adults, research is recently blossoming in the field of mindfulness practices with children and adolescents. A recent study shows that mindfulness-based cognitive therapy for children (MBCT-C) increases attention and significantly reduces anxiety symptoms (Semple, Lee, Rosa, & Miller, 2010). Furthermore, two recent meta-analyses found support concerning the positive impact of mindfulness practices in a clinical setting for children as young as three through adolescence (Burke, 2010; Zoogman, Goldberg, Hoyt, & Miller, 2015). Though mindfulness is difficult to define as a psychological construct because its practice is broad and takes many forms, numerous child therapists have experienced the positive impact of mindfulness with their clients (Shapiro, Carlson, Astin, & Freedman, 2006). My hope is that research will continue to provide evidence for the success that many of us see in our own practice.

Gross Motor Involvement for Activating Social Engagement

Ben and his younger brother, Stew, were playing in the living room while their dad worked in his home office. Their mom was at a work event for the evening. After playing for a while, Stew went into the office to ask their dad for a snack. He came back out and told Ben that Daddy was asleep. Ben then went into the office and tried to wake their dad. He could not wake him and called 911. The emergency worker who answered the call talked him through how to do CPR, and Ben, at just six years old, pushed on his dad's chest rhythmically while waiting for the ambulance to arrive. However, he was unable to be revived, even by the emergency workers. Ben had tried to call his mom before calling the police, but she had not heard the phone because of the noise at her work event, and it was not until she pulled into the neighborhood and saw the ambulance that she knew there was an emergency. Ben became quiet and withdrawn after his father's death. He was avoidant in his first therapy experience and avoided talking about the events of that night with his mom. He

seemed to have responded to the trauma with first a mobilization response, working diligently to resuscitate his dad, followed quickly by a collapse into immobilization when the emergency responders took over. In the language of polyvagal theory, his body responded with a subdiaphragmatic activation of the immobilization response, bypassing his social engagement systems in a way that made it exceedingly difficult to access the social support of his mother and grandmother, reinforcing his sense of isolation over and over again.

When he came to Nurture House, our first goal had to be helping him reactivate his social engagement system. Building on his natural gift for sports, I took him into the big open area near Nurture House and simply played Frisbee with him. The truth is that I had not dressed properly for playing a baseball type of Frisbee, and this young boy, who had been so hard to reach, began to laugh out loud at me almost immediately as I attempted to haul myself quickly around bases in a long skirt. I did not mind being the butt of his joke if it got him socially engaged. He won, hands down—and I did not give it to him. This full body kinesthetic involvement, combined with the triggering of his apparently naturally competitive bent, provoked what I call (unscientifically) a surge of competency hormones in his body. I got smiles and giggles that I understood later to be some of the first in a long time, a change of state brought about by full body engagement focused on the relationship between us as competitors—a form of social engagement that was meaningful to him within this context. I thought, yes! This is the way in for this young boy. I continued to up the ante, saying each time, "OK, I think this was too easy for you, as you won so quickly. This time, you have to catch the Frisbee (and, to be clear, the Frisbee was a newfangled nylon circle with at least a 12-inch diameter opening in the middle) with your head!" This was not an impossibility. He and I would take turns flicking the Frisbee at each other and then running like mad to get our heads under the opening before the Frisbee landed on the ground. We were mainly unsuccessful, but I laughed harder than I have in a long time and so did he. It was in the midst of this shared laughter that his social engagement system was activated with me. It was not until he trusted me to see all the health, all the typical "kidness" inside of him, and delight in it that he was ready to process the really hard and scary moments of his father's death and his own attempts to resuscitate him.

After several sessions that looked a lot like what was described above (although I learned to dress more appropriately for his sessions), I introduced my domino people. I understood that this child, who was just coming back into resonance with his own body, needed more structure and challenge to any activity that might narrate the events of that night, so I enlisted the help of my domino people and some very small sticky notes. Most of the kids at Nurture House are drawn to the idea of lining up dominoes and watching the whole chain of them fall over with just the touch of their finger. What this allows for clinically is a blow-by-blow breakdown of what the child encoded from the traumatic event. I often save this activity for children who are self-blaming, who believe that some failure of their own caused the devastating

outcome that they are now living with. In this case, I had been gifted with a bit of self-disclosure in a previous session. Ben, during one of our many contests of strength or endurance, gifted me with his deeply held belief that he was responsible for his dad's death. If he had been stronger, if he had been able to do the compressions harder, his dad would still be alive. Ben was fascinated with the domino people and began to set them up right away. He went through what happened step by step, starting with walking into his dad's office and thinking he was asleep, shaking him, and realizing he was not breathing. He was able to talk about calling 911 and the compressions he tried to give while his dad was still in the chair. He talked about watching the emergency workers enter their home and take over. And as we went back through all the details, he realized there was nothing he would have done differently.

The kinesthetic engagement was part of what helped him stay with the story long enough to make the cognitive shift away from self-blame. None of his actions brought his dad back to life, but none of them contributed to his death either, and there was a certain peace in coming to this awareness. Interestingly, Ben asked me to take a picture of the line-up of dominoes with the parts of the story close by (see Figure 3.8). I did. Finally, he set them all back up, and he asked me to take a slow-motion video of them being knocked down (honestly, he had to show me how to do that). I told him I thought it was important for his mom and grandmother to support his new discovery that his dad's death was truly not his fault. I asked if it was OK to invite his grandmother into the

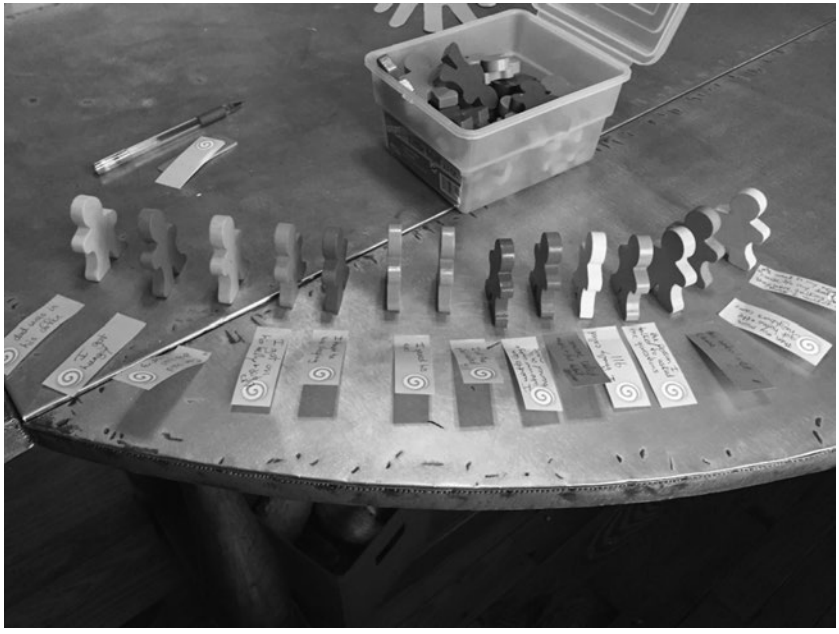

Figure 3.8 Step by Step

session. She took the video, and for a few minutes he watched the slow, relentless sequence of dominos knocking into each other. As the three of us watched it again together, it was powerful. The sound that had been a tinny "tink, tink, tink" as one domino hit another became a massive echoing bang as each domino hit the next in the slo-mo version. He and I experienced together the power of the initial cardiac event and its relentless cascade toward death. This is not meant to be morbid. Indeed, it is meant to highlight the opposite—the growing sense of freedom from responsibility that my client felt as he watched the inevitable cascade again and again. After several playbacks, Ben sighed deeply in satisfaction and said, "OK. Let's go play outside now." So we did.

Conclusion

Returning to the beautiful simplicity of need meeting can be the fastest and most effective way to build rapport with the traumatized child and/or his caregivers. In a parallel process dynamic, we train our clinicians (who train the parents who train the children) to check in with their bodies and ask themselves what they need. Particularly when negative behaviors or irritation is present, asking whether the child has had proper hydration, nutrition, or sensory need meeting should be the first line of defense (Purvis et al., 2007). Empowering our bodies and the bodies of those in our care builds safety, establishes us as need meeters, and helps calm the lower brain regions of traumatized children.

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4 Bigness, Smallness, and Containment

The Use of Space and Presence in Play Therapy

This chapter will explore the myriad ways we provide containment for children and families as they tame the trauma. A focus on the role of physical space in the child's ability to face trauma content will be discussed as well as the use of containers and containment in chunking trauma work, empowering clients, and reinforcing boundaries. Examples will be given of how the therapist becomes a container and of how boundaries, whether spoken or physical, provide containment. The question of bigness matters in terms of the physical space in which therapy is completed, but it matters even more in terms of the bigness or smallness of the therapist's presence.

A few years ago, at a time when I had been traveling extensively, I came home to find the pantry a mess. I took the kids to The Container Store, and we had a field day choosing containers that would be "just the right size" for the foods that are our family staples. We noticed that some were tall and skinny, some were short and square, and some were large enough to hold quite a lot. The size of the container was chosen based on what would go inside it. Therapists are very much like these containers—and I do not mean individually. I do not mean that each container represents a different therapist. On the contrary, I see each of us as being all the containers at different points in therapy. It is our job to morph into the bigness, smallness, or whatever level of containment is needed by any particular child or family in our care. On certain days, I feel a little like a metamorph, becoming smaller and quieter for one child and large and in charge for another (see Figure 4.1). The only part of the pantry containers that was the same across different sizes and shapes was the lid. Each lid fit the container exactly and would suction to it in a way that did not allow air in to potentially make the food stale. Sticking close to our clients and attuning to their needs allows us to become bigger and smaller in our presence as needed.

Containment

The idea of containment has long been an important one in the field of therapy. In 1962, Bion talked about parents as the "psychic containers" for their children. Indeed, it was posited that a psychic container was essential for the

Figure 4.1 What Kind of Container Are You?

healthy development of the child. Infants, particularly, experience waves of intense sensory and emotional experiences that can be overwhelming for them. The parent sorts these experiences, has time to assimilate and consolidate them, and can then give coherence and structure back to the baby to make sense of what has been felt. If the parent is unable to be this psychic container, the child does not have the emotional experience organized and may remain in a heightened state of arousal, attempting to deal with disparate, scary, and sometimes crushing experiences on their own.

Some people are naturally better at containment than others. Some people exude a natural groundedness, a safety that emanates from them and allows others to approach them with difficult things. I think that some of this may have to do with a person's natural internal rhythms, the pace of their communication, their kinetic energy, and their ability to be present. At Nurture House, we begin immediately with new clinicians to hold their big feelings, their anxieties around the work, and in this way model being bigger, stronger, wiser, and kind. Fortunately, no matter what capacity a parent or beginning therapist brings to the work, the mentorship of a bigger, stronger, wiser, kind other can help expand their containment capacity. We have a myriad of psychoeducational strategies and exercises that we employ with both clinicians and parents in training, but none of these is as important as the holding environment created for the mentee by the mentor—the holding environment created by the clinician for the parent.

Being a container also means acknowledging our own pain and our own need for holding along the way. Because we contain so much for the families and children in our care, we must have safe havens of our own. Sometimes our first job is to be a safe place for parents, which means becoming a container for them. In this way, becoming a container is a parallel process. Whenever I sit with a parent, I am cognizant of the truth that we can only give what we have received. Any quality of communication, holding, listening, or responding that I want a parent to have with a child must begin with my modeling that quality with the parent.

All That We Hold

My Nurture House team went on a staff retreat recently. One of our group-building challenges was to create a sandtray together that characterized what we do and who we are at Nurture House. The symbols that ended up being the center of the tray are pictured below. Added by one or more of my colleagues is the central image of a fiery volcano in active eruption (see Figure 4.2). Surrounding the volcano is the superheroine Elastigirl from the movie *The Incredibles*. She can stretch to reach whatever she needs to get the job done—*and she is flexible enough to bend herself into whatever shape is necessary to save the day*. Elastigirl can put her arms around any situation, no matter how big or scary. When I am in the middle of a difficult session, I will sometimes close my eyes and pull up this image from our joint sandtray and remember that I am meant to be Elastigirl-ish (is that a word?) for the child and/or parents in front of me. As I have reflected on this image, I have understood more deeply that our job is not to keep the eruption from happening but simply to be big enough to contain it—and then begin to invite change.

The Use of Physical Space

We have long understood that some physical spaces are inviting for us while others are off-putting. Many hospitals are becoming interested in how the arrangement and aesthetics of space enhance or impede healing (Curtis, Gesler, Priebe, & Francis, 2009; Curtis et al., 2013). Gesler, 2003; Gesler, Bell, Curtis, Hubbard, & Francis, 2004). Some places we describe as "warm" or "cozy," others as "bright and spacious," and still others as "overwhelming." Some homes you walk into and feel like you can snuggle right into the couch. In others, there may be plastic on the furniture, and although the home may be "beautifully appointed," it is clear that you are not supposed to touch anything. Large, fluorescently lit chain stores can be immediately overwhelming for people, and certainly are experienced that way by many of my clients with sensory defensive tendencies. For others, they are a beacon of exploration—people are empowered to shop 'til they drop. Some people prefer small spaces and feel best when cozied up in the window nook of an old house with a book and a cup of tea, whereas others may feel claustrophobic, hemmed in by a space that feels too small for them. Part of the work in helping

Figure 4.2 Wrapping Arms Around the Eruption

families heal from trauma is providing safe space since "safe" may feel different for different people. At Nurture House, we have designed therapeutic spaces that include options for experiences of bigness and smallness, expansiveness and containment. This permission for clients to choose bigness or smallness begins in the lobby area, where we have a larger waiting room with full size adult chairs and tables. Parents and children may decide to camp out here in any number of configurations (child playing at the table and mom on her phone, child and parent building blocks together or playing with puppets, child on mom's lap, child as far away from parent—or vice versa—as one can

get in the lobby). Their use of the space provided gives us valuable information and is, in fact, part of our initial assessment of how parent and child function together. Indeed, their connectedness in interaction, their physical proximity to one another in the lobby, and the frequency of their communications with each other can provide a beginning look at how their attachment dance works and can inform the treatment plan.

Understanding the traumatized child's need for containment, for snug spaces, we created a smaller, contained space for kids within the larger room so a child can sit inside the shelter of the enclosure while keeping in visual contact with mom (see Figure 4.3).

There is also a small space set entirely apart from the larger lobby. I often find my clients with anxiety disorders sitting in this area with their parent. I see this part of Nurture House as almost like a "warm-up" area where their senses can "get used to" the smells, sounds, and colors of Nurture House before they have to negotiate more direct interactions with others—even others in the larger lobby. This need for smallness, for close containment, has been shown to us by clients in various ways. The picture below (see Figures 4.4 and 4.5) was created by a boy who had lived in a domestic violence environment for several years and seemed to wish for a return to the enclosure of a womb-like environment. One day early on in treatment, he came to the playroom and began playing out a scenario in which a baby was really scared by what was happening around him. He ran and got the child safe, opened it, carefully arranged the baby (doll) inside, and closed it up tight. The child actually breathed a sigh of relief once the baby was safely enclosed.

Hiding and Joining

Over the years, I have worked in many different environments, and in each I have had traumatized children who simply needed to hide as part of their joining. Sometimes the hiding is a simple communication that the child does not want to be seen. The child may be showing us the very savvy coping strategy that was used to avoid punishment from the enraged parent. Other times the child is inviting us to find them. They may even be expressing a need to be found. The simple act of hide-and-seek can answer profound questions for traumatized children. I have gone away. I have withdrawn myself. Will anyone notice? Am I worth finding? In the momentary play interaction, the child is saying, "I am unreachable. Can you reach me? Does someone care enough to come after me?" Children who have felt unseen, forgotten, or neglected seem to be asking, will you look for me? will you do the hard work of finding me? On one level, the simple dance of hide-and-seek brings an essence of playful curiosity to the beginning of a session, to the "hello" of a relationship. When I come into the lobby and find a parent (who I know has brought a child with her) alone, I will ask, "Where is Johnny? Did he go to Alaska?" The parent almost always begins to play with me and will offer another place where Johnny may have gone: "I think he flew to Zimbabwe!" I will express my

Figure 4.3 Small, Snug Area for Children Who Need More Containment for Felt Safety

disappointment: "I was really looking forward to seeing Johnny today, and I'll miss him if he's really gone." During this ritual, the child pops out, and the mom or dad and I can both delight in his return. I often cup his cheek and check to see if he brought his "beautiful brown eyes with [him] today." With older kids, I might tussle their hair or offer a high five. In this hello experience,

Figures 4.4 and *4.5* Baby in the Safe

the child waits for and perhaps even needs the validation/reminder that I want to see him, that the relationship with Johnny matters to me, and that I would miss the connection if he were not present.

Some of this is clear recapitulation of the attachment relationship. When my children were young, the connections between us were neurophysiologically reinforced. I experienced delight with them and they with me. I comforted them and they comforted me. There were exchanges of interaction, from laughter to snuggling, that released oxytocin and dopamine— powerful bonding and joy chemicals—in both our bodies and gave us both a feeling of being "just right" together. When I went to work or went to speak at a conference, there was a period of time during which the dose of connection sustained us, a window of tolerance for time apart that grew incrementally as the children grew, but the stress of being apart would leave us both "jonesing" for a fix. If it sounds like addiction, that's because it is. The pleasure that comes from connection, from the powerful chemical reactions that happen between parents and children, increase the desire and the felt need to stick together. We are not meant to be apart from our young for long stretches of time. Many of my clients from hard places did not have a preferred other and need many reassurances that the relationship is important, that they matter, and that they can have positive power in the relationship—power to provide delight to another. In this hide-and-seek scenario, the child decides when he or she is ready to be seen, which gives them comforting, empowering control. The ability to control the moment at which the child pops out mitigates the vulnerability they may feel in coming to treatment and most likely mitigates the sense of powerlessness felt during whatever experiences of trauma or neglect have brought them to Nurture House. In previous work environments, children have had to hide under a chair because it was the only available space to hide. With this need for cloaking in mind, I positioned my very first play therapy helper underneath the table in the middle of the lobby. Patrick, a giant stuffed dog that I bought when I was attending my very first play therapy conference, has been with me for over 20 years. He sits snuggled under the table unless a child needs him. He is large enough to completely cover a small child and has functioned in that role many times (see Figure 4.6).

Other children benefit from having smaller spaces with clearly identified worlds. Figure 4.7 below shows the inset fireplace of the upstairs loft at Nurture House. It sat empty for a period of time after clients started coming, then it had a wishing jar in it and other prominent items displayed. However, the children mainly overlooked the inset. I was given a fairy door recently, and this sparked an idea to use the space as a little fairy nook. Since we created a total environment in that space, complete with moss, fairies, a mailbox for in and outgoing mail, etc. (see Figure 4.7), children have begun to interact with this world differently. I have one client, in particular, who wants to be a fairy and used the fairy world with his grandmother to play out some interesting power dynamics between himself and his mother, with whom he does not live. For this client, miniaturizing one ecology provided a scaffolding for his story.

Figure 4.6 A Hiding Friend for Little Ones

Figure 4.7 Tiny, Controllable Yet Magical World

Clients' Compartmentalization as Containment

The child may have developed strong and protective containment strategies of his own. Young children who experience something that is overwhelming, terrifying, and beyond their control will "contain" the experiences in a way that leads to dissociative behaviors. They may put the trauma behind such a series of locked doors that getting to them takes time and patience. When multiple instances of abuse have been experienced, it may be necessary for the clinician to offer opportunities for the client to become kinesthetically engaged in chunking the experiences. It can be physically soothing and provide the child with an element of control to quantify the traumatic experiences in some concrete way and then let the child play with the icons. A case example may help to explain. Jack was a six-year-old boy who had been sexually abused at four years of age. After working with him for four months using a combination of child-centered play therapy and the Tackling Touchy Subjects curriculum (Goodyear-Brown, 2013), he had gifted me with multiple glimpses and snapshots of his abuse. As in most work with little ones, we danced toward and away from the trauma together as he gained confidence that we would all survive the telling, and he asked if his mom could tell him the story of what happened.

Jack's mom was a big container and was able to take the pieces of the story that Jack had told us before and create an age appropriate narrative. We had been using a combination of play therapy and eye movement desensitization and reprocessing (EMDR) thus far in treatment. As part of this work, Jack and his mother had identified a song that helped him feel safe and powerful. He sat on his mom's lap, and they sang together "God is bigger than the boogeyman" while I provided bilateral stimulation for Jack. After rehearsing his safety song, Jack's mom began telling the story that he had been telling/showing in snippets throughout the course of therapy.

She was about three minutes into the narrative when Jack's body language began to change, although he did not give any signs of overt distress (he did not tell his mom to stop, cover his ears, shush her, or hop off her lap and effectively distract himself and us from the narrative process). He just appeared to check out. I gently placed my hand on his mom's knee to have her stop telling the story, and I went to get the Slinky. Jack and I had used the Slinky before as a measure of how scared/scary a piece of content was, so he knew what to do with it. I said, "Jack, can you show me how scared you feel right now?" He seemed to come back to himself, hopped off his mom's lap, told her to hold one end of the Slinky, walked all the way across the room to the other wall, and said, "This much." The Slinky and the fear spanned the whole length of the room. I said, "It seemed like you were having a big feeling. I'm glad you showed us how big it is. Seems like even though we've played around with the parts of this story before, putting it all together is just too much right now. So, let's take it apart." Jack looked relieved.

We had a printed copy of the story with us. I got out scissors, and we cut up the parts of the story and put them in an envelope. Jack used the rest of

the session to engage in co-regulating play with his mom. In between sessions, I went to The Container Store (one of my favorite places) and bought a set of clear plastic rectangular containers. Each one looked like a pillar a little bit higher than the one before it. They can be stacked inside of each other, much like nesting dolls, but you can see what is inside through the walls of each container. They ranged in size from one to eight inches tall.

When Jack came back for his next session, I said, "I was thinking about you this week and about how it was too much to look at all the scary stuff at once last week. I got these and thought we could play around with which scary thing that happened should go in each, then you can decide if/when we look at each one." Jack became very thoughtful and said, "Should I put the most scary thing in the smallest one or the biggest?" I reflected that in here he could decide. He decided to stack each container within the next. He placed the paper with the least scary experience in the largest container and folded up the most scary experience and put it inside the one-inch container in the very center of the nesting pattern. Jack, his mom, and I spent the next several weeks working through just one paper at a time with a combination of EMDR and play therapy. The Slinky never got too big again, and within six weeks, his mom could tell the whole story again without it being overwhelming. This chunking of experiences accomplishes several therapeutic tasks: it provides literal physical containment and it empowers the client to choose where each experience goes, which requires distancing and reflection on each part in relation to the whole, continuing the desensitization work but with additional levels of structure, containment, distance and choice. Many forms of containment devices for chunking content are available, and I particularly like using nesting dolls in this work.

For many of the families that we see, the number of traumatic events that have occurred may be difficult to quantify and are certainly difficult to pull apart from one another. When a child has a parent who screams at him/her daily or parents who scream at each other daily, it may be difficult for that child to even tease out one incident of yelling from another. When a child has had multiple experiences of sexual abuse with the same person, in the same environment, teasing out discrete traumatic memories, one from another, may be impossible and is not the ultimate goal of treatment. In fact, therapists can create iatrogenic effects by aggressively pursuing "the story" or the details of the story in situations where the memory is stored as a set of bodily sensations and not in conscious or explicit memory. I sometimes combine EMDR with play therapy and find that the two methods work fluidly together. For example, I may enhance the feelings of safety engendered through the creation of a safe place sandtray with bilateral stimulation. I may also enhance attachment relationships or stories around early care and nurture with bilateral stimulation as well.

Recently, I worked with a nine-year-old boy who was having a posttraumatic reaction to a recent car accident. He had developed a set of avoidance symptoms that was going to be best treated with a play-based exposure/response prevention protocol. Several years ago I wrote several therapeutic stories aimed

at helping children externalize and then work with their anxiety in order to help them develop a sense of mastery and control over the anxiety. One day, when I went out to get the family in the lobby, Jack had the *Worry Wars* book (Goodyear-Brown, 2011b) on his lap. I could tell that he really wanted to read the story *Daniel the Dragon Slayer*, and when I offered to read it to the whole family, he nodded his head eagerly. I escorted everyone into the front room of Nurture House, a larger room with light walls and high ceilings—plenty of space for mom, brother, client, and myself to read the story. As soon as I began to read, Jack became agitated. He jumped up and ran across the room and got under a blanket. I responded by saying, "Your body is letting me know that this is kind of hard for you, to read this story with me. Seems like this room may be too big for reading. I'm going to let you choose the room in which we read it" (fortunately, I did have the house all to myself at the time).

He said, "Can we go upstairs to the nook?" I said yes, and we went, the child, his mom, and his younger brother. There are two small closets in the loft of Nurture House. Neither has doors, and while one has been outfitted with a nylon circus tent and puppets, the other functions as a small kitchen and dress-up area. Jack dove into the circus tent and then asked for the dragon puppets. Jack and his brother squeezed into the tent (see Figure 4.8), and their mom and I sat right outside the tent while I read the story. If another therapist had come upstairs at that time, she might not have even known we were there. We were all squished into such a tiny part of the room. But this smallness provided Jack with the containment he needed. His neuroception of safety was reinforced by the small space and his ability to decide when he stuck his head out of the "door" to look at the pictures of the dragon, when he used the dragon puppet to speak to us, and when he wanted to stay hidden. He could, without comment or commitment, just listen, which mitigated his approach to the "scary stuff." In his case, the scary stuff was learning how to boss back anxiety. This serves as another example of how play therapists can set up intentionally small, snug spaces as options for helping children regulate as they approach difficult content.

Offering Titration in Creative Space

In the kitchen of Nurture House is a wall painted with chalkboard paint. On it we have placed several frames of varying sizes and offer paper as well as the chalkboard surface. At first glance, this wall looks like just a cute Pinterest picture—an attractive way to decorate a wall. What we are actually doing is intentionally offering a titration of bigness and smallness for clients. The offering of a chalkboard surface invites people to draw on it—it invites creativity, which is a good thing. Some children may run to the chalkboard wall, ask for chalk, and begin creating large, mural-like art creations on the lower half of the wall. However, some traumatized children can feel overwhelmed by a large blank space but experience increased safety with the boundaries of a smaller frame. Still others might respond best to the roll of paper offered on the wall, as they can choose (control) how much or how little paper they use (see Figure 4.9).

Figure 4.8 A Smallish Space, Safe Enough to Listen

Titration in Sand Spaces

Sand has a long history as a therapeutic tool. From tiny Zen sand gardens, often featured in therapists' lobbies, to sandboxes large enough for children to sit in, a child's exposure to sand can be titrated, as can a child's immersion in a world created in the sand. In the sand tray room, we have three kinds of sand: Jurassic sand (that is soft and soothing), white sparkly sand that is

Figure 4.9 Titration of Space in Art

more granular for sensory seeking clients), and kinesthetic sand. Offering sand of various kinds allows choice to children in meeting their sensory needs in an attuned manor. Bigness and smallness are not just measured by length, width, and diameter—they are also measured by depth. Some children feel most comfortable approaching a shallow tray of sand, one that is only an inch or two deep, whereas others prefer the portable sandtrays

we offer that have sand as deep as three and four inches. Especially when children want to engage in burials and resurrections, they often gravitate to the deeper sandtrays. While we are able to offer a sandtray experience in any room of Nurture House, our dedicated sandtray room allows for titration in multiple ways. We have three separate sandtrays in that space. One is a traditionally wooden sandtray with a blue bottom and sides, created in the dimensions of a standard sandtray. In it we keep a snowy-white crystallized sand. It looks sort of magical. In the center of the room is a slightly more shallow but longer and wider sandtray that we keep filled with rich, dusty, orange-colored Jurassic sand. It is the softest sand I have been able to find and is very, very regulating for the sensory systems of the children that we see.

The third sandtray is a portable, extra deep plastic sandtray with kinetic sand in it. Oftentimes our traumatized children will start with the kinetic sand, mainly because it is more controllable, and early in treatment traumatized children often need more control over their mediums. The kinetic sand can be packed and molded, allowing for certain internal states to be manifested in a way not possible with traditional sand. A child's need for bigness or smallness can also be mitigated by the size and kind of sandtray they choose. Since the backyard renovation was completed, children have had their choice of sand enclosures ranging from a boundaried circle of sand that is ten feet in diameter (pretty big) to as small as an octagonal wooden sandtray measuring three inches across (see Figures 4.10 and 4.11).

Figure 4.10 Our Largest Sandtray Offering

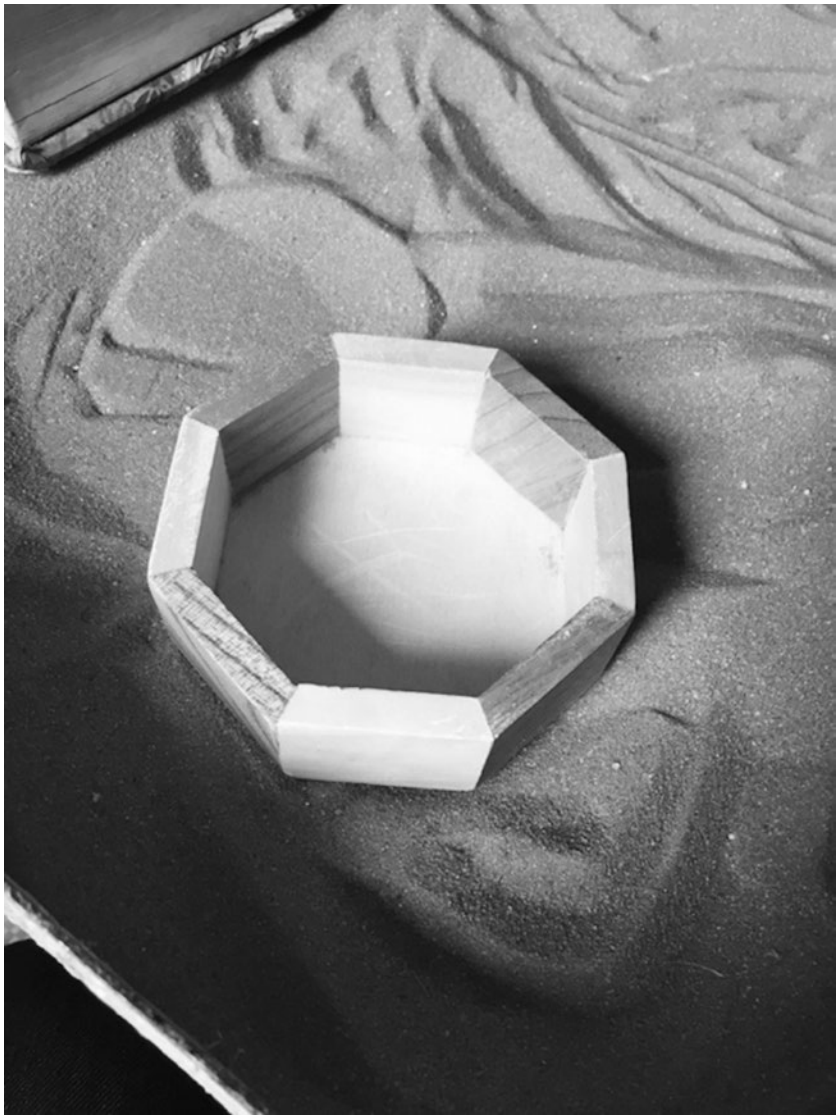

Figure 4.11 Our Smallest Sandtray Offering

Sand can offer different kinds of sensory experiences based on the consistency of the sand chosen (smooth to rough, dark to light, packable to amorphous), and we can offer titration of expression through the bigness or smallness of the sandtray offered as well as the shape in which it is offered. The traditional rectangular Zen sand garden comes with a rake and allows for the creation of patterns in the sand without a client having to come in contact

with the sand itself, a potential mitigation for children with sensory defensiveness who might avoid physical contact with the sand. So, we find that even the tools offered to clients in the sandtray work can help titrate their approach to letting go of control. When a rake or shovel or smoother sand is offered, clients can spend a great deal of time trying to make the sand "just so." As stated earlier, we recently finished our renovation of the backyard. The project included the construction of a large sand circle in the middle of the space, giving us—and potentially clients—the freedom to do sand work on a full body scale. Already children are having different experiences of "bigness" in this space than they are able to have in a regular size sandtray. Most recently, children have lain right down in the sand to make sand angels, taken off their shoes, asked to have their feet buried in the sand, and used the oversized wooden blocks seen inside the circle below (see Figure 4.10) to build bridges and paths, to divide the space, and to do work related to balance.

How Children Perceive Their Own Bigness or Smallness

The sandtray is a powerful landscape for helping children communicate their sense of their own bigness or smallness (either in terms of actual physical size or in terms of their personal power) in relationship to the bigness or smallness of others. Below is the family play genogram (Gil, 2014) of a child referred to me for extreme anger outbursts. When I asked him to go and choose toys to be his mother and father, he chose the tiny metal soldiers. Then I asked him to go and choose a toy to be his brother, and he chose the gummy blue guy. Then I asked him to go and choose a toy to be himself. He chose a disproportionately large figure, the Martian popping doll. While the Martian popping doll communicates volumes all on its own (when you squeeze it, the applied pressure makes the eyes, ears, and nose pop out), effectively mirroring the client's blowups when he gets outside of his window of tolerance, what is most striking here is how much larger and how much more powerful this figure is than the tiny soldiers (see Figure 4.12). This child clearly has an internal schema of himself as bigger than his parents, and, indeed, at the time this child entered treatment, his parents were actively afraid of triggering him, walking on egg shells to avoid his tantrums. His perception of their fear and ineffectiveness in containing him seemed to be scary for him. Notice that his figure does not have any hands or arms—he cannot do for himself, he cannot act upon the environment, he must rely on the capability of others, and yet he deeply doubts others' ability to take care of him. This initial snapshot of his perceptions of his family dynamics was extremely useful in helping the parents understand and support the treatment goals around helping them communicate their role as *bigger, stronger, wiser, kind* safe bosses more effectively, more frequently, and more authentically.

A client's self-perception of physical bigness and smallness can be especially important to understand when working with children and teens who struggle

Figure 4.12 The Family

with eating disorders. Elli was a teenage client who struggled with anorexia. I invited her to create a sandtray showing how she sees herself and how she wants to see herself (see Figure 4.13).

Elli chose the clearly obese boy pictured below. He is holding a corn dog in one hand and a four-scoop ice cream cone in the other. This was how she saw herself at the time she created the tray. She chose the knight pictured on the right for how she would like to see herself. Notice that the figure is made of metal, the knight's visor is down, and his sword is at the ready. I asked her to give three descriptors for the boy. She chose fat, gross, and laughable. I asked her to give three descriptors for the knight. She chose small, protected, and vigilant. Clearly, neither figure is a fully integrated, healthy sense of self, but the tray gave us both valuable symbols for the work ahead.

Physical Containers

Containment can be physical. The younger the child is developmentally, the more helpful it is to provide physical containers. As children are concrete thinkers, it can create a sense of mastery for them when they can take difficult content and lock it up somewhere, giving the difficult content solid, visible boundaries. What kinds of difficult content might benefit from containment?

Figure 4.13 Fat Self and Skinny Self

1. Big feelings that may threaten to overwhelm the child.
2. Visual images, words, or identified somatic experiences related to a discrete traumatic event.
3. Perseverative questions or "confessions" of previously disclosed scary content.
4. Specific instances of traumagenic experience within a scope of trauma work.
5. Perpetrator symbols.

Big Feelings Containers

Frequently, children who grow up in families with highly conflictual parents can feel overwhelmed by the emotions in the family. Jenny is one such little girl. Jenny's parents sought out treatment for her when she began having heightened emotional outbursts. They readily accepted their role in creating an environment that might foster distress, and they recognized her need for a safe place outside the family system. Jenny's parents sat down with myself and Jenny soon after we met, and I offered the idea of making a container to hold all of her big thoughts and feelings about the things she experiences at home. Jenny's eyes widened, and she clapped her hands, then became quiet very quickly. I said, "It seems like you're thinking about something. You can ask me anything you want." She looked at her parents sideways, from underneath her eyelashes, and said, "Will my parents see it?" I said, "Great question! It

sounds like a container will only be helpful to you if you can put any thought or feeling in there without worrying that your parents might see it, that it might hurt their feelings. Mom and dad, can we get your permission to keep the things that go into Jenny's box private?" Both parents agreed and went out of their way to reassure her the box was just for her. I offered Jenny a set of brightly colored note cards to write down anything she felt needed to be "dumped" into or "held" by the "big feelings" box. Jenny would come to session each week and ask for her box. She would write down two or three new cards, go through all her old ones, and then say she was ready for whatever else we might be doing in therapy that day. We purchase basic wooden boxes and vessels of all sizes and shapes. We offer art supplies to decorate the containers. We make sure to have some clear boundary signals among the supplies children can choose from. Below is an example of a Big Feelings Box that is covered in stop signs made of foam. The words "keep out" are also fashioned out of foam stickers (see Figure 4.14).

After a period of time, many of her big feelings were held in the box. We began talking about ways she might use her voice to talk to her parents about some of these big feelings. We agreed that one of her goals could be "using my voice," and that she might begin writing cards for her box that included examples of using her voice. We had a session with her mom and dad that helped everyone understand how to respond when Jenny took the risk to "use her voice" to share her feelings directly with her parents. We created a simple

Figure 4.14 An Example of a Big Feelings Box

script and role played, having her parents reflect and validate her feelings. Jenny came back the following week and was excited because "it worked!" I asked, "What worked?" She said, "I used my voice, and they listened!"

I talk about this idea of containment regularly at Nurture House and have multiple containment devices for children to choose from. Clinically, having at least one size of a jail is helpful to clients. I have several sizes, including one that is three inches tall and three inches deep—perfect for sandtray work—one that is big enough for full size action figures, and one that is big enough for a whole hand puppet. I also recommend a locking box of some sort, regular and miniature handcuffs for use in containment of perpetrators, and personally created containment devices. We also keep a combination safe in one of our playrooms that displays the combination numbers on the bottom of the safe.

A colleague of mine, Amy Frew, gave me a wonderful example of containment recently. In her own private practice office, she has a safe, and while working with a child who has nighttime anxiety, she offered to contain the worries inside the safe. What follows is her description of the interaction:

> We were playing with the toy safe and talking about how things that were in the safe stayed there until someone decided to open it. I said, "Sometimes kids decide to leave their worries here (in the playroom)." Client started listing the worries she could leave ("I could leave my worry about the dark. I could leave my worry about being alone."). Then she said, "I could leave my toots here!" She walked over to the safe, squatted on top of it, and farted. Smiled and said, "Wait. I have another one to leave!" and farted again.

Boundaries: Limit-Setting as Caring Containment

Every evidence-based play therapy includes a limit-setting strategy. Limits are vital for children. If done well, giving a limit clearly and calmly when needed establishes a safe boundary while providing freedom within the boundary. I am struck again and again by how scared children can feel when they believe they are actually bigger than the adult who is with them, that they can create harm without having a safe boss helping them regulate. Randy was a ten-year-old child who had been removed from his biological home after five years of intense abuse and neglect. He had intense fits of aggression, and when he moved outside of his window of tolerance, he took his internal chaos and acted it out all around him. Then he would feel worse for having destroyed an environment and would spiral into shame. He carried so much shame, it was difficult for him to play or talk at all about his anger outbursts. One day he asked to borrow my iPad. At Nurture House, we use technology in therapy only selectively and with clear clinical ends in mind (Goodyear & Gott, 2019). I wondered if, in this case, the iPad would serve as a distancing device that would allow us to approach his dysregulation through visual imagery. I opened up an application that allows you to draw colored lines and shapes on a black background, sort of like an Etch A Sketch. He sat and silently drew for

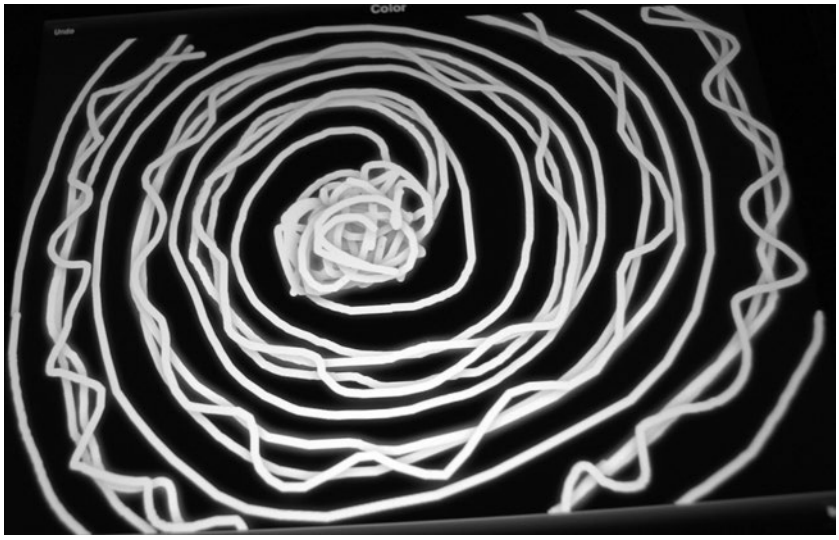

Figure 4.15 Chaos Spinning

a while. When he was done, I simply asked him if he could give it a title, like a book. He labeled it *Chaos Spinning* (see Figure 4.15).

He then began a new drawing, and when he was done, he again showed it to me. When I asked him to title his second creation, he decided to call it *Chaos with Boundaries.* We sat silently looking at each picture in turn together. Then I asked, "Which one feels better to you?" and he immediately gestured to the *Chaos with Boundaries* creation (see Figure 4.16).

Randy recognized on some level his internal disorganization and his need for a safe boss who could organize his experience and help reassure him he would not be allowed to be powerful enough to bring destruction to his environment. Randy's adoptive mother was learning to provide high structure and high nurture for Randy, and he was beginning to thrive with the calmly enforced boundaries and the close physical proximity his mom kept in order to be able to intervene quickly if he began to become disorganized. He was not, in that session, ready to acknowledge the real-life limits his mom had begun putting in place, so we stayed within the metaphors of the art. However, he did ask to show his mom both of these images. We invited her into the session, and she was clearly struck by the images. At the end of the session, Randy ran ahead as I was walking them out, and his mom said, "It will help me to think of myself as providing those smooth lines for him."

When someone asks for something from someone else, the response becomes the spoken boundary. *No* is a clear demarcation line, whereas *yes* is permission. In all innocence and trust in the better nature of humanity, most of us are born believing that when we say no to other people, the *no* will be respected. When

Figure 4.16 Chaos With Boundaries

a verbal *no* is not respected, it can call into question our right to set the boundary in the first place. Children are set up for harm when their voices are disrespected. It is part of the safe boss job of caregivers to enforce with the children in their care the boundaries that lead to internalized care of others. Indeed, when boundary violations between two children go unaddressed by the caregiver on duty, both can be set up for unhealthy sexual boundaries (Gil & Shaw, 2013; Goodyear-Brown, 2011a; Goodyear-Brown & Frew, 2015).

The example I give when I am teaching is of two children and their depressed mother. Karson, age five, and Cindy, age three, are siblings. One day Cindy is playing with a shiny red Matchbox car when her brother grabs it out of her hands without asking. She screams, "No, give it back!" Karson ignores her or, worse yet, laughs at her, and Cindy cries and tells their mom, who is lying on the couch watching TV and does not respond in any effective way. This happens over and over, without Cindy's boundaries being reinforced by the safe boss on duty. What are the children learning? Karson is learning that he can take things he wants when he wants them and that he can take what he wants without asking. Cindy is learning that it is OK—even to be expected—that people can take things from her when they want whether she gives them permission to or not. Fast-forward this learning curve by ten years and introduce the development of a sexual self. Why would this entitlement to take what he wants when he wants it not extend to sexual behaviors and beliefs? Karson at 15 may believe it is OK for him to take sexually from a more

vulnerable person, and Cindy is likely to believe that people can take sexually from her without permission.

At Nurture House, we keep the buttons you see below. The "No" button says no in varying degrees of strength when pressed. We also have a "Yes" and a "Maybe" button and are often helping survivors reinforce their verbal boundaries through playing with these buttons. We also have two smaller circular recording devices. A child may speak into the device whatever boundary they want to give voice to and then hear it over and over again simply by pressing the button. This activity delights children who have felt like their voice was previously unheard.

Containment of Perpetrator Symbols

Some boundaries are established through limit-setting. Other boundaries are created by the child in an effort to exert some control over a monstrous presence. In a previous text, *Play Therapy with Traumatized Children* (Goodyear-Brown, 2010), I gave some case examples of the ways in which children begin to contain perpetrator symbols in order to feel safe to approach them. Below is an expansion of this idea. In addition to containing just perpetrator symbols, clients will sometimes need to contain snapshots or glimpses of the trauma story itself. In this way, the containment is not just around the danger associated with a perpetrator, but the more somatically overwhelming felt sense of the encoded experience or the flood of scary cognitions related to the trauma. I often see this kind of containment needed by children who create play projections related to witnessing domestic violence. Below is a "scene" created on the chair of my old office space by a child who was growing up with an abusive father. This six-year-old boy had chosen the two-headed dragon for the dad figure; a pale, drawn woman for the mom; and a small, naked baby who stuck very close to the woman for his self-object. Once he had chosen these miniatures, he explored the room further until he found the box of cotton balls. He painstakingly unraveled one in order to create "fire" breathing out of the dragon's mouth and explained that sometimes the mom and baby get burned by the dragon. He was quick to explain that the other head does not breathe fire, so sometimes the mom and baby do not get burned. I reflected his words and wondered out loud how the woman and child could know which head was going to be in charge at any given time, adding that it sounded confusing and maybe dangerous, depending on which head was in charge. He nodded vigorously, then explored the room further and came back with the police caution tape. He quarantined off the chair by placing the tape, with the words "enter at your own risk," across the front of the chair. Once he had contained the danger in a visible way, he let out a deep breath and turned away to peruse the other toys (see Figures 4.17 and 4.18). His created boundary contributed to a felt sense of safety that allowed him to drop the hypervigilance and literally turn his back on the danger in order to begin asking the developmental question, what next?

Figure 4.17 Dragon Burning Mom and Child

Figure 4.18 The Scene Contained

Jenny, a seven-year-old girl who was bullied by an older boy at school came into her first session with a quiet, cautious demeanor. After ten minutes or so of exploration, she chose an oversized beetle, put it in the sand, and chose a disproportionately small female figure, a tiny girl with downcast eyes wearing a hoody that covers part of her face (I wondered internally if this was Jenny's self-object). We processed the tray as she had created it, and as I wondered out loud how the girl with the hoody felt being so close to the beetle, she chose several pieces of barbed wire fencing and began making a square enclosure to surround the beetle. After a few moments of deep concentration, she sighed and said, "It's not right. I need it tighter." I gestured to our shelving area that holds various fences. Her eyes lit up when she found the length of white picket fence that is bendable. She shaped it carefully until it was just the right size to enclose the beetle entirely and closely. Once the beetle was enclosed, she spontaneously turned her attention to adding in aspects of her life that bring her joy. Once she had provided some containment for the bully, she could build the richness of her world outside of these bullying encounters.

Another containment symbol that has been powerfully used at Nurture House is the wooden house pictured below (see Figure 4.19). There are four numbered doors, each with its own lock and matching key. All the keys are attached to the top of the house so that the power to lock and unlock the doors is always available to clients. We recently had a family in which two preschool-age children witnessed the rape of their babysitter. The two

Figure 4.19 Perpetrator in the Doorway

children and their babysitter had gone into the wooded area of a park in order to ride their tricycles, a man followed them, and as the babysitter was attacked, she called out for the children to run. It was not until later, as we processed the trauma, that we understood the children's goal as they ran was to find sticks and stones to throw at the "bad man." In the aftermath of the trauma, the children insisted on sleeping with their parents and could not go to sleep unless the door of the bedroom was locked from the inside. They would also double check all the locks of the house before bed. Our locking house became an important part of their posttraumatic play. The children came together for a couple of sessions, and during the safety-building phase, they took turns locking various creatures inside the house. They would decide together how bad a creature was, if it deserved to be locked up, and then decided when each creature came out. Sometimes the creatures were locked in because they were bad, and other times they were locked in for safety from the bad guys. Either way, all four doors were always left locked as the children exited the playroom.

The parents were highly anxious about telling the story of what happened in a way that would bring coherence without scaring the children further. After mom, dad, and I crafted the story, mom and dad were able to tell it to the children while the children were snuggled in between them. Each received bilateral stimulation during one telling of the story and got to listen in a posture of repose for the second telling. After this session, both parents reported feeling significantly less anxious, and the children began to leave sessions with the doors of the house unlocked.

Some of the neglected and abused children who come to Nurture House have described parents with at least two—and often three or four—distinct "moods," if not personalities. These children never know which parent they are going to get when they come home from school or when they wake up in the morning. Children will sometimes draw pictures or tell stories about their parents in which they rename them based on these moods. Sometimes the moods are altered through the abuse of drugs or alcohol. I have had teenagers rename their parents "Dick on Drugs" and "The Alcoholic Ass." When I began practicing play therapy, I had two-headed dragons as well as single-headed dragons/dinosaurs and thought I was offering enough variety. It was a 12-year-old girl named Samantha who taught me that I needed even more nuance. She had been in multiple foster homes after being removed from her biological mom's home because her mom was addicted to drugs and had left her unattended at home on multiple occasions when she was too small to fend for herself. She identified the "cookie mom" as the one who would drink one to three beers, become super happy, and play upbeat Broadway tunes while baking cookies with her and her baby brother. She identified the "angry mom" as the one who had snorted some white powder and had a couple of shots, who might slam the pantry door if she could not find the snack she was after, or who might call her boyfriend and yell at him for several minutes about whatever was upsetting her or, worse, yell at Samantha and her little

brother for not cleaning the kitchen or their rooms properly. Then she identified "blurry mom," who would show up by 9:00 p.m. on school nights and by noon on Saturdays and Sundays, who would lie in her bed or on the couch, mumbling nonsense, asking Samantha to bring her some ibuprofen or to turn down the noise. Samantha knew that her job at these times was to move into caretaking mode. When I asked Samantha to choose a symbol to represent her mother, she chose the three-headed creature you see below (see Figure 4.20).

Although she was a very articulate young woman, when I asked her what she needed to do with the three-headed dragon to feel safe, she chose two sets of miniature handcuffs and put three of them around the necks of all three heads, leaving a fourth cuff. She became flustered as she noticed the fourth cuff dangling. I reflected, "You put a handcuff on each of the creature's heads. It's hard to know what to do with the fourth one . . ." She decided to bury the fourth cuff in the ground, as if there were a magical grounding place that would keep her mother anchored in such a way that she could not wreak havoc on those around her. Once we both understood that she had anchored the three-headed beast, I asked if she could choose a miniature to be herself. She chose the disproportionately small tuxedoed man that you see beside the dragon in the picture to represent herself. This tiny, buttoned-up male figure stood rigidly in the shadow of the three-headed creature. I wondered out loud with her about what it felt like for the guy in the tuxedo to be so small. She said, "He can't do much." When I began to wonder with Samantha about this well-dressed figure, she said that it was her job to make everything look OK so that they would not get taken away from their mom. I said, "I wonder what it feels like to be in black tie." She said, "Argghh, the tie is so tight, it's like

Figure 4.20 Three Moods of Mom

it's cutting off his airway. He can't breathe." She began to breathe in a more constricted way in the session as she acknowledged the sensations of the miniature. I said, "I'm starting to feel really tight in my chest as I imagine what it's like for this guy. I need to breathe myself." So I began breathing in for a count of three and out again. I did this quietly as I observed the sandtray. After a couple of moments, her breathing began to resonate with mine. We breathed together quietly, and after 30 seconds or so, she said, "He hates being in this suit!" I said, "I wonder if there is some way to make it safer or more comfortable for him?" Samantha looked, breathed, looked, breathed, and after another 30–45 seconds said, "I know, let's turn him into . . ." and she chose my small warthog that looks like a porcupine: ". . . he's a porcupine." I reflected her choice and then wondered out loud, "I wonder how it helps him to be a porcupine." Samantha immediately replied, "Well, she'll get hurt trying to grab ahold of him." I said, "Oh! I get it. He isn't made to save her. The three-headed creature has got to figure out a way to do that for herself . . . or not." After this session, Samantha's play (keep in mind that she had already been in a couple of foster homes at this point) would start out trying to figure out a way for the tuxedoed man to save the creature. Halfway through treatment, the tuxedoed man was permanently replaced with a warthog. The warthog brought its own set of troubles, however, as new caregiver-friendly creatures in her tray would see the warthog as dangerous. They confused it with a porcupine and acted to steer clear of her poisonous quills. As Samantha and I grew in our relationship, she allowed me to join her team and become someone who could trumpet her true vulnerability and need for connection that was often "miscued" through her learned defenses.

Conclusion

The number of ways in which containment may be needed and can be provided are legion for traumatized children. The good news is that play therapists are in a unique position to offer these many forms. Play therapists can attune ourselves to the bigness/smallness needs of children within the physical space and redesign these as needed. We can provide physical containers for chunking trauma content. We can provide the symbolic play tools for children to construct containment scenes for perpetrator symbols or protective scenes for self-objects. Most importantly, we can grow our own capacities to function as living containers for those in our care.

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5 Metaphor and Medium

Trauma is stored predominantly in the right hemisphere. It is stored iconically and somatically, and for these reasons is often more easily accessed and worked with through expressive mediums and through metaphor than through the stark linguistic narrative. Indeed, when I have a supervisee describe a stuck place in a case with a traumatized child, one of the first things I am likely to explore is what metaphors and what mediums have been used by the child so far. We can often jump-start a child's processing again if we offer a metaphor that has already been important to them but can be further explored through use of a different medium.

Our understanding that "mind" is an embodied and relational process that is constantly regulating the flow of energy and information within the body and within our relationships (Siegel, 2010, 2015) guides all of our interactions with clients at Nurture House. The embodiment of mind is aided by therapeutic tools that invite all of our different somatic ways of knowing. Kinesthetic involvement, which has long been understood as important for children, is part of the growth of a child's mind. If one form of kinesthetic involvement, say fingerpainting, provides a pathway to expanded knowing, then varying our forms of tactile grounding and varying the mediums in which we work offer additional ways of knowing. Play therapists share in the relational process with traumatized children, and as we curiously invite our clients to look at the trauma from a new angle of expression, we can potentially help them integrate different aspects of the trauma. As our field is understanding the limitations of talk therapies more deeply, we are also understanding that there is a powerful right brain to right brain relational resonance that begins to happen as a child creates an image, a sculpture, a sandtray and we witness it with them. The shared experience of what has been created and communicated increases the shared mindsight between therapist and child. When families engage in shared sandtray or art creations, new shared mindsight is offered to the system. Their family lexicon, which up to this point may have been mainly conversational, expands to embrace other forms of communication, impacting both the givers and receivers in new, potentially transformative ways.

Containment Through Control of Expressive Arts Media

There is a long history of appreciation within the expressive arts therapies for the power of the medium used for creation (Malchiodi, 2013; Malchiodi & Crenshaw, 2015). The medium one chooses for creating can give rich insight into the creator's need for control over their environment and allows them to work with boundaries and containment in increasingly complex ways. One form of quantification, media dimension variables, was set forth by Kagin in 1969. She identified three categories of general assessment related to the materials used: structure, task complexity, and media properties. Each of these three categories gives rise to ends of continuums: unstructured vs. structured, high complexity vs. low complexity, and fluid vs. resistive. How much fluidity or internal resistance a material has can tell us much about the person using it, as can the ways in which they use the material. The eight-year-old child who dumps large amounts of finger paint on paper and then slides it around, all the way to the edges of the page and onto the surrounding table, may be communicating something very different about their own boundaries (or those enforced for them) than the child of the same age who chooses to use acrylic paints with a paint brush. She acknowledged that fluid materials require containment so as not to spill haphazardly all over the place. In fact, one way of beginning to categorize the mediums was to work backward from the container for the medium to the medium itself. One way of looking at media dimensions is to ask what kind of container is needed and how much needs to be contained (Graves-Alcorn & Green, 2014).

The expressive therapies continuum (ETC) (Kagin & Lusebrink, 1978; Graves-Alcorn & Kagin, 2017) delineates four different modes of expression that can be helpful to those of us who integrate the expressive arts into our therapeutic work. The ETC provides a helpful framework that can be adopted by expressive arts therapists and used to better understand where, developmentally, a client's creative energies may be currently directed. Its bottom-up assignations mirror stages in the developmental process that all humans move through and are heavily grounded in the developmental theorizing of both Jean Piaget and Margaret Lowenfeld. Kinesthetic/sensory is the descriptor given to the foundational level of expression, perceptual/affective is the descriptor used for the middle of the continuum, and cognitive/symbolic is the descriptor given to the top layer of the continuum. The fourth level is the creative level and represents an amalgam of all of the other forms of expression. Additionally, variables around whether or not the client wants to have direct contact with the materials or have them mediated are worthy of our attention, as is the distance a client chooses to have from the media.

The clients' need for control over their materials is in essence a need for containment. There can be a powerful neurochemical payoff for a child after wrestling an expressive material into the shape they want it to have: competence as a neurochemical rush. I have had children spend 20 minutes in absolute silence packing a ball of kinetic sand so tightly that when they drop it from

a height onto the hard surface of the tray, it does not break apart. Which materials are seen as the least controllable and most controllable have undergone some development over the evolution of our field, and while we can all agree that some materials are more fluid or more resistive, we have also learned to have a healthy respect for children who present with sensory seeking or sensory defensive tendencies. A breakdown of materials that I particularly like was offered by Sue Bratton in a chapter on integrating expressive arts work into supervision of child therapists. She builds on a continuum of expressive arts materials originally offered by Landgarten (1987). Bratton's list, however, includes other play materials that might be found in a fully equipped playroom. She conceptualizes materials from least controllable (things like wet clay/wet sand) to most controllable (things like colored pencils and lead pencils). Between these two extremes, from least to most controllable, are oil pastels and watercolors, dry sand and miniatures, stand-alone figures, puppets (and the storytelling and dramas that accompany these), collage-type activities, model magic and modeling clay, and crayons and markers.

Landgarten was a foundational member of the art therapy community and helped shape thinking around the ways in which art can be used to both understand family dynamics and enter the dynamics to begin to change them. At Nurture House, we offer a whole range of art materials, from fluid to resistive. Since all of the choices listed above are available to children, we are careful to notice which materials children are drawn to during the assessment phase. Their choice of materials and the control they exert over these often inform the therapist's understanding of where they are developmentally in their need for control over their environments.

We can often gain valuable insight into their sensory profiles as well. The child who avoids the sand completely may have some sensory defensive leanings that would be valuable for parents to understand, whereas the child who comes in and immediately buries his feet in the sand is telling us something about his sensory seeking tendencies. This child's trauma work may be mitigated best by deep sensory input. I am remembering Johnny, an 11-year-old boy who lost his 16-year-old brother to suicide. He was entirely shut down and unable to process the way in which his brother died or his subsequent grief. Understanding from his early encounters with the play materials that he was sensory seeking and also felt competency surges through increased challenge, I arranged for our session to be outside near the tire swing. I introduced a giant exercise ball into our work, and he almost immediately began to bounce on it, then attempted to balance on it while getting into the tire swing without having his feet touch the ground. As he bounced vigorously on the ball, he was able to access storying capacities around his brother's death that were not able to be accessed any other way.

I have found that traumatized children often gravitate to the kinetic sandtray in our sandtray room instead of the Jurassic sand or the sparkly white sand. I believe this has to do with how much more controllable the kinetic sand is than the others. It can be packed, molded, brought more easily into

submission to the child's will. It can cause a great deal of frustration to an already dysregulated child to try to create a pyramid or a mountain in the flowing sand mediums because they do not stay put. I have had children try to knock over the sandtray before when a shape they were trying to create would not hold in the flowing sand. Justin created the image you see below. He had just been in the second car accident of his life. His mother wisely recognized that the recent accident exacerbated posttraumatic symptoms that had been with him since a much earlier and much more damaging car accident. His mom was also chronically ill and had an understanding that her limited or intermittent availability to her son had made his resolution of the trauma symptoms brought about by the first accident very challenging.

Justin and I had established a rapport, and I had in mind the TraumaPlay™ goal of enhancing his adaptive coping. At the start of a session, we entered the sandtray room. Justin looked at the tray of kinetic sand and said, "This stuff feels so cool!" He started picking up handfuls of it and letting it drip through his fingers. After a few minutes of experiencing the medium, he said, "This is kind of like me . . . it falls apart . . . and I fell apart after the accident." I said, "Sounds like you didn't know what to do after the accident," and he said, "Yeah." I asked him if he could shape the sand into the shape he would like to be when he thinks about the car accident. He said, "I want to be strong no matter what comes, to know I can handle it." He began to pack the sand, and then found an empty rectangular container and packed the sand in it so tightly that when he got it out, it held together. Justin said with delight, "Hey, it's still standing." He then proceeded to make several other large packed columns. He tried putting one on top of another, but the top one was too heavy, and the bottom one began to slide around and break apart. He sighed and said, "Too much weight in one place." I said, "You are figuring out how to build it so it will stand up under stress." He experimented with different shapes and sizes of packed sand and various distributions of weight before he landed on the construction you see below (see Figure 5.1).

He put a flag in the top and called it "Justin's Strong Tower." Then he said, "Let's test it." He took handfuls of sand and let them rain down over the structure. He did this over and over again until he had almost covered it up (see Figure 5.2). We both agreed that his Strong Tower could withstand a whole lot of storms. In a future session, we returned to the picture we had taken during this session and identified adaptive coping strategies for each of the building blocks of his Strong Tower.

One of my new favorite expressive therapy offerings is the Zen water board, which can be purchased in multiple sizes. At Nurture House, we have the large one and several smaller ones (see Figure 5.3). The underboard is covered with a paper that is easily made wet. The "canvas" sits on top of a trough of water with a paint brush. The paint brush can be dipped into the water, and bold, darkening marks can be made on the board. The image is at first very bold and stark, and then, as the water evaporates, the image begins to disappear. I have written previously about the power of the dry-erase board for children with

Figure 5.1 Solid Coping Foundation

traumagenic stories (Goodyear-Brown, 2010). There is a real power in being able to create an image that is shared in the moment between two people but can be erased at will so that there is no permanent record of it. Children tend to draw images on the dry-erase board when they need more control over the telling. The Zen board is another favorite among children who want to offer the therapist a glimpse of their experience. Then the therapist and child may have a shared experience of watching the depiction on the paper disappear.

Tammy was an 11-year-old girl who had spent her first ten years in an institution in a foreign country before being adopted by a family in Tennessee. She was drawn to the water board but quickly developed a love/hate relationship with it. When she understood that you could make the light paper turn black

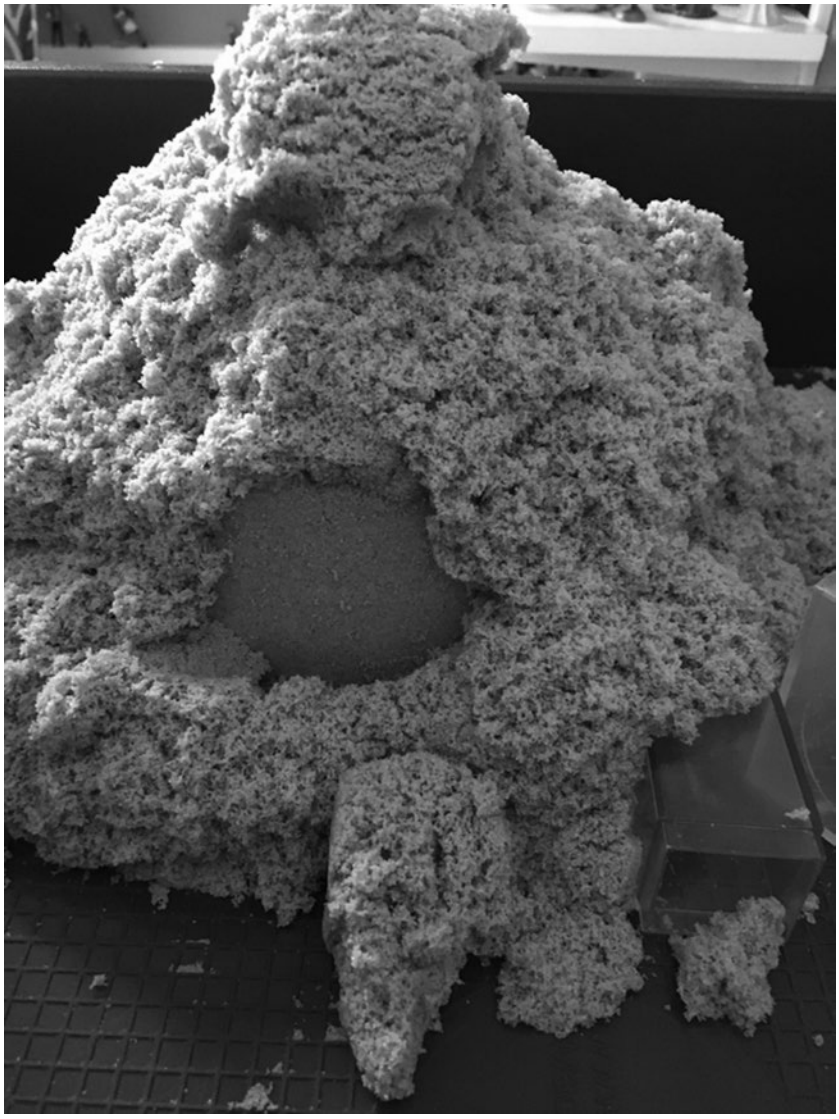

Figure 5.2 The Strong Tower Holds Up Through Heavy Rains

simply by adding strokes of water, she focused all of her concentration on trying to make the whole board black. This required a great deal of work and water, but eventually she succeeded. As soon as she finished the last stroke, however, and sighed with the satisfaction of having darkened all the edges, the first strokes she had made began to dry. The drying creates shades of gray before returning to the baseline color. She spent an entire session working

Figure 5.3 Creating Glimpses and Watching Them Disappear

to keep the whole surface as darkened with water as she could. At the end, she sighed again and said, "It will always eventually go away." I reflected her frustration and agreed with her assessment. The next session, she went directly over to the water board and drew a picture, in bold strokes, of a small person in a bed and a man looming over the bed, and she drew a penis on the man that was disproportionately large. Then she said, "This was in the orphanage." I reflected her words and thanked her for sharing it with me. She pulled up a counter stool for herself and one for me, and we sat together, watching the image fade. Then she looked at me and said, "This goes away too." This child did most of her trauma narrative work in this way. It seemed to bring her great satisfaction to be able to show me a glimpse of her story and have us hold the space together as we watched it disappear. It seemed to comfort her greatly that the images disappeared on their own, needing no additional effort or intervention from either of us. Since this seemed to be her preferred method for working through her life story, I introduced a few sets of bilateral stimulation just after she had completed each water board. Then I asked her to notice what happened in her body as she watched the image disappear. She described a kind of relief (very articulate 11-year-old) and a weight lifting from her chest. We further installed this sense of lightening with BLS as well.

Children may also approach an aspect of their traumatic experience and work with it in one medium, such as visual art, and then approach it again through a

Figure 5.4 A Broken Heart in the Kinetic Sand

different medium. Penny, a 12-year-old, verbalized early in treatment that she was broken-hearted over some of the abusive things that were said to and about her during her traumatic experience. The left brain verbalization of having a broken heart was one expression of her experience, but I wondered if deeper knowing and, potentially, healing might come from working in some right brain mediums. In the next session, we returned to the phrase "broken-hearted," and I asked if she could show me what this was like for her. She carefully packed the kinetic sand into the shape of a heart and then took the shovel and spent time creating a crack all the way through the center of the heart (see Figure 5.4).

During another session, I offered her canvas and paints, changing up the medium. The painting below depicts a heart with multiple breaks and the words "Would anyone care to mend it?" This opened up an expanded discussion of the hurts she had experienced (see Figure 5.5).

As we continued meeting together, I introduced a thin, wooden, heart-shaped puzzle. The creator had cut it into around eight separate strips of wood, and the pieces could really only be placed beside each other, not interlocked to create a perfect fit. At first, Penny hid the pieces around the room and insisted that I find them. She gave me almost no help and teased me pretty mercilessly when I failed to find the pieces. Over time, she began to give me hints, and it became easier to find the pieces of the broken heart. At one point, we switched roles, and Penny asked me to hide the pieces and give hints to help her find them. Toward the end of treatment, Penny asked if we could

Figure 5.5 A Broken Heart on Canvas

glue the heart together so that it would not break again. I felt like this tool had become important enough to her that I was willing to do this. Penny took the glued heart home after our final session as a reminder of our work together.

Kinesthetic Telling in the Lobby

Randy, a ten-year-old boy who was sexually abused by a biological father who is currently in jail, was waiting in the lobby with his adoptive mother when I came to greet them. Randy had several finger puppets in front of him, and I commented on this, saying, "You found the finger puppets!" He had a cloth monkey finger puppet on his finger when I came in but quickly took it off—almost like he was in trouble—as soon as he saw me. He said, "It's weird how they have the hole in them." He made a yucky face. I responded, "You're not sure about those holes." He put his finger back inside the monkey and made another face. I said, "You look uncomfortable with where the finger goes." He nodded, and his mom said, "Yes, he's mentioned it two or three other times when we've been here." I sat down and, picking up a finger puppet myself, said, "You know, it makes sense to me that you would see these holes differently. Lots of kids who have been sexually abused might think of these holes differently—more like private parts." Randy looked up and seemed visibly relieved that I understood why it seemed yucky to him. The matter-of-fact

verbal connection between his play and source of discomfort gave permission for him to share his discomfort and shaped an expectation that it could be contained and given structure. His mom also looked relieved and said, "I didn't know what to say when he would mention it, so it's good for me to see you do it. It's OK to just talk about it?" "Yep, you are one of his primary history keepers now, and as you hold the story and his big feelings, you bring safety and containment to both." Randy requested to be in the sandtray room today, and after I closed the door to the room, I said, "I'm so glad you let us know it was bothering you. Some of the kids that I see have had fingers, penises, or other objects inserted into their bottoms, and I really get that having that happen to you could change the way you see putting a finger into the puppet." "Yeah, Dad put his finger in me." I reflected the language, and the client abruptly moved to the sandtray shelves. We always notice abrupt shifts in attention or changes in the play and may perceive the shift as the client's communication that he has pushed up against the edge of his window of tolerance for looking at or talking about or playing out that scary thing that happened. In this case, Randy seemed to want to give it a different expression. He created his most elaborate sandtray to date. Following is a slightly edited version of the story he told as he created the tray: *Once upon a time there was a castle guarded by snakes, spiders, frogs, monkeys, gorillas, owls, worms, and one bird. There were many big cats (lions, tigers, cheetahs, leopards) who wanted to take over the castle. One giant monkey was assigned to be the leader and stood guard out in front of the castle, watching for the tigers. Inside the castle, the two owls were always afraid of the tigers coming, and so they never went outside. There was a big, gigantic bear hiding, and it was on the tiger's team. The two owls really wanted to go bowling with all the animals* (see Figure 5.6).

Suddenly, the cheetah moved. The owl team attacked the tigers, and they won (see Figure 5.7). *The two owls realized that when you have a team looking ahead and around for you, you don't have to be as afraid*, and the worm was eaten by the gigantic tiger, and the tiger got bigger than anything you've ever seen. *The tiger felt squirmy. He could feel the worm moving on the inside of him.* (I wondered here if some of the somatic expression of feeling like the worm was inside of him was a glimpse of his experience of the sexual abuse.)

Guards appeared at the top of the castle (see Figure 5.8), and instead of the gigantic snakes and monkeys and spiders and frogs attacking, *the knights did the hard work of protection. They also saved all the animals from dying. When all the animals were at war, the guards shouted out, "Stop fighting! I will fight them for you! You can just chill and watch!"*

The story was powerful, and after Randy told it, we were both silent for a while, taking it in. I asked if he would like to take a picture of the sandtray, and Randy expressed great pleasure in this idea. I watched him absorb the idea that he could create a photo document of the story. He seemed to enjoy the different perspective he got of his sand world as he looked at it through the camera. He seemed to embrace the distancing effect that the camera provided. Randy got to decide how close up or far away elements of his story would be. He

Figure 5.6 The Owls Can't Come Out

became the director, showing me what angles he wanted documented, when to zoom in on just the owls, and when to give a longer view of the entirety of the battle. In fact, the photography became another method of titration for Randy, "sitting with" the story but with the added layer of distance provided by looking at the closeness or distance on the screen. He could literally, using two fingers, increase or decrease how far the image was removed from his vision.

Figure 5.7 The Mighty Battle

Another nonverbal nuance of the narrative involved the miniscule changes you see in the images below. When we got to the part of the story where the owls are scared to come out of the castle, Randy looked more intently, with a photographer's eye, at the placement of the owls inside the castle. It may help us to remember that Randy and his brother were removed together from their sexually abusive father. Internally, I wondered how close Randy was to the edge of his window of tolerance for focusing on this content. However, since the work was all happening in metaphor, the threat level was significantly reduced. I wondered if we might extend the moment of focus by shifting mediums. The world in the sand was one medium, rich with metaphor. The storytelling was a second medium for exploration. Would he appreciate a third medium? I decided to offer. He took a first picture in which the owls are deeper inside the castle and tucked close to the wall. He was not satisfied with the arrangement. He paused, moved the owls closer to the entrance, and took a second picture. It felt like he needed to depict the owls' miniscule risk in coming closer and closer, by degrees, to the entrance of the castle to risk seeing the world differently. He would move them ever so slightly closer to the door and see how it felt. I printed off the pictures he had taken so that we could begin a hardcopy book at his next session. He was unhappy with the quality of one picture. His empty Doritos bag was sitting by the sandtray, and he wanted it cropped out of the picture, and while I am reasonably adept at editing, I could not figure out how to do this. Randy suddenly said, "I know!

Figure 5.8 Two Guards Come to Help. The First Humans in the Animal World

We can get Brad to do it." Brad is Randy's newly adoptive father, and enlisting his help was a huge shift: it acknowledged both a need for help and his growing internalization of his new dad as a "bigger, stronger, wiser, kind" person who is becoming *his* helper.

Creating the hardcopy involved focusing, sometimes with multiple repetitions, on smaller, chunked pieces of text. This became yet another exposure in the titration process. He cared deeply about which parts of the text accompanied which

picture. After we took the pictures, I wondered out loud if we should show the tray to his mom. Randy immediately went to get her and brought her back to the room. I invited her to sit and read the story out loud while Randy ran his hands through the sand. His mom heard the underlying themes of struggle, of isolation, of the owls' helplessness, and their solution to let the two guards come help. She, too, sat in silence, acknowledging the power of the narrative.

Randy's sandtray story was created just after having his concerns about the holes in the finger puppets acknowledged and held. I made the connection between putting fingers in the puppet holes and children who have been sexually abused. When we respect the child's risk-taking as they test for containment, we allow the child to take further risks. As they learn that they can take further risks with us, we give room for implicit experiences to be brought into explicit memory in tolerable doses. In Randy's case, we made the doses tolerable by adding layers of narrative as we explored together. The first "telling" of the story was his non-nonverbal process of choosing and carefully arranging miniatures in the sandtray. The second "telling" of the story was in a verbal but created story that kept the symbols in their character contexts. The third telling of the story, for him, was through the lens of the camera, returning from left brain verbal narrative to right brain pictoral/symbolic telling, but this time with layers of removal that allowed him to begin titrating and tweaking the story, allowing him to move back and forth between deeper and more shallow waters of exploration. The fourth telling involved integrating all the previous parts into book form.

An Overdose of Flies

Jillian is a four-year-old girl who is being raised by a whole posse of people, including dedicated grandparents and parents who both want to be in her life and who have been wrestling with addiction issues for years. Each of her parents has had abrupt departures—sometimes without meaningful goodbyes—to treatment centers, where the treatment regimens have lasted anywhere from 30 days to several months. Jillian has had addiction explained to her, in developmentally sensitive terms, using several different kinds of explanations. One such explanation talked about how her mom and dad have a switch that does not flip properly in their brains. Most people, after they eat one serving of ice cream, will feel full and know that one is enough. Some people might have a second serving and then feel overly full and stop eating. Her mom and dad's brains do not tell them to stop eating. In fact, if they eat one serving of ice cream, they right away want another, and they will keep eating ice cream even after it gives them a stomachache. Their "stop" button does not work well. Does this explanation get through to Jillian? It is difficult to know, but in my experience, I would say that no explanation from an adult is as impactful for the child as the metaphors they create themselves. Very young children benefit significantly from a child-led play therapy approach, particularly when trying to work through family dynamics that are confusing and for which words may be woefully unsatisfactory as explanation, so Jillian and I engaged in lots of child-centered play. She was drawn to the sandtray and to the symbols that

Figure 5.9 Manta Ray

could speak volumes when words were insufficient. During a season in which one of her parents was away in treatment, she went over to the shelf with the sea creatures and chose a large manta ray (see Figure 5.9).

ME: You chose that one.
JILLIAN: Look, Miss Paris. He has a big mouth [*after flipping the figure over and seeing its underside*].

ME: He does have a big mouth. You found it.

Jillian noticed a set of bugs nearby. She picked up one of the flies and experimented with pushing it into the manta ray's open mouth.

JILLIAN: He's swallowed a fly! He's hungry.

ME: Yep, he's got one inside now.

JILLIAN: It's gonna make him sick.

ME: Oh! The fly is bad for him.

JILLIAN: Yeah, the flies make him sick [*nodding and picking up another fly*].

ME: He just ate another one! Even though they make him sick.

Jillian picked up several more flies and shoved each one into the manta ray's mouth until there was no more room in his mouth.

ME: He just keeps eating more flies [*with a worried tone*] (see Figure 5.10).

JILLIAN: Yeah . . . and now he's dead.

ME: Oh, no [*some concern infused in my tone*]. He died from eating the flies that were bad for him.

JILLIAN: Now he gets buried.

ME: You are covering him up with sand now.

Jillian works with great focus to make sure that the manta ray is completely covered up.

JILLIAN: There [*stepping back from the sandtray*]!

ME: You buried him. He can't be seen now. Only you and I know that he's under there.

After a few seconds of sitting with the reality of not being able to see the manta ray, Jillian abruptly pulls him from the sand.

JILLIAN: He's alive again!

ME: Oh! You brought him back from the dead.

Jillian shakes all of the flies out of the manta ray's mouth, enlisting my help with the last one that is stuck way down inside.

JILLIAN: All out!

ME: You got them all out!

Jillian and I were quiet together, feeling what it felt like to see the manta ray again and to have him empty of the flies that killed him. Then Jillian sighed and started putting flies back in his mouth again.

This overdose of flies, the passion of the death, burial, and resurrection of the manta ray, becomes the child's psychic processing of this family pattern. The pause after the first cycle of play, followed by Jillian's sigh and decision to begin the cycle again, may signal her resignation to the inevitability of this pattern repeating in her family. While she has hope that her parents will come back to her (whether this is in relation to their physical presence or emotional presence), she may be engaging in self-protective preparation for the pattern repeating even as the play helps her make more coherent sense of the pattern as she has already been experiencing it.

Figure 5.10 Full of Flies

Conclusion

Metaphor provides an astonishingly rich wealth of expression. Children never cease to amaze me with the ways in which they will act out the horrors they have experienced in a language removed from reality. Many times the work is

done solely in metaphor, symptoms resolve, and children integrate the trauma content. Other times, offering extended ways of working with the metaphors by offering different mediums of expression—paint, sand, photography, puppetry, collage, drama, movement, writing—can bring deepening levels of integration. Because it is the gentlest approach to trauma content, metaphor should always remain prominently displayed on the Play Therapist's Palette and be an offering whenever children or families appear stuck.

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6 Playing the Affective Accordion

Titration in Aspects of Emotional Literacy

Symbols for Big Feelings

Many of the children that we see in therapy have very little language associated with whatever traumatic events have occurred. Many of our clients with developmental trauma disorder have delays in their expressive or receptive language competencies, and visual representations, especially three-dimensional visual images, of their emotions often prove helpful in providing a different form of integration. Moreover, young children "live" more in their right brains than in their left brains regardless of whether they have experienced trauma, so symbolic expression can often be more accurate than verbal articulation in capturing the essence of an experienced emotion. With some children, we begin emotional literacy work by simply identifying a feeling and then identifying a symbol, a miniature in the playroom, that evokes this feeling or represents this feeling for the client.

I am often combining TraumaPlay™ and EMDR and was using the Thoughts Kit for Kids, created by Ana Gomez, to help George identify negative cognitions. However, he was not able to identify or articulate his thoughts, but he did spontaneously generate these three feelings on small Post-it Notes. I read each word out loud while I attached each feeling word to one of the blank cards that come with the game, and then asked him if he could choose a symbol from my miniatures to represent each feeling. George chose a disproportionately small naked baby to represent the feeling of vulnerability. He chose the nun symbol (who can have sparks fly out of her mouth when she is cranked) to represent angry (see Figure 6.1). Finally, he chose the symbol I call the Invisible Man to personify the feeling of powerlessness he had experienced during his sexual trauma. The pairing of icons with words helps move the processing from left brain to right brain and back again.

Felt Feelings

Many children come into treatment with a constricted emotional vocabulary. One of the ways we help children expand their vocabulary is to expand their somatic understanding of emotion. How do their bodies let them know that

Figure 6.1 Fire-Breathing Nun Symbolizing Anger

they are having an emotion? This can be even harder to explore without a tactile anchor, a concrete way to explore the abstraction, so icons are sometimes more useful. A host of icons is placed before the child. These concrete representations of somatic experiences can be as varied as your clinical imagination and can be pulled from multiple sources: you can find images on line, you can cut them out of magazines, or you can draw them yourself. Icons might include fireworks, flames, a tornado, a pair of handcuffs, or even a black hole. The child is offered a visually nuanced set of images that can reflect experience of different emotions, or even the same emotion. In a sampling of three children, all of whom can verbalize that they often feel anxious, one may experience his anxiety as a tornado in his head, another may experience it as fireworks exploding in his heart, and a third may demonstrate his experience of anxiety as a big black ball of heaviness in his stomach. So, the exploration is two-fold: how would you characterize your feeling iconically, and where do you carry that feeling in your body? The set of icons you see below was created by a previous intern at Nurture House, Bethany Berryessa, after she attended a training with Lori Myers, LCSW, RPT-S, and was introduced to felt feelings, Lori's adaptation of an intervention she learned at a TF-CBT preschool learning collaborative.

Sam is an eight-year-old boy who came in to therapy with Bethany because of angry behavior and suicidal ideation. When he was three years old, Sam was physically assaulted by his preschool teacher. Following the assault, Sam was interviewed by the police and removed from the school. Therapy was not recommended for the client at the time of the assault. Five years later, when Sam started psychoeducation around trauma using resources such as the book *A Terrible*

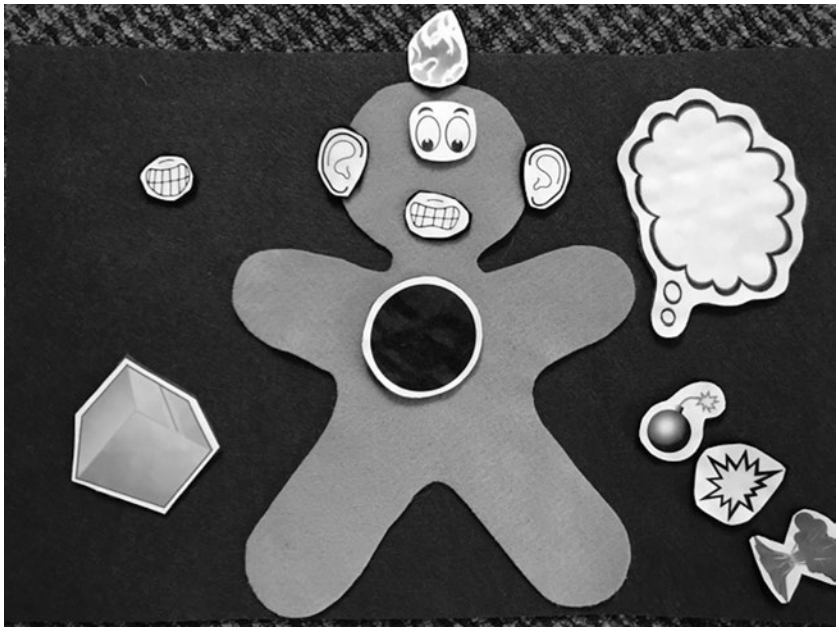

Figure 6.2 Sam's Somatic Experience of Anger

Thing Happened, he became dysregulated and verbally shut down. Bethany offered the felt feelings board, and he was able to show the therapist how his body felt when he was angry. As Sam created his felt feelings board, he described how each of the images correlated with specific physical sensations and, eventually, suicidal ideation (see Figure 6.2). Because of the intervention, he was able to self-regulate and show what he was feeling before being asked to use words.

In the following session, Sam asked to create a felt feelings board to show the therapist how he felt at school when he would try to make cuts in his palms with scissors. Sam asked for a pair of child's scissors in the playroom to add to his felt feelings board. He used an image of a box in his board, which later became an important image for EMDR reprocessing of the event (see Figure 6.3). Because the client felt safe showing his experience (as opposed to having to talk about it), the therapist was able to provide alternative coping skills to replace self-injurious behaviors, regularly assess for safety, and increase physiological and emotional awareness.

Facial Expressions

Emotional literacy is about not only being able to name an emotion that you yourself are feeling but also being able to accurately identify what those around you may be feeling. This becomes really important between parents and children, as the mirror neurons we referenced in the chapter on the neurobiology

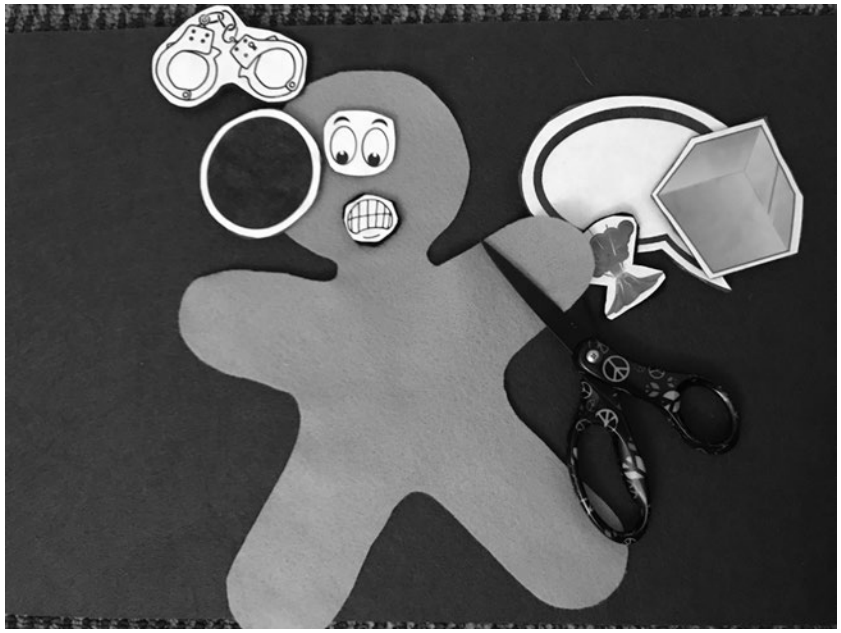

Figure 6.3 Sam's Elaboration of Self-Harm

of play and trauma can influence the experience of one person's emotions through the expression of another. We know that when a mother smiles at her baby and the baby smiles back, this process is not simply a reflexive one involving a mimicking of facial muscle movements, but rather an exchange of neurochemical experience in which the dopamine released in the mom's brain as she enjoys her baby is simultaneously released in the baby's brain as the baby experiences the mom's smile almost as its own.

When a parent and child are securely attached, they are able to read each other's facial expressions even from a distance. When the attachment relationship is insecure, children may overperceive negative emotions or underperceive positive emotions in the faces of their parents. This is an especially noticeable problem of perception between foster and adopted children and their caregivers. For these reasons, we at Nurture House are continuing to explore ways to work with facial expressions of emotion. There are several interventions that we employ in this process. The newest of these revolves around a dry-erase face that we have installed in the kitchen of Nurture House. Since its installation, it has yielded profound moments of discovery for adults and children alike, both in terms of how they perceive the facial expressions of others and the ways in which their own facial expressions are understood by others.

The first such aha moment occurred even as we were adhering this new tool to the wall. My office manager, Linnea, whom we all agree is the most regulated person at Nurture House, was helping me hang it. I asked if she would use the

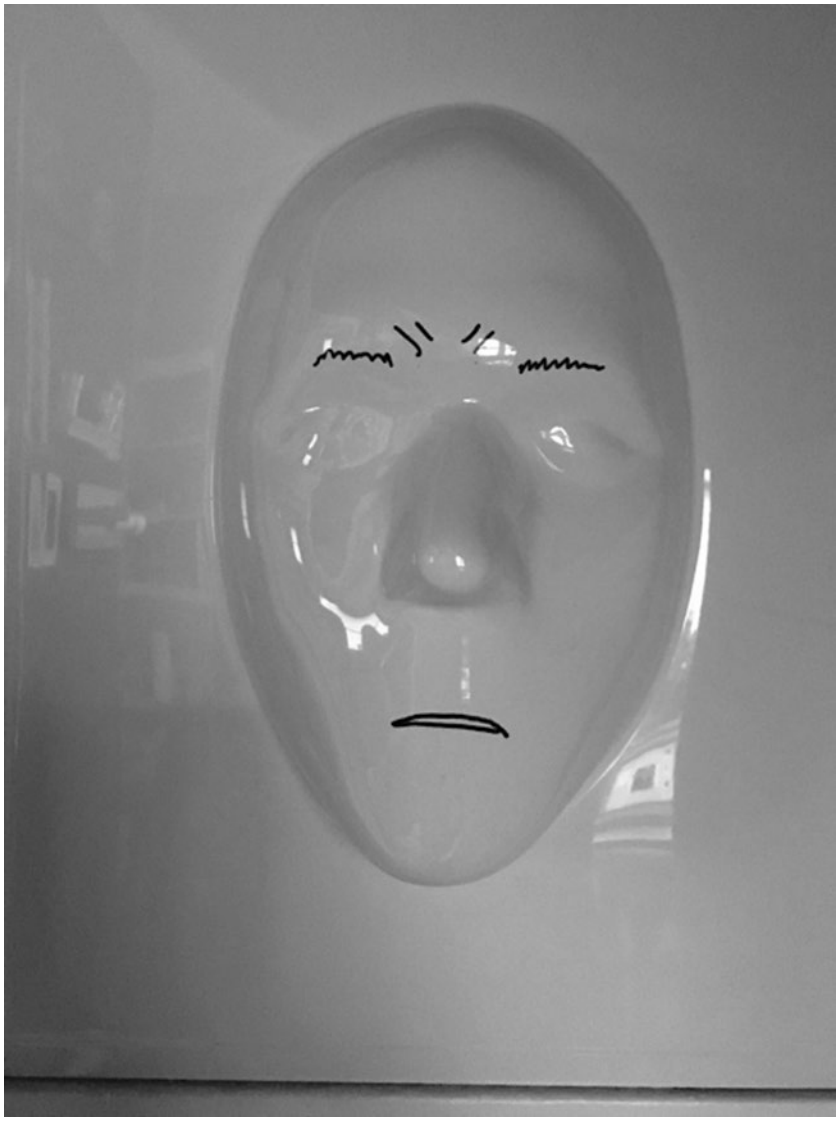

Figure 6.4 Linnea's Expression of Anger

dry-erase markers to create her own expression of anger on the face. She chose the black marker from the rainbow of colors offered and drew eyebrows and a slightly frowny mouth, then drew two thin, short, slanted lines to represent her disapproving brow (see Figure 6.4). Here is how the conversation went:

ME: That's your angry face?
LINNEA: Yep, I guess so.

ME: This is what makes you so good with people—you don't get super angry.
LINNEA: Well, or I don't show it.
ME: Hmmm . . . that may be good for others but not so good for you.
LINNEA: Well, then it may not really be that good for others [*referencing here the way that unexpressed anger can come out sideways in our most intimate relationships*].

It was not until later that I realized we both had some insight into her physical expression of anger and how this might affect her relationships. Several different prompts can be given with the dry-erase face:

1. Draw your face when you are . . . (fill in the emotion: angry, scared).
2. Draw your mom's (or dad's) face when she looks . . . (fill in the emotion).

Once either one of the above prompts has been drawn, two additional prompts can yield powerful information:

3. Erase the scariest part of the face.
4. Redraw the emotion the way you would like it to be shown.

At Nurture House, we are often teaching caregivers the SOOTHE strategies, a set of co-regulation strategies meant to provide comfort and regulation when a child is no longer in his choosing mind (Goodyear-Brown, 2010). The "S" in the SOOTHE acronym stands for "soft tone of voice and face." Referencing our mirror neurons again, if we can acknowledge how powerful they may be in generating a shared experience of a positive emotion (such as delight in one another), we must also acknowledge that this same neuronal substrate may provide shared experiences of frustration, anger, fear, and disgust. We keep handheld mirrors at Nurture House to help parents and kids play with this idea together. A mom, for example, holds the mirror out in front of her, and the child gets to draw features on the mirror that augment what the child perceives as mom's communication of anger when she is angry and vice versa. Sometimes this exercise is done in a parenting session where mom and dad take turns showing the anger expressions of the other. It is important that an exercise like this be saved until there is a great deal of safety within the system, as it is meant to be a more concrete way for each party to learn what the other perceives and is in no way meant to be a tool for shaming or teasing. Fear, concentration, anger, and confusion can all look pretty similar. The dry-erase face can be used to compare and contrast parts of the expression of each that are similar and/or unique to each expression.

Soon after we hung the face on the wall, one of my sexual trauma survivors, a 15-year-old girl, was in the kitchen with me. Her mom had mentioned Cassandra's tendency to blunt her affect, to seemingly shut down emotional communication whenever her mom brought any correction. I shared her mom's concern, and she said, "Yeah, I probably look as blank as that face!"

She pointed to the dry-erase face. I said, "Do you think you could show me what you are really feeling underneath the blankness at those times when mom corrects you?" Below is the face she created (see Figure 6.5).

I said, "What would you call this expression?" She replied, "Unbridled fear!"

What she was showing her mom was a mask for intense feelings that actually needed soothing during those moments of correction. We brought her mom into the session and helped her understand her child's face differently.

Figure 6.5 Unbridled Fear

Symbols as Embodied Feelings

As children begin to feel safe and can tolerate looking at more difficult feelings without believing these feelings make them bad, we often begin to see spontaneous visual depiction or even spontaneous articulation. We keep sticky note pads of emoji starters for times like these—only the eyes are already drawn within a round face. What you see below is the work of Josh, a client who had his first several sessions in his car because he could not regulate enough to come into the building. Over the course of those first few sessions, I would bring several options of play materials out to the car, as Josh alternated between refusing to come inside and wanting to come inside but being too aggressive to safely enter the building. Even the simplest games were sometimes met with intense frustration the moment Josh experienced a feeling of failure for any reason. For example, if he had been tossing a ball and dropped it, he would hurl it across the car. During those times, parents and therapists offered names for some of the feelings being displayed while continuing to welcome him back in his distress. On his seventh visit, when he had become more regulated and more assured that his caregivers could be bigger, stronger, wiser, and kind in the face of his worst behavior, he was able to enter the art room. I offered him an open studio and free rein to use the art materials as he wished, and he chose the emoji sticky pad. Josh spent the majority of the session creating faces to represent the sad self, the angry self, the happy self, the scared self, the cool self, and the loving self. He asked for a piece of paper on which to display them all, and once he had stuck them all on the page, I asked if he could title the page, like you would a book. He thought for a minute and then said, "The real Josh" (see Figure 6.6).

Emotional Expression Hand Puppets

We have established that many children live more in their right hemispheres than in their left. Therefore, while the left brain may hold the words of an emotion, the right brain may hold the expression of the feeling. Long ago, I bought a set of two hand puppets with many Velcro parts (eyes, ears, noses, mouths, hands, feet). As I was working with a little girl, it became clear that she was not able to verbalize her feelings beyond "bad" and "sad," so I introduced the puppets and their parts. She carefully perused them and chose some eyes that were wide open, with sweeping eyelashes, and a toothy smile to be "happy." In a subsequent session, I introduced the idea of an emotion called "worried," and after exploring the puppet parts very carefully, she chose a set of eyes encased in glasses, a mouth with two top teeth and two bottom teeth exposed—clearly an open mouth—nonmatching legs/feet, and a watch. I wondered out loud about the inclusion of the watch, and she said, "Because there is never enough time to get everything done." When I shared the puppet pictures with her mom and dad (see Figure 6.7), the symbolic representation of her worry helped them shift their understanding of her defiant behaviors in

Figure 6.6 The Real Josh

the morning. She woke up most days feeling anxious about whether she would be able to get everything done before leaving for school. With her parents' understanding of her pervasive worry came a paradigm shift that empowered them to co-regulate her instead of discipline her in the mornings. This small shift changed the whole tenor of their home.

Kinetic Involvement Mitigates the Approach to Feelings

As we discussed in the chapter on need meeting, some children are going to mitigate their approach to emotional exploration through the use of their physical bodies. Particularly for latency-age boys, activities that allow them to feel strong in their bodies and that provide a high challenge make for an easier approach to emotional literacy titration. We keep two laminated sets of feelings stuck to the wall in each room of Nurture House, and within each space is a way to target particular feelings on the laminated pages with various projectile toys. In the kitchen, we keep a wooden catapult, a wooden crossbow, and mini marshmallows. We dip the mini marshmallows into pools of glitter glue on paper plates and launch them from the sink. Whichever feeling the marshmallow hits is the one we explore. On a practical note, it is important to coat the marshmallow with something that will leave residue on the laminated feeling

Figure 6.7 Worried Hand Puppet

face chart; otherwise, the speed at which the marshmallow sometimes flies across the room makes it impossible to accurately judge which feeling was hit.

Naming Big Feelings Together

Katherine, an eight-year-old-girl, and her mother are in session together. Katherine's mom, a doctor, had developed a drug addiction and went to rehab

for a period of time. I had spent time with both Katherine and her mother before her mom went to rehab, helped them through the hard goodbye, made sure attachment anchors were in place, and helped them through a meaningful hello period after mom came home. As is sometimes the case, the role addiction had played in the family was its own kind of anchor and, when removed, led to a destabilization of the family. As it became clear that the family dynamics were shifting, Katherine faced the very real potential of divorce between her parents. Her mom had expressed this fear to me also, but neither mom nor daughter had shared their fears directly with each other. This mom had been working on her own ability to be a safe container for her daughter, and after some discussion, we agreed that she was able to hold her daughter's big feelings about all the changes in the family. Years ago, I created an intervention called The Mood Manicure (Goodyear-Brown, 2002). In my early work, this intervention was often completed between the therapist and the client but is often now offered to a parent/child dyad and facilitated by me. In this case, I felt that the combination of high nurture, connection, and physical touch that Katherine had missed while her mom was away would augment the sharing of big feelings between Katherine and her mom. At the beginning of the session, I ushered Katherine and her mother into the kitchen/art studio and offered them a set of multicolored nail polishes. I invited them to explore the various colors of nail polish and assign each a feeling word. These deliberations took some time, and Katherine's mom gave choice and voice to her daughter throughout the process as they choose feeling words for each color. Katherine chose yellow to be happy, and her mom agreed. Her mom chose blue to be sad, and Katherine went along. They deliberated for a while over which color would be lonely and eventually decided on purple, and they designated orange their "worried" color. After the feeling/color associations were made, mom and daughter painted each other's fingernails, asking first what color the other wanted on each nail. Both parties understood that for each nail painted with a certain color, they would verbalize one situation in which they had felt the feeling represented by the color. Mom took Katherine's hand in her own, pulled out her pointer finger, and said, "Which color would you like on this finger, sweetie?" Katherine pointed to the orange. The action of pairing colors and feelings together and then working with the names of the colors (as opposed to working directly with the feelings themselves first) offers an immediate titration, allowing clients to begin approaching their emotional experiences and sharing them with important attachment figures through a first filter of color, without having to name the big feeling words directly yet. Then it was Katherine's turn to pull out her mom's pointer finger and ask which color she would like painted on that finger. Her mom also chose to have her pointer finger painted orange. I looked at the color/feeling grid and said, "I see that you both chose the color orange. Let's see, orange is worried. So, Katherine, what's one thing you worry about?" Katherine said, while looking at her fingernail, "Well, you and Daddy have been arguing a lot." Mom reflected her words and validated her feeling. I then asked Katherine's mom for one thing she worried about, and she stated, "I worry that the kids are

scared when dad and I argue." Katherine shook her head and pointed to the blue, and her mom said, "You feel lonely? When we argue?" Katherine nodded slowly as she held her hand out to have her next finger painted with blue. After her mom painted her fingernail, Katherine said, "I feel lonely because I think you guys will get a divorce and I'll be alone more." Katherine began to cry. Mom reflected her big feeling, acknowledged the possibility that she and her dad might be getting a divorce, validated her daughter's feeling of loneliness, and sat with her in the sadness. Mom and client held the uncertainty together, cried together, and affirmed that they would still be a family and mom and dad would still both love her no matter what. Mom and Katherine left in a much more connected state than they arrived, having faced the big, unnamed possibility of divorce together (see Figure 6.8).

Naming it together brings connection. By the end of the session, both mom and daughter's hands held worry, loneliness, and sadness. Through titrated doses of exposure to difficult emotions (mitigated by physical touch and comforting kinesthetic activity, i.e., painting their nails), their hands became a microcosm for holding each other's big feelings in titrated doses. At the end of the session, both parties seemed visibly relieved that the other had acknowledged the possibility of divorce, that both had permission to feel sad and lonely when thinking about this possibility, and that both felt less lonely than when they arrived because of their shared holding of the story of these feelings.

Figure 6.8 Enhancing Emotional Connections

Approaching and Naming the Emotions Projected by Others

In the chapter on the neurobiology of trauma, we looked at mirror neurons and the role they can play in affective attunement between parents and children. We learn how to express emotion and how to regulate emotional expression from our caregivers. Even when a foster or adoptive parent has been nurturing and stable, providing modeling of modulated emotional expression, these new interactions may not outweigh the earliest influences of the biological parents' emotional expression as it was perceived by the child. Children who have had several caregivers who have influenced their emotional development can benefit from having a projective way to quantify the emotions of those who influenced them at different stages. In the course of trauma work with families, we are always trying to bring integration to aspects of the life narrative—aspects that include thoughts, feelings, and sensory impressions. Helping children increase their reflective capacity for identifying and naming the primary emotions they "feel" from and with others can further their understanding of self and others.

Dan Siegel's phrase "name it to tame it" (Siegel & Bryson, 2011) is a short encapsulation of the idea that when we can give words (executive functioning/neocortex involvement) to the limbic experience, we can mitigate the need for the body to express the emotions as intensely in a kinesthetic, full body way. The naming of the emotion diffuses its intensity and brings integrations between lower and higher brain regions, opening pathways to the neocortex for thoughtful responses to the emotion being named. When a child has a parent with high emotional literacy who can give words to the child's experience, the attachment between the parent and child is enhanced, the child is anchored, and their shared mindsight evolves. When a parent is themselves disorganized internally, unable to name—or potentially even reflect on—their own emotional responses, the experience of difficult emotions is one parent and child each struggles through alone. The image I will sometimes offer to clients is that of a mother and child wading into the shallows at a beach as the child has his first experience with the ocean. The child is being held by the mother as they wade in together. A small wave comes, and a small, pleasurable excitement is produced as mom and child together get buoyed up and down by the wave. She is holding on tight, and the child is secure and able to enjoy as she enjoys even though it is a little new and therefore maybe a little scary. Let us contrast that with a mother and child who wade into the water and are hit by a wave that is much larger than the mom anticipated. She is knocked off her feet. It is impossible for her to hold on to the child, and he goes tumbling. When a parent has been overwhelmed by a wave of emotion, without any readiness for it or ability to understand it, the child has the experience of being pummeled helplessly by the same wave of emotion but without the anchoring lifeline, the grounding presence, of the parent.

Steven is a ten-year-old boy. His adoptive parents brought him to Nurture House one week after bringing him into their home. He and his siblings lived

for the first seven years of his life with a mother who was intellectually impaired and nonprotective and a father who was sexually abusive to all the children in the home, violent with the mom, and physically abusive to the children. Steven was eventually placed in foster care with a safe family who was willing to take all the siblings. While this home was safe, loving, and fun, it would have been impossible for the parents to meet the needs of all the children in the home for the long term. During this foster placement, Steven continued to have intermittent visits with his mom, and sometimes during those visits he would have unsupervised phone conversations with his dad. Understandably, his felt safety, because of the constraints of the system, was never truly allowed to grow. Finally, Steven was adopted by extended family and began work with me. You will read more of his story in the chapter entitled "Holding the Hard Story: Narrative Nuance", but I will share here his work around exploring the emotional lives of his caregivers over time and how his schemas about whether grown-ups are safe and can be trusted began to shift through the reflective activity.

Steven enjoyed art. He especially enjoyed the dot paints and asked to use them every session. While we were working to enhance his emotional literacy, we normalized that all adults have all kinds of feelings. He responded with, "Not my mom. My first mom. She was never happy." I said, "You never saw her feeling happy? Can you show me what feelings you did see in her? I know you like the dot paints. How about you pair a feeling word with each dot color? I'll draw an outline of mom and you can add as many dots for each feeling inside of your first mom as you like." He chose the blue dot paint for sadness and began energetically pounding the paint marker all along the inside edges of his biological mom's body outline. It became clear, after a couple of minutes, that his intention was to color in the whole of his mother's body with sadness. I reflected this, saying, "You are filling her whole body with sadness!" He nodded and then began filling the space outside the figure with blue dots. "You have put blue dots all around her too!" Randy seemed please that I was tracking with his unspoken communications.

He asked to do one for his foster mom and a third for his adoptive mom, so I got to work drawing two more mom outlines. He then put one dot of blue on each of his other two mom figures. He picked up the red paint and completed a similar process for anger, putting much anger in and around his "bio mom" and only one dot on his other two caregivers. The client repeated this process with feeling/color pairings of anxiety, disappointment, and overwhelm. When he was done with all the more difficult emotions, he decided that the last one would be happiness (green), and he ended with a reverse process where he put one dot of happiness on the picture of his bio mom and covered the figures of his foster and adoptive mothers with it.

After he had completed the activity, he sat back, and we sat with our heads together looking silently at all three figures.

Steven spontaneously said, "Hers is colorful [*pointing to the first mom drawing*]. It looks fun, but it's not."

ME: Those are a lot of big feelings . . . pretty confusing for a little boy.
STEVEN: Yeah, I didn't even know 'em.
ME: Well, babies don't have words for their feelings, they just feel.
STEVEN: I didn't have words then, but I have them now!

Steven was able to bring his current developmental achievements to bear while reflecting on his early experience, and it seemed to bring a sense of competence. He also remarked on how similar the other two mommy pictures looked.

STEVEN: These two look the same [*pointing to the pictures of his foster mom and adoptive mom*].
ME: These two moms do look almost the same.
STEVEN: Maybe most people are like this.

I reflected his maybe and understood that Steven was struggling with his early mental schemas and his more recent corrective emotional experiences. He was trying to wrap his head around his early experience of a disorganized emotional life, his resulting belief that people cannot be trusted to take care of him, his more recent experience with more organized adult caregivers, and what the patterns of care offered by multiple safe adults might mean for how he relates to the world. As he continues to work this out, he will move more and more to felt safety in his current environment. Part of the power of play and expressive arts is that the symbolic representations of content—in this case quantifications of the internal emotional experiences of those in authority over him over time—can be explored for patterns. Then those externalized patterns can be reflected on, tested out, and potentially integrated into new mental schemas that include the potential that the disorganized caregiver was the exception and that most adults will be helpful.

Helping Children Grow Reflective Capacity Around Emotion

Many of the children I see, especially those who have been adopted from hard places or have had emotionally disorganized parents, have very little ability to identify difficult emotions. My first goal for these clients is to help them increase their window of tolerance for sitting with an emotion. Sitting with an emotion is another capacity that can be expanded through titrated doses. Play and expressive therapies offer mediums that mitigate the approach to difficult emotions and aid in the titration. Almost all creative art materials (from sand and clay to paints and pipe cleaners) can help provide distance while a child works to quantify, reflect, describe, etc., the experience of a particular emotion. Many clients will have explosive behaviors or intense crying jags but then are unable to tell us what they were feeling. Sometimes the resulting shame of having wreaked havoc by hitting, kicking, throwing things, etc., or by making enraged accusations or threats to their parents is so intense emotionally that it blocks their ability to reflect on the emotions involved at all.

Distancing techniques that allow them to manipulate quantities and qualities of emotion can be particularly helpful when shame is involved. James was an 11-year-old boy who was adopted at four after having been in the home of drug addicted parents for a couple of years. He was then removed and placed with older caregivers who had trouble keeping up with a high-energy toddler. He was eventually adopted into a new family with a couple of older biological brothers. When I first met James, he was hiding under a blanket in the car. Having just been released from a psychiatric hospital, he was carrying deep shame and a core belief that there was something desperately wrong with him. The first goals of therapy were simply helping him feel connected, safe, and like a kid who could be enjoyed again. We then worked through enhancing attachments with his caregivers while helping them make the necessary shifts to become bigger, stronger, wiser, and kind for him more of the time. When he felt safe, liked, and connected again (a process that took six months), I introduced some emotional literacy games. Critical tasks in emotional literacy work are setting the bar individually for children from hard places and sensitively remaining within their windows of tolerance for acknowledging and reflecting on big feelings. We first just played a matching game with feeling face cards. Like a classic game of Memory, the cards were all face down, and mom, client, and I took turns turning over two cards at a time until we found a match. There was no attempt to tie actual content from his experience to feeling words; this first "dose of exposure" to difficult emotions was simply finding two faces that matched. He did not even have to say the name of the emotion the first time around, nor did the adults name the feelings the first time around. James has high visual-spatial intelligence, and part of my thought process was to build on his innate strength, giving him competency experiences as he found matches. Competence is experienced neurobiologically as a surge of dopamine (the joy chemical) in the brain, and these competency surges mitigated his exposure to emotions such as *disappointed, frightened*, and *embarrassed*. He was instantly rewarded with being able to remember where he had seen a particular feeling face before. James exhibited a lot of positive affect each time he got a match, and as neither his mom nor I have the same visual-spatial intelligence he has, we were easy to beat. He became more playful along the way, engaging in some light teasing of his mom and me—a form of social engagement I had not seen before.

James asked for this game again the next time we met, but he had ideas about how to make the game more challenging, and he won again. As the novelty of this set of cards wore off, I introduced a second set of feeling cards. These Todd Parr cards display an emotion like "left out" on one side and "connected" on the other. James initially wanted all the cards to have their positive side up but was able to tolerate exposure to several more difficult emotions after we compromised on how many face cards of each kind we would use. To help mitigate his approach to the emotions, I offered him and his mom colored cardstock and a revolving set of scissors, each with a different cutting pattern. As we co-created the activity, we named it Zig-Zag feelings, with a nod toward the strangely shaped scissors and another nod toward

the ways in which our feelings can, and often do, move from one extreme to another as we are learning to regulate them. Each of us chose a feeling card and got to work creating a cardstock symbol to represent it. James's mom chose the Todd Parr feeling card *carefree* and created a yellow sun shape with slightly jagged edges to symbolize it. James chose *bored* first and cut out another white cloud to match the rain clouds on the card. Clients are often helped by having an experience of success that may be modeled off an existing representation, like the cloud on the card. Even using emotion cards informs the titration: is the card just a face? is it a specific scenario that might engender that feeling? are you offering only "core emotion" cards or more complicated feeling words, and if so, why? At Nurture House, we keep several sets of feeling cards, some with very simply drawn faces, others with scenarios that might engender that emotion, and some beautiful mixed emotion cards that are artistically drawn and highly evocative. The titration of exposure to feelings vocabulary—naming feelings, recognizing them in others or in ourselves, communicating them to others, and managing them internally—requires titration of the dose of exposure. James appeared to feel a sense of competence when both his mom and I accepted and understood his symbol, and this surge of pleasure, albeit small, scaffolded him to work with a more difficult feeling during the next round. He chose *bored* first, and after experiencing success chose *left out*. The jagged layers of black diamond shapes that he created to expressed left-outness are pictured below (see Figure 6.9). He took great care to create a much smaller and almost identical jagged

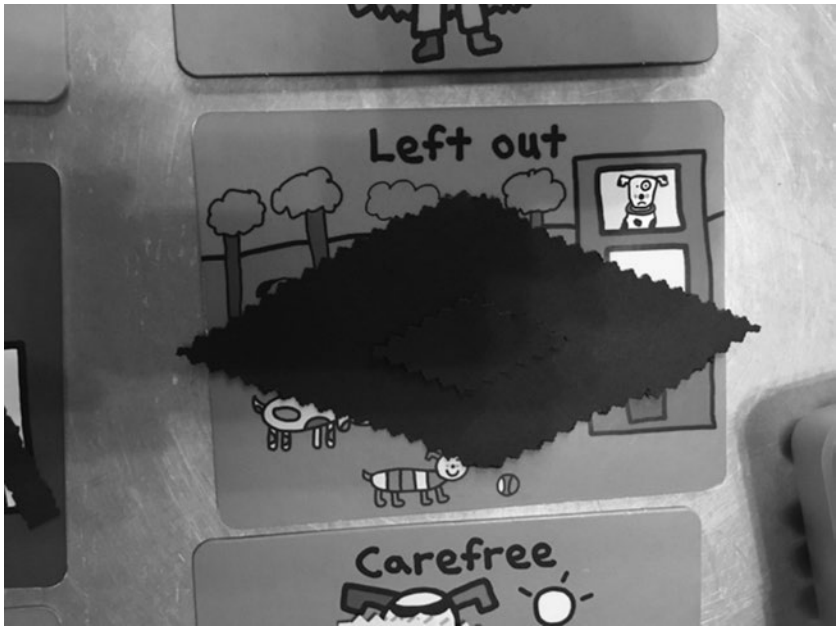

Figure 6.9 Left Out

diamond shape that sat in the center of the larger shape. Very few words were shared as mom, client, and I all absorbed the dark, sinking feeling associated with James's symbol.

Growing Reflective Capacity in the System

Sydney, adopted domestically at age four after having been in a couple of placements, was referred at age ten when on the brink of being sent to residential treatment. When I first started seeing the family, he was having rages that required physical containment by his parents, runaway behavior, destruction of property, and an inability to tolerate delayed gratification to meet the needs of another family member. He had very little understanding of his life story, a severely constricted ability to reflect on his emotional life, and a lack of trust in his safe bosses. Sydney and both of his parents worked very hard in therapy to make sense of how his early life affected his current behaviors. His parents did work on their own sets of "shoulds"; practiced kind, compassionate responding; met him in compromises; and filled his tank. He also dug in and began finding small ways to help around the house, began to ask for permission or supervision more frequently, and became more regulated.

We began with double sessions twice a week until we were out of crisis mode and then moved to a double session once a week. As the family continued to connect and regulate more and more independently, we titrated sessions down to a single session once a week. Recently, however, the parents described several troubling moments in which the client escalated and the situation was then unable to be de-escalated. This ramp-up in dysregulation happened at the same time every year, and as we began making sense of his history, it became clear that this time of year represented the traumaversary of his abrupt removal from his birth home by police officers. Months into treatment, Sydney and I had developed enough trust that we had been going on walks together. During his previous visit, we had agreed it would be cool to try to catch a fish in the Harpeth River, so between sessions I had gone to the dollar store and gotten a fishing net on a long, skinny pole. At the beginning of the next session, I met Sydney excitedly in the lobby to show him the new butterfly net I had just bought. We agreed we would spend half the session with his mom and then use the net at the river's edge. Mom and Sydney engaged in a bucket filling ritual they had developed for nurturing one another, and then mom asked to talk about a hard thing that had happened at school. Sydney's first response (as it is for many of our children who come from hard places) was to lie. However, mom had physical proof with her and showed it to him. I could palpably perceive his upset as his amygdala became armed. The flight, fight, or freeze response that gets triggered when a perceived threat is near has gained the healthy respect of his parents, and I watched him engage in all three sets of behaviors in succession. First, he froze, hardly moving, barely breathing, staring at the table. Then he ran out of the room, demanding to leave Nurture House and storming out of the

building. I serve some families in which if a child left the room, I would need to immediately go after them, but in this case I hoped the secure base we had established would bring him back, and, indeed, he did return to the room quickly. He could not seem to decide what to do with his body. He paced back and forth, opened and closed the door, and repeated himself almost robotically, saying, "Take me home. Take me home." At one point, he screamed over and over again for me to stop looking at him, although I did immediately shift my eye gaze away from him. It was not helpful for either his mom or I to speak, as he was fully in his reptilian brain at this point, and his mom and I breathed through it. At one point, he went and picked up the new fishing net and broke it over his leg. He eventually calmed enough to leave the building, but because of other clients waiting for me, I was not able to help him come all the way back to baseline and engage in any redos or reflection. His mom explained that while many aspects of family life had improved and Sydney had made significant gains in treatment, it was still "impossible" to talk about hard things outside of Nurture House, and accepting responsibility for any of his negative actions was still extremely difficult.

The session had been hard for everyone and had ended in rupture with no repair. This is the reality of our work at times. The next session after an unrepaired rupture is critical and requires the therapist to answer several questions, including, are we at the point in therapy where he can face harder things? Clinicians ask themselves this question, which is one of titration, all the time. And the answer is always case-dependent and largely colored by an additional set of questions: "how strong is the therapeutic relationship?", "is there enough trust and ability to co-regulate for the dyad to move into more treacherous territory?", "what is going on in the child's life outside of the therapy space?", "can the clinician provide safety even if a client escalates?", and "could going through the storm together and coming out the other side together strengthen both the therapeutic relationship and the client's sense of being able to face hard things?" In this case, I thought it was worth a try. After much thought and some peer supervision, I decided to trust and hope that he could meet me in the harder place. When therapy began, it was standard for both parents to accompany him in order to provide enough safe boss coverage. At the beginning of therapy, both parents had always accompanied Sydney, but eventually enough trust was rebuilt between Sydney and his mom and dad that just one of them could bring him without fear of an out-of-control episode happening in the car on the way to or from treatment. Mom and I agreed to move back to double sessions for a short period of time to allow enough time for deeper processing, especially in the event that he had another escalation in session—I wanted to be able to work it through to repair.

When I went into the lobby to meet them the next week, Sydney was sitting calmly, but slightly nervously, on one bench in the lobby, opposite his parents who were sitting together. Another form of titration has to do with how we use our proxemics with children who become easily escalated. I smiled at him and said hello but immediately shifted my gaze to his parents and engaged

them (disarming his fear response by not focusing strongly on him at first) while I sidled up to him. This gave him a chance to understand that I was the same person I had always been and was not actively angry with him over breaking my toy. Still looking at his mom and dad and laughing with them about something, I gestured for him to scoot over, which he did, and I sat beside him silently letting him know I would continue to stick with him. After another moment or two, I completed one round of communication with him, tousled his hair (a routine we established a long time ago), and offered him the art room or the sand room. He chose the sandtray room, which signaled that he was in need of the regulation and anchoring the sand provides him. I explained that since our last session was hard, we would be sure to have some fun time today even if we also did some hard work. We went into the sandtray room, counting on the sand to be both regulating and to provide a visual focal point for joint attention that would titrate the family's approach to hard content by decreasing the need for extended eye contact and offering symbols to buffer the work.

Sydney immediately turned his back on us and dug his hands into the kinetic sand. I addressed all three and said, "Last week really helped me understand some things." While I spoke, I picked up a midsized orange metal bucket and put it in the middle of the center sandtray. "I have been seeing so much growth in Sydney, I hadn't been thinking about how hard it is for Sydney to make repairs when he thinks he has injured a relationship. I think it is super scary for him to admit, 'Yeah, I messed that one up.' But it's a real problem because part of what has to grow in us in order to be in healthy relationships is an ability to admit when we made a mistake so people can love us through it. Last week, when Sydney felt caught in a lie, he might have said, 'Yeah, I lied, I'm sorry,' but I think that Sydney still has this deep, deep question about his own goodness or badness. I see kids who believe—really believe—that admitting a mistake is like saying they are bad kids. So right now, when he makes a mistake, I see him like this." (I put a small boy inside the bucket with his head far below the top edge.) "It's like he's in a deep pit with clay-packed walls. It feels impossible to get out of." As I continued to put sand up against the sides of the bucket, Sydney's dad began to talk about sand traps on golf courses (a sport he enjoys with Sydney) and how hard they can be to get out of. Up to this point, Sydney had kept his back turned to us and his hands in the kinetic sand, but once the little boy was in the bucket, he turned around and moved to run his hands through the softer sand, facing us but keeping his hands occupied. I also explained, "Right now, the pattern is that Sydney gets an uncomfortable feeling, and that uncomfortable feeling is so hard to face, he shifts the blame to someone else. It becomes someone else's fault for *making him* feel this feeling, and he gets very angry at whoever caused it. Only, I think he feels even yuckier after he has blown up." All this was said to the parents, with Sydney getting to listen without buy-in or comment.

Then I addressed Sydney directly and said, "I don't believe that you are a kid who really wants to hurt people or destroy their stuff, but if you want to stop, you are going to have to learn to handle uncomfortable feelings." Referencing the parents again, I said, "His window of tolerance for handling uncomfortable feelings and remaining regulated is pretty small right now, but it can be grown with practice, just like weight lifting. While we can't lift much at first, we keep practicing and get stronger over time."

I then introduced Sydney to the mixed emotion cards, a whole stack of beautifully illustrated and evocative cards that carry one feeling word per card, ranging from core emotions to complex feeling words. I said, "Pick three cards that describe the feelings you felt when mom confronted you on your mistake last week and you ended up breaking the fishing net that I had bought for our walk. You don't have to say the feelings out loud, but choose three cards and we will go from there."

Mom and dad and I engaged in some small talk while he chose his cards. I, of course, was simply praying he would continue participating, that the relationships in the room would be both supportive enough for him and meaningful enough to him at this point in therapy to mitigate the hard work. I am not sure what we should call this—it may be a clinical skill—but I believe it has some sort of overarching spiritual component to it, the communication with our whole hearts and minds as therapist to the family that they can do this, that we have them, that we can hold the space for them. It is more than assigning positive intentionality, and there is no pen-and-paper scale that will quantify this quality of interaction, but I feel it over and over again with children from hard places and with the parents who hope so much for them. He chose the three cards without speaking and handed them to me. I set them each upright in the sandtray and then read them aloud: Trapped. Depressed. Hopeless.

After reading the cards out loud, everyone was quiet for a moment, just looking at them in the sand. All of us were struck by the strength and specificity of emotion and level of introspection that Sydney had demonstrated. It felt to me like there was respect by everyone in the room for the risk Sydney took to identify and share those big feelings. Then I said to everyone, "How about each of you choose a symbol or set of symbols that represents each feeling for you and place your symbols near the feeling card?" Thus began some very focused time in which each family member moved inward and perused the shelves. The only negotiations happened around how to place their own experiences of "trapped" close enough to that card while allowing the other two to also have their experiences of feeling trapped nearby. The nonverbal navigation of space paralleled what I believe is the continual navigation of emotional space within the family. As Sydney's mom and dad opened themselves up to visiting their own prior feelings of being depressed, hopeless, or trapped, they connected with their own experiences and naturally became more compassionate toward Sydney's experience.

Sydney picked up a giant snake and coiled it around the *trapped* card (see Figure 6.10). Later, he would tell us, "You know, when a snake is completely wrapped around you and squeezing you, you can't get out."

Sydney's dad chose a castle and said that since he works inside all day, he likes to be outside on his time off and so can feel "trapped" in the house. After reflecting on the snake for a bit, Sydney went and chose a small house with an open front, and after hearing others talk about their symbols, he added a piece of fencing in front. His mom chose a tiny house made from a pumpkin. It was

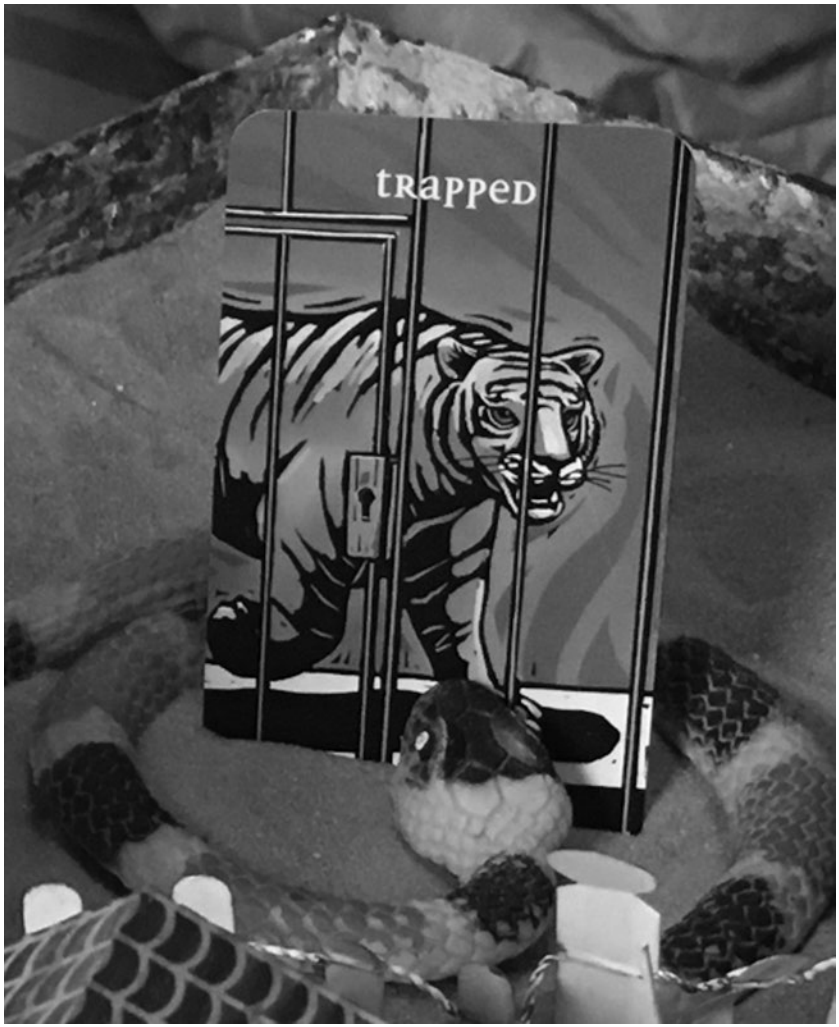

Figure 6.10 Sydney's Snake Coiling

interesting that both parents associated the feeling of being trapped with their home. Sydney had put a fence around the *hopeless* card, and he put a skeleton lying sideways within the fence. His dad chose an alligator and a figure that was disabled and talked about the feelings of hopelessness that might come from that. In the area of the tray designated for *depressed*, Sydney had tossed in the John Smith heroic character from *Pocahontas*. I am always trying to be attentive to how clients choose their figures and how they place them in the sandtray. In this case, Sydney looked at me and said, "I'm putting him face down on purpose." Later, he was able to talk about how the guy could not see his way out.

Sydney's mom chose a tiny brass alligator that I had picked up from a street merchant in Nepal as her expression of the feeling card *depressed*. When I asked her about the alligator, his mom said, "Well, it is very small and it is very hard." Sydney also built a section of sand separate from any of the three cards that included four stone walls and a little golfing-type figure of a boy. He later explained that it was a very deep sand trap, validating his dad's interpretation of him as stuck in the sand. All family members had been able to vulnerably choose figures. The symbols added much more richness of expression for each family member and deeper insight by other family members. Taking the temperature in the room, it seemed that mom, dad, and Sydney were more connected at this point than when the session started, and the system seemed to be regulating through the symbolic expression.

Reopening the Compassion Well

I offered an extension. My prompt was, "Let yourself be drawn to one or more of the symbols in the sandtray." To the parents, I said, "Focus your attention on it and bring your own kindness, compassion, or desire to help to the symbol." To Sydney, I said, "Look in the tray until you find a figure that needs help and figure out a way to bring some help." I was already experiencing the work as very rich, but watching all three of them find a way to hold another family member's distressing feeling symbolically took the exercise to another level. Below is a picture of Sydney's symbol of hopelessness—the skeleton fallen over (see Figure 6.11). After studying the hopeless figure for a while, Sydney's mom chose a fairy and placed her in such a way that she was outside the fence (potentially outside the circle of hopelessness) but holding the skeleton's head (see Figure 6.12).

She said, "I think to be dead is to feel like you don't exist, and I think if the skeleton is held, if the fairy can see him, he will know that he is seen and he is not alone." Wow. Mom's compassion well was reopened as she placed the fairy, and Sydney's hope for possible connection was reinforced by the visual creation of a new connection where there had been only hopelessness before.

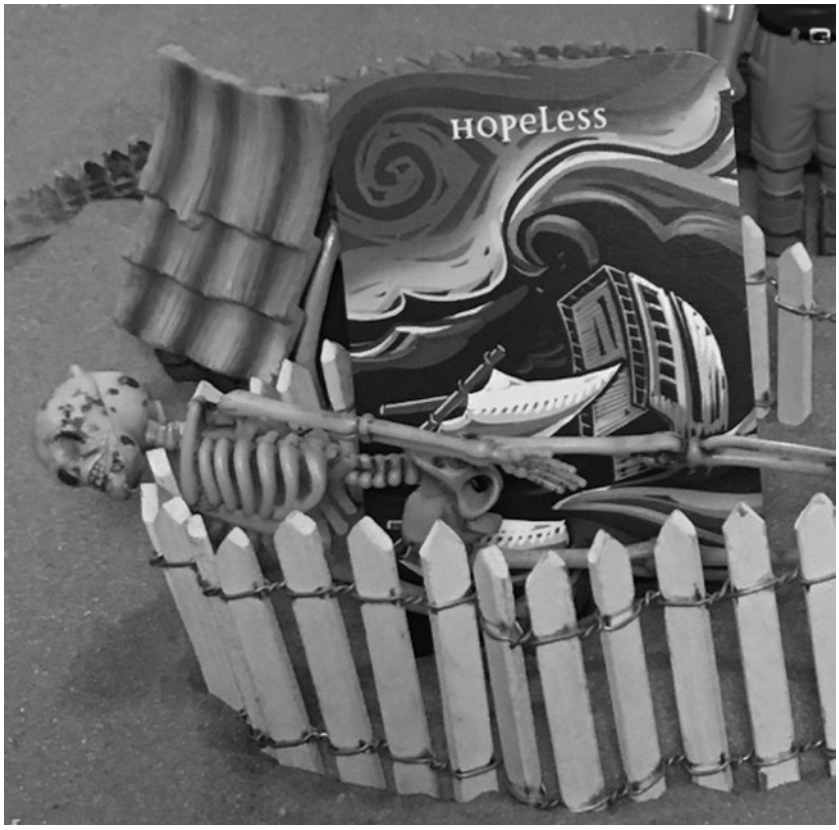

Figure 6.11 Hopeless

Conclusion

I called this chapter Playing the Affective Accordion because in my mind's eye I am always looking for the child's growing edge for all aspects of emotional literacy: naming big feelings, tolerating big feelings in a regulated way, talking about big feelings, expressing big feelings, and helping family members communicate them to one another. An accordion allows for great expansion and can communicate more as it is expanded. It has been my experience that children and families greatly expand their window of tolerance for being able to hold their individual big feelings, to express them to one another, and to become larger containers for received feelings when play and expressive therapies become the mediums through which the emotions are handled. I am excited about the possibility of new emotional understandings and new levels of emotional resonance that can be achieved within families if the titration of emotional content is delivered through play and expressive therapies.

Figure 6.12 Hopelessness Held

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7 The Nature of Play

The phrase "nature-deficit disorder" was coined by Richard Louv. He wrote a book called *Last Child in the Woods* (2008) that trumpeted concerns around the decrease in children's time spent in nature and the correlation of this statistic to an increase in behavioral problems. One of my life maxims is *those who risk nothing gain nothing*. When children play outdoors, they are training their bodies and brains to take developmentally appropriate risks. Anticipation and prediction skills are honed through various forms of play. Perspective taking, turn taking, negotiation and cooperation with others, integration of sensory systems within their own bodies, accomplished in part by running full speed through an open field or riding a bike along a neighborhood sidewalk—each of these is a natural form of bilateral hemispheric integration that used to happen as a matter of course as children played outdoors. Outdoor play also offers many experiences of competency, and effective navigation of the natural environment leads to increased self-esteem. So why are we not playing outside?

With the age of electronic media, many children are spending upwards of seven hours a day on screens, forgoing the realities—the sights, smells, sounds—of our natural environment for a virtual reality devoid of these sensory experiences. We live in a culture of fear, and as parents hear horror stories about children being taken or hurt, they limit their children's outdoor freedoms more and more. Gone are the days of children grabbing their bikes and going to play with the expectation that they will return by dinnertime. Children who do play outside often do so in the milieu of organized sports. These are good for children—offering proscribed limits and boundaries early in their development—but do not allow for free-form play. Children are amazing, and when left to their own devices in the natural world will create forts, make mud pies, and fight mighty wars, all with dirt, sticks, and trees. The benefits of imaginative and pretend play in the outdoors should not be minimized.

The Disney/Pixar movie *Wall-E* came out several years ago. Most people thought it was a cute, uplifting movie about a computer's quest to find true love. I found it a depressing commentary on where our culture may be headed. In the movie, the remnants of earth's population have relocated to a space vessel in the hopes of one day colonizing another planet. But they have forgotten how to be human, how to interact with the real world. All the citizens

float around the airship on levitating chairs, with their attention captured by a screen in front of them. It feels like this is not too far from what we could become if we do not have a radical shift back to valuing the natural world.

This alarming devaluing of outside play in our culture is not limited to families. Whole school systems are choosing to eliminate recess in earlier grades as a response to pressures to achieve more academically. Recess is particularly important for the children we see at Nurture House, who are often having to push through all sorts of somatic and emotional regulation issues to get to their executive functioning skills and be able to perform academically. Especially for children, the time they spend in their bodies during recess provides a form of stress management. We know that, at the least, exposure to sunlight provides regulating vitamin D, and the interactions with peers on the playground allow for many forms of valuable learning that cannot be measured academically.

Nature has been associated with therapeutic healing of the mind, body, and spirit from early Buddhist traditions to Roman baths to medieval monastery gardens to cure cottages. People had an inherent leaning toward the valuing and integration of the natural setting into an overall sense of health, well-being, and a healthy respect for the very real nourishment and equally real destruction that can be wrought on humanity through nature. As our world became more industrialized and people lived in closer proximity to one another in big cities, often with very little thought giving to sanitation needs, the positive and negative effects of the environment became more loudly articulated by such thinkers as Olmsted, who ascribed curative value to pleasurable nature scenes (Pollock-Ellwand, 2010). It is believed that the most powerful separation of nature from healing began with the emergence of germ theory between 1850 and 1920. Germ theory, an understanding that diseases are caused by microorganisms that operate within and multiply or are killed by the introduction of other materials—such as vaccines—into the physical body, minimized the need for a focus on the external environment as a source of healing or disease.

The benefits of nature on our psychological well-being are well documented. The restorative influence of nature on our physiology, and consequently our emotional state, also helps us sustain attention (Ulrich et al., 1991). Exposure to nature can provide a restorative break from direct attention tasks, allowing us to extend attention and perform better when we return to the task (Tennesson & Cimprich, 1995). This appreciation of nature as providing a restorative environment (Hartig, Evans, Jamner, Davies, & Garling, 2003; Herzog, Chen, & Primeau, 2002; Kaplan, 1995) supports the use of nature as a tool of titration, mitigating a child's approach to trauma content. A wise therapist is attuned to when a child is at the edge of his window of tolerance for processing trauma content and is able to offer a shift to the outdoors, offering nature as a co-regulator.

A study conducted through the National Trust in the United Kingdom found that children spend half the time outdoors that their parents' generation

did. Shockingly, 10% of study respondents had not been in a natural environment, such as a park, beach, or forest, for over a year. As children and parents play outside together, children learn to take risks, they strengthen their bodies, they are delighted in by their parents, and both parties are refreshed. It is a time of day when the family can be unplugged from devices and open and close circles of communication with one another. An act as simple as pushing a child on a swing set provides rhythmic repetitions of contact as parent and child are physically connected and then the child moves away again. When a child says, "Push me, Mommy, higher, higher!" the touch of the parent is an important part of helping the child to literally reach higher and higher heights. When I have dyadic sessions outside, I will often position the parent in front of the swing. As the child returns, I may extend the moment of connection by having the parent hold the child's feet, lift them higher and higher while smiling into their eyes, extending the suspense, and then let go. The child usually squeals in delight while saying, "Again, again!" If a child needs to feel fully in control of the swinging, we learn that too. Sometimes we sing rhythmic songs or turn taking songs in which the parent sings and the child responds in song, practicing opening and closing circles of communication while the child is somatically regulating in the swing. All this good stuff from a little outside time between parent and child, and yet it is getting harder and harder for parents to make time for this in their daily lives. A recent US study of almost 9000 children found that 50% of preschoolers went without even one parent-supervised outdoor playtime (Tandon, Zhou, & Christakis, 2012).

The profound and beautiful balance through which nature and humanity co-exist is established by the exchange of breath: the trees breathe out oxygen and breathe in carbon dioxide while we breathe out carbon dioxide and breathe in oxygen. If the breathing in and breathing out—both of nature and humanity—are maintained in an attuned fashion, what is achieved? Regulation. As I am writing these words, I am sitting on the front porch, hearing the loud evening sounds of cicadas, watching the pink tinge of sunlight as it slowly fades on the horizon, and feeling that all is well. This feeling is an overflow of my somatic interaction with the natural world around me.

The Nurture House Nature Play Area

We have designed our backyard as several concentric circles arranged in three separate tiers. We have only a few carefully selected pieces of play equipment in the backyard. The list is as follows:

1. A tire swing that hangs from a giant oak tree.
2. A fairy hut that hangs from a tree and can be enclosed on every side.
3. A JumpaRoo that consists of an inflated tube encircling metal poles that children can hold on to while they jump.
4. A slackline, covering a distance of 25 feet, that attaches at either end to trees.

5. A spinnable swing seat large enough for two people.
6. A seesaw of some sort. Over time, we have had a traditional seesaw and a seesaw with blowup rubber balls as seats so the child's landing on either side is buffered and bouncy. Most recently, we have added a rocking hammock. This is great for core grounding and balance work.
7. An ENO (a nylon hammock that can be hung between two trees).
8. Bird feeders, as feeding the birds can be a jumping off point for what kind of caretaking each creature needs to live.

Using Outdoor Equipment to Build Attachment Bonds

Most of the traumatized children we see have trouble trusting their caregivers in the beginning, especially in foster and adoptive situations. Building trust requires vulnerability and need meeting. Foster children who come into adoptive families after the age of three or four can do many of their basic need meeting tasks themselves. They can feed themselves, take care of their own toileting needs, and dress themselves. While these may seem like good things, the independence can actually get in the way of a child recapitulating an attachment relationship with his new parents. It seems counterintuitive to some, but our ability to be autonomous grown-ups begins in being wholly dependent on the other.

It can be difficult to fashion experiences that entice a child into risking trusting a new parent—a safe boss—as these kids can do so much for themselves. At Nurture House, therapists create scenarios with specific outdoor play equipment that invite a powerful payoff for the child after they allow a safe boss to help. The slackline is my favorite activity for this work. Some slacklines come with a second line that is strung above the child's head so they can balance by hanging on to the upper line. At Nurture House, we offer only the bottom line in an effort to create an environment that requires teaming, that requires the child to allow external support in order to be successful. No matter how balanced you are or how athletic, it is nearly impossible to walk the whole course of the slackline without any help from people on the ground. I have parents who tell me at intake that they are saddened by their child's inability to trust them, to allow them to help. Soon after beginning therapy, we explore the backyard together. Sometimes the titration of trust means that the child and I make this exploration alone first, as it is easier for the child to allow me to help than the mother or father who represents the greatest danger of vulnerability based on their previous trust injuries. The desire to conquer the slackline mitigates the discomfort that comes from relying on help. I usually extend my hand and say they can hold on to it to mount the slackline. Some do and some do not. They quickly realize that in order to get balanced, they need the hand. They often let go immediately, wobble, and step back off to the ground. Eventually, many children allow me to support them all the way across the 25 feet. Once the client is able to trust on this level, I invite the parent to join the game and eventually move myself out of the support

role, and the parent takes over, providing the anchoring support for the child's competency experience. It is a real win for us all when the child begins to fall, reaches out and grabs his adoptive mom's hand, and I get to say, "She's got you! She was right there to help when you needed her."

One does not have to have a slackline installed to have the benefits of balance and trust work. A sidewalk edge may suffice. A stream with stepping stones can provide a rich environment for this work, as can several stones placed in a pattern on any form of ground cover. My family was recently on a hike in the woods. We enjoy crossing streams together, and having happened upon one, we spent time figuring out where to place stones in order to be able to cross it. Each of us crossed independently, but getting back was trickier business. A couple of the rocks had shifted, and our youngest, Nicholas (age 8), who had previously been wanting to cross independently, said, "I think I need some support for this part." Perhaps because of my heightened focus on the intersection of interpersonal trust and the natural environment, this phrase, which I am sure Nic has said before, resonated differently this time (see Figure 7.1). One of the goals of trauma work with

Figure 7.1 Trust and Risk in Action

children, as I see it, is to help children grow a healthy balance between independence and interdependence, to be able to enjoy the accomplishments they create independently while simultaneously being able to ask for help when they need it without the expressed need creating shame or doubt. The stream, the slackline, the tire swing (that is strung slightly higher than a child can get into on his or her own)—each represents, embedded in the physical environment, Vygotsky's zone of proximal development and allows for children to do more with the support of a helpful adult than they can accomplish if they remain solidly entrenched in a posture of control that does not allow for help.

A few years ago, we took the whole family on a mission trip to Mexico. Most days were pretty busy, but one beautiful afternoon, we were granted free time to venture out into the city. After taking the kids to the lively Mercado and getting fresh cut mangos with lime (one of my forever favorite foods), we wandered into a local park. What struck me immediately was the difference in size between the playset on this playground and the playsets in America. It was almost twice as tall and made almost completely from painted metal. I climbed with the children all the way to the top (you had to climb upward through a series of tires stacked to create a vertical tube, with just enough space between the tires to afford you a foothold as you squeezed your body through each tube and up to the next level). We were rewarded at the top as we stepped onto a platform, looked over the edge, and realized we were somewhere between 12 and 15 feet off the ground (see Figure 7.2). It was exhilarating and scary, mainly because this seemed twice as high as the American playsets we were used to. I would imagine that American playgrounds have all sorts of safety rules for maximum height. Perhaps this is due to some very careful science that supports a certain height as less likely to cause injury (if you fall from it). It is interesting to me that this playset was in such a public center of a large town in Mexico. Clearly, lots of children came to play on it, and lots of parents, who have the same basic need to protect their child from imminent danger, let them play on it. It did make me curious about how our interactions with the outdoor play equipment offered in different cultures may influence our neurological presets for danger, setting the initial bar for acceptable risk individually based on our early experiences of outside play.

On this same playground, I followed the children through a tunnel made of metal spirals to a platform of monkey bars. I work out regularly doing kickboxing and boot camp, but I still find it very difficult to cross a set of monkey bars. The upper body strength required appears to be too much for me. My son, however, decided to try. The set of three images below shows you his initial swing out onto the path, his concentration in moving from bar to bar with his legs swinging wildly below him, and his eventual arrival at the bar on the other side. The third picture was taken at the instant he reached the final bar, before his neocortex had even realized he was safe. One can still see both the

Figure 7.2 They Don't Make 'Em Like They Used To!!!

intensity of focus and the vulnerability of risk that were at play as he crossed the monkey bars (see Figures 7.3, 7.4, and 7.5). What you cannot see is the moment after, when his thinking brain caught up and he grinned from ear to ear and said, "I did it!"

Figure 7.3 Risk

Figure 7.4 Still Risking

Figure 7.5 Safely Across

Desensitization and Sensory Integration in Nature Work

There are many elements of the natural world that can be challenging and/or rewarding for the traumatized child. Some children may be more sensitive to changes in temperature, to the sound or feel of a breeze, or to changes from direct sunlight to a shady area. Whether the exposure involves touching a squiggly, slimy earthworm or packing mud into "clay bombs," play in nature requires children to take risks to experience and enjoy the natural environment. Mud provides an intense sensory experience and is one form of messy play that children with perfectionism and anxiety may shy away from. I was on a walk recently with a child with significant sensitivities to heat and cold. We had been walking on the shadowed side of the street, and he had been regulating well, but as we turned the corner, we came into direct sunlight. It was a profound moment for me to watch that child stop, turn to face the sun, close his eyes, stretch out his arms and say, "There it is!" with such intensity of pleasure. He was drinking in the warmth of the sun and put me in mind of an iguana soaking in the warmth from a heating rock. I turned also and drank in the sun. He took a couple of steps backward—as if he were going to continue our walk backward—with his eyes closed and his face uplifted to the sun. We were on a street where cars could come around the corner, so I offered to be on the lookout and walked very closely beside him for an entire block as he trusted me to protect him and warn him of any impending danger or any need to open his eyes while he absorbed the warmth of the sun. By taking this walk together, I was able to share in this client's experience of being warmed by the sun. Recent sensory ethnographic studies have attempted to examine further the experience of experiencing nature with others by *making sense of our senses* together (Allen-Collinson & Leledaki, 2015). Through therapy, this child gained regulation skills and was able to enjoy the warmth of the sun with me as I helped to keep him safe by being his lookout.

Creating Art From Natural Elements

This summer, we had a bush around the corner from Nurture House that grew berries. Everyone agreed it would not be wise to eat the berries, but we had tons of fun picking them, smashing them up into "paint" on the rocks, and then painting pictures on rocks, paper, and even leaves. We have another plant nearby that grows "elephant ear" leaves that are as big as a sheet of paper and are smooth on one side and velvety on the other. We have a tree that grows long string bean–looking growths. Children sometimes use these for outdoor sword fights, or they can turn them into paint brushes or writing utensils. Sometimes we create family trees by first having the whole family go into the yard, choose the leaf that fits them best from the variety of trees there, and bring one back to the kitchen. I draw or paint the tree trunk and the branches on butcher paper. I offer brown finger paint and have each family member coat each other's thumbs and fill the tree trunk with bark, which is

made from pressing their individual thumbprints into the trunk area, creating a tree completely unique to that family. Each family member decides where their leaf fits on the tree, slides it under the paper, and makes an impression with whatever color of crayon or chalk they choose, and in this way we create their family tree.

Imaginative or Pretend Play in Nature

One of the great joys of my childhood was making mud pies. I still delight in my youngest when he brings me "chocolate balls" made from mud. His hands and face are covered with dirt. He has experienced his environment and has made a glorious mess! The symbolic nature of young children's play is a critically important part of their development. Nature lends itself to pretend play in ways that facilitate social and cognitive development. Other children pretend there is a pit of fire or a vat of toxic pig snot in the yard and we have to figure out ways around it.

Sometimes the great outdoors become a kitchen. A six-year-old boy finds a long, smooth stone in the yard and says, "This is the griddle." "Oh, it's a griddle," I say. Then he instructs me to go and choose flat, smooth stones to be the pancakes. After a moment, he joins me and explains that we also need to find things to be the syrup, the banana slices, the chocolate chips, etc. He and I enjoy a feast of warm pancakes with delicious toppings—all in nature (see Figure 7.6).

Metaphors in Nature

Metaphors abound in the natural world. Talking about the things a plant needs to grow—sunlight, water, and soil—often leads directly into a deepening awareness of what we, as humans, need to grow. People sometimes choose to plant a tree in memory of a loved one who has died. The ideas that new life can come from death, that healing can come from hurt, that positive change can come from (and in fact may require) deconstruction first are all rich metaphors to be observed in nature.

Using Plants to Talk About How to Care for Living Things . . .

Ryan is a client whom I have had the great honor to work with over the course of several years. I met him when he was just on the cusp of turning four. He was one of the children who participated in Camp Nurture. He had an autoimmune disease that had kept him inside for almost the entirety of his life. To my chagrin, I at first thought his parents were exaggerating, and while we diffused essential oils to limit his exposure to germs in public areas, it was not until we went on our first nature walk that I understood. He kept stopping every 30 seconds to notice something else. At one point, he picked up a

Figure 7.6 Rock Pancake With Chocolate Chips and Bananas: Delicious!

small twig, turned to me, and said, "This is the first time that I have touched bark." Several years ago, I offered a camp for adoptive families who were raising children from hard places who struggled with intense dysregulation and had difficulties connecting and therefore experienced difficulty in every area of family and community life.

Ryan is school-aged now. He is diagnosed with autism, has sensory defensive behaviors, and needs special accommodations to deal with a classroom environment. He has particularly pained responses to loud sounds and to the way certain textures feel on his skin. This child has such severe sensory

defensiveness that he often has to wear noise-canceling headphones in loud places or places with lots of ambient noise. On the first day of Camp Nurture, I had to accompany Ryan to the bathroom. A colleague came with us (we have a two-adult rule if we need to help a child with a bathroom routine), and she and I were chatting while he went to the bathroom. When he was ready to flush, though, he hesitated and looked upset. I asked if he was worried about the loud noise the toilet would make when it flushed, and he nodded. I asked, "Could I put my hands over your ears to help you?" Ryan smiled and nodded but still hesitated. I turned to my colleague and said, "Miss Jodi, would you help us make sure Ryan's body feels safe with the flushing? Will you put your hands over my hands on his ears?" Miss Jodi was, of course, willing, and Ryan decided that two sets of hands should be enough buffer between himself and the flush. His look of pride when he flushed was great, and after we washed hands, the high fives all around were good and strong.

Ryan fixates on certain kinds of bugs at different times. In order to meet him in his greatest place of joy, we often spend part of our session outdoors looking for bugs. We had a magical moment a few months ago where he asked to find an earthworm. It was very hot outside that day, but wanting to give yes to his request, we went into the backyard and started turning over stones, one by one, until we found an earthworm wriggling around. This sealed the deal in terms of my trustworthiness in his eyes (no kudos to me, as it was a spontaneous happening, and we have had many overturned stones with no signs of earthworms since), but it also became a shared piece of history unique to our relationship. Ryan was the first child who had ever requested to go earthworm hunting. My surprise and slight bewilderment about how to hunt them, combined with our shared success in finding one, added another moment of delight and shared positive history to our relationship. The neural pathways that will tie me (as therapist) to safety and fun, even when the scary stuff is introduced, are being enhanced every time we have a moment like this. Moreover, though he is fascinated with earthworms, the sensory experience of holding one is challenging to his window of tolerance for sensory input. While he might want to just drop the worm, startled by its slimy wiggling in his hand, he knows it is fragile and pushes himself to hold it safely even with the uncomfortable sensory input.

Just recently, he asked to go find earthworms again. We tried, but this time there were none to be found. However, we were able to use the moment to become more mindful. I said, "It's disappointing when we can't find an earthworm. I wonder if there are other bugs we could notice if we really focused on what else there is to see around us right here and right now." Indeed, as soon as we let the perseveration on earthworms go and opened up to a different kind of focus on the natural world surrounding us, we discovered a giant spiderweb in the backyard with a giant spider (disturbingly big for me) still working on the web. We sat, at a distance, to watch its work. The spider seemed to know it was being watched and ascended to the top of the web (which was

attached to a lamppost) to hide. We wondered about why it might feel like it needed to hide and how we might help it feel safe enough to come back down.

A couple of times, Ryan remarked, "It's OK, Mr. Spider, we won't hurt you."
I wondered out loud, "Do you think Mr. Spider knows that we are safe?"
Ryan watched the web a little longer and said, "I guess not. He's not coming out."

ME: *I* know we are not going to hurt him, and *you* know we are not going to hurt him, but his instinct is to hide if anything unusual comes along. Do you think we are unusual?

RYAN: Yes [*giggling*]!

ME: Wonder what he needs to feel safe?

Up to this point, Ryan had twice gently jiggled the web, pretending to be food caught in the web, hoping the spider would come down to investigate.

RYAN: He probably doesn't want us jiggling his web.

ME: Huh. You think the vibrations are too much?

RYAN: Yeah . . . maybe he needs the wind to stop too.

Here, Ryan sees the sensory stimuli that the spider might be perceiving through his own sensory worldview, giving us rich information about his own experiences and also showing an ability to engage in some perspective-taking, putting himself in the spider's place. We ended up agreeing that we cannot make something come out of hiding before it is ready. We can attempt to send it powerful messages that we will not hurt it, but until it experiences what it needs to feel safe, it will stay hidden. It was a powerful parallel to the journey that this adopted child has been making in coming out of hiding, in sharing himself more and more fully with his adoptive parents.

Sometimes nature just keeps on giving, and after we shifted our focus away from the web, Ryan bolted to the JumpaRoo (a really neat bouncy toy that has colored metal poles converging on a center point). Children hold on to the poles while bouncing on the fully inflated inner tube that wraps around the poles. He noticed some fire ants crawling on the tube, and while I was crouching to look at these, I noticed an interesting beetle-type bug on the yellow pole. It stood out because it is mainly black with an orange stripe around its center. Ryan looked up and carefully focused on it for a few seconds, then his gaze dropped down to the fire ants. Suddenly, he remarked, "There's a baby one!" I crouched down again, and, sure enough, there was a miniature version of the black and orange bug far below on the inflatable tube. He said, "They're mommy and baby!" I said, "Huh, the baby is kind of far away from the mommy. They must know how to get back together again." We then spent time wrestling through the client's separation anxiety symptoms using the mommy and baby beetles on the playset. We were discussing whether we should try to move the baby up onto the pole to be with its mom. After some discussion, Ryan said, "I think we should leave him there. His mommy knows

where he is, and she'll come find him." Powerful stuff, and completely separate from anything I could offer organically inside the building. An interaction with nature, with the natural environment itself, provides powerful metaphors for work.

The natural world continues to be the most powerful connector for Ryan. He asks to go on nature walks or bug hunts regularly now, and during our latest walk, we began moving onto a nature path that is not open to regular car traffic, making it a particularly nice place to take children. We had just walked past the gate to this path when Ryan said, "Stop! A snake!"

I glanced to my right, and, indeed, there was a skinny green snake, bright on the black asphalt path. It was about 16 inches long, and I would have probably absorbed it as a long blade of the grasses that grow near the path had Ryan not exclaimed. He immediately leaned closer into me, and I put my hand on his shoulder.

ME: It is a snake. What strong eyes you have. Let's back up a little until we know which way he's going. [*We stepped back three steps.*]
RYAN: My mom would have passed out!
ME: You sound kind of concerned about whether or not she could stick together with you and a snake. Your mom is pretty good at sticking with you in everything.
RYAN: Yeah, she is. I have always wanted to see a snake in real life, and I never have . . . before now.
ME: I have never seen a snake crossing this path, and I have never seen a green snake on black pavement, so this is a first for both of us.

This moment of shared, spontaneous experience will lend itself to a sense of shared and unique history between us, deepen the therapeutic relationship and our shared mindsight, and potentially become part of our therapeutic narrative over time. We stood quietly for a full minute, watching the snake engage in a small but persistent back and forth wiggle with just its head and upper body. It moved back and forth so quickly it looked like an onlooker at a tennis match—back and forth, back and forth.

RYAN: He's moving his head so much!
ME: Yes, he is. Wonder what he's doing.
RYAN: He's checking.
ME: It does seem like he is checking left and right, asking a question with his body.
RYAN: Is it safe? Is it safe? Safe to cross the road [*pretending to be the snake's voice*]?
ME: Yep, it looks like he's saying, "Should I take the risk? Is it safe?"

We watched quietly for several more minutes as the snake continued craning his neck and upper body back and forth, back and forth. Ryan and I talked

about how scary it might be for the bright green snake to feel so exposed—clearly visible—against the black asphalt. Eventually, he crossed the road, and once he had slithered into the grass on the other side, it was impossible to see him. It was such a sudden disappearance, we might have each disbelieved what we had seen had we not shared the experience together.

ME: Wow. He went way out of his comfort zone. I don't understand why a snake who is so green and small would risk being on the black pavement. All kinds of predators could see him.
RYAN: He must have really wanted to get over there [*after a pause*].
ME: I think so too. There must be something over there that made it worth the risk.
RYAN: Well, now he is hidden again, so it's OK.
ME: Yep, he gets to decide when he takes a risk—and when he rests.
RYAN: And when he camouflages himself so that no one notices him.
ME: That too.
RYAN: I bet he's trying to get back to his family.
ME: He wanted to be with them pretty badly.

We walked on together for a few minutes and then began identifying recent risks that he has taken: to talk to a friend at school, to accept a change in his schedule, etc. We also talked about whether he ever tries to blend in. He was able to identify times in his classroom when he does not understand what is being asked, but he sits quietly, blending in, instead of raising his hand and asking for clarification. Ryan was able to engage in this level of self-reflection in part because we were in motion (walking together), in part because it was anchored by a metaphor found in nature, and in part because he had received a pleasurable release of neurochemicals as we experienced the novelty of finding a snake in the road.

Therapeutic Walks

A nature walk may be the most powerful way we have of helping our clients expand their capacity for mindfulness while increasing their overall sense of being at peace. Teenagers, particularly, often have a significantly decreased resistance to connection with their therapist if it is happening in the context of a walk. There are several aspects of walking that buffer and benefit relationship-building with teens. We know that the natural environment—and particularly exercise in the natural environment—increases our sense of well-being (Penedo & Dahn, 2005). The teen does not have to make deep and extended eye contact with the therapist while walking. Attunement can be explored as the therapist tries to match the teen's pace, and challenge can begin as the therapist or child chooses to change the pace. Many times I have been on a walk with a client who appears hardened—even cynical—in the clinical setting but is suddenly disarmed as they notice a beautiful flower, a

cool butterfly, or a gorgeous sunset. Tiny bursts of joy (or, more scientifically, tiny releases of dopamine and/or oxytocin in the brain) are engendered by the novel experiences of natural beauty, and the teen can enjoy the moment in joint attention with the therapist. We have an open air market where plants and produce are sold. It is a ten-minute, nicely landscaped walk on a pretty brick sidewalk. Many of my clients request to go there seasonally. We believe strongly in the therapeutic value of nature and kinesthetic involvement in therapeutic work but also understand that stepping outside the building, even to swing in the front porch swing, limits our ability to guard or guarantee the client's confidentiality. Therefore, we have embedded specific permissions in our paperwork to address this issue. Parents decide whether they will allow their child to play in the front yard or backyard or go on a walk with their clinician in the neighborhood. Some parents give permission easily and right away, some parents express that they would like time to get to know the therapist before deciding, and others decide their situation is sensitive enough that they would just prefer to keep all therapeutic intervention in the building. We would recommend that any clinician who will be taking their clients outside the clinical building have these types of special consents in place. In all cases, the consents are just a starting place. The therapist is attuned to the needs of the child and respects the natural environment as both a mitigator and a co-therapist with children who are approaching hard content. Some children come to Nurture House in such a dysregulated state that moving outside the building could be unsafe for them or for us.

I love taking children on walks around Nurture House for so many reasons. The act of walking outdoors together seems simple, and that simplicity is part of what provides the child a sense of comfort. However, there are several skill sets required for both the therapist and the child and several clinical questions that must be answered prior to taking a child client on a nature walk. The three questions we ask before we take any child on a walk include:

1. Is the child/teen able to trust the therapist to be the safe boss on a walk?
2. Is the child/teen able to trust themselves/regulate through being separated from the parent?
3. Does the child/teen have enough access to his/her executive functioning systems at this point in therapy to be able to choose between options?

Let us unpack each of these. The answer to the first question—Is the child/teen able to trust the therapist to be the safe boss on a walk?—is critical to the decision to venture outside of the controllable indoor environment. I have mentioned the permissions we have parents sign when we take children outside. These permissions have to do with helping parents acknowledge the limits of confidentiality that come with being outside the building. However, there are other kinds of permission that are clinical in nature. In terms of the clinical arc of therapy, our clinicians must assess the degree to which any particular client is able to give the therapist permission to be the safe

boss on a walk, especially as it relates to following the therapist's directions involving physical safety.

Many of our clients have trauma, neglect, or maltreatment backgrounds that have interfered with their ability to develop a healthy ability to trust and to come up and under the safe boss authority of other grown-ups. There is a sort of invisible string that exists between parents and children. Parents and children in healthy enough family systems are constantly negotiating the invisible boundaries that define the comfortable distance that can be allowed/encouraged between the parent and the child. You can see this in the park, in the grocery store, and in the mall. Little ones will run ahead of their parent, turning back occasionally to make sure they can still see them. If the distance gets to be too large or too uncomfortable for one member of the dyad, they adjust. In some cases, you will see a parent begin to run until they catch up to the toddler. In other instances, the child will slow down or stop and wait for the parent to get closer. In a healthy family system, the safe boss functions as a secure base from which the child can move out in exploration. When the child is hurt, scared, tired, hungry, etc., their attachment system (their need to be close to the caregiver) overrides their exploratory system, and they return to the parent (who is now functioning as a safe haven). Maltreated or neglected children are, by definition, children who have not experienced a secure base from which to move out in exploration, and they have not experienced the safe haven that meets their needs when they are experiencing them. They do not have an internalized sense of the boundaries of physical proximity with their caregivers. Many of these children move out in exploration and continue moving.

Many foster and adoptive parents have looked at me in bewilderment as they describe the way their adopted child will run away from them in the mall or in a parking lot and just keep moving, never checking in and never seeming to feel a sense of danger at being too far away from their parent. As we begin to lay down new neural wiring for what safety feels like through thousands of repetitions of need meeting both during clinical sessions and in assigned therapeutic homework for parents, traumatized children begin to reference their adults differently. There is a sense of accomplishment for both parents and children when the child develops the capacity to entrust the therapist with being the safe boss on a walk. If a breach of trust occurs on a walk, meaning the child is unable to stay within the boundaries set, the conversation goes something like this: "Your body is letting me know that we need to stick together some more at Nurture House before you will feel safe to let me lead you on a walk again."

The second question—Is the child/teen able to manage the anxiety of being separated from the parent?—is often an important consideration, as we see children who are unable to separate from parents at all when they first come to Nurture House. These dyads often meet the criteria for an ambivalent attachment pattern and need some reworking of the relationship, expansion of positive coping, and possibly some play-based exposure work before the

child can confidently manage anxiety through self-regulation and/or allow the therapist to become a surrogate co-regulator of anxiety while on a walk. Sometimes the therapist helps the client imagine an invisible string that gets longer and longer during the walk and gets rolled up as they return to Nurture House. Sometimes the therapist helps the dyad make "love connectors" (see Goodyear-Brown & Andersen, 2018) and uses them to aid in separation. This intervention was really created by my son, Nicholas, when he was six years old. He was watching me pack for one of my speaking trips and remarked, "We need more love connectors!" I stopped packing, got on my knees in front of him and said, "We do need more love connectors. What should we use?" I did not truly understand what he meant by love connectors, but as we searched the house for items that might work, he eventually landed on my hair ties. He put one on his wrist and told me to put one on mine. Then he explained that we both had to keep them on the whole time we were apart from one another. The next morning, as I walked him into his preschool, we were holding hands. Our love connectors were touching at the wrist, and he said, "Mommy! Our love connectors are powering up!!" Each night while I was gone, we would FaceTime. He would check that I had my love connector on, and then we would touch them to each other through the screen and "power them up" for another day. We have used this idea in a variety of ways as he has grown, and it has given him (and, OK, me too) a concrete reminder of our connectedness across time and space. Another way to articulate the love connectors, per the lingo of object relations theory, is to describe them as transitional objects. We will sometimes take bubbles, a peacock feather, or a stress ball with us in case the child needs additional aids to manage anxiety at any point along the way.

For children with separation anxiety, the act of moving outside the building, even if we only make it to the backyard or the front porch, is its own form of exposure work, allowing them to feel the discomfort of distance from the parent and manage it in relationship to a safe other. As the client's neural circuits for anxiety become regulated to the external environment, we begin to explore. Moving even a block down the sidewalk allows for the exploration of a variety of plants that are not on the Nurture House property. Currently, there are gorgeous yellow leaves falling from the trees right outside Nurture House, but a few steps away are beautiful deep red oaks. As long as these doses of novelty are titrated, the excitation brought to neural pathways by novel experiences in the natural world further trains the brain to experience new things as interesting and pleasurable instead of overwhelming and scary.

The third question—Does the child/teen have enough access to his/her executive functioning systems at this point in therapy to be able to choose between options?—must also be answered in the affirmative before a child/therapist dyad can go on a walk. Nurture House is one house on a residential block that has been turned into part of the historic district in downtown Franklin, Tennessee. Soon after stepping off the front porch of Nurture House, one must decide whether to turn to the left or the right. To the left is downtown Franklin, with its many shops and crosswalks and a healthy number of people

on any given day. To the right is a cemetery (a powerful icon for therapeutic work) and a quaint brick walkway that winds around to the Harpeth River. There are overlooks, rocks for sitting on and watching the river, and an open market that sells fruits and vegetables grown by the Amish as well as plants and pumpkins seasonally.

Simply by exiting the building, a two-choice prompt is set up and an ability to choose is required. Which way do we go? There is no one right way for the choice to be navigated. Does the therapist choose the direction? Does the child? Do they negotiate a process together? Does the child freeze? Does the child ask the therapist to choose? It often puts me in mind of the moment in the Wizard of Oz when Dorothy gets to the crossroads and the scarecrow informs her that "some people do go both ways." However the choice is made, we glimpse the coping strategies the child employs and what sorts of experiences he or she is drawn to in the natural world. Sometimes the choice is made in advance while we are still with the parent in the building. Perhaps we are celebrating a special occasion, like a birthday or a graduation from therapy. When this is the case, we already know our destination, though we may still be making choices about which way to get there. The therapist can set up as many choices on the walk as seem clinically beneficial in extending the client's window of tolerance for choosing. Much like in the playroom, children with significant anxiety can benefit from learning to make decisions for themselves and then experiencing the pleasurable outcome of the choice. This can increase self-confidence and self-esteem. The metaphoric implications of acknowledging the many different paths that may be chosen regularly lead to conversations about choices in other areas of our client's lives.

The physical benefits of walking are well documented (Duncan et al., 2014; Grant, Machaczek, Pollard, & Allmark, 2017; Lee & Buchner, 2008) and include maintaining a healthy weight, weight loss, strengthening bones and muscles, lowering cholesterol, lowering blood pressure, and protecting against type 2 diabetes. The psychological benefits of walking have also been well documented (Rogerson, Brown, Sandercock, Wooller, & Barton, 2016; Brown, Barton, & Gladwell, 2013; Gladwell et al., 2012; Barton, Griffin, & Pretty, 2012; Revell, 2016; Wood, Angus, Pretty, Sandercock, & Barton, 2013) and include elevated mood, stress reduction, enhanced self-esteem, and restoration of certain aspects of mental health (Donaghy, 2007).

Certainly, nature walks can be made even more therapeutically beneficial by introducing mindfulness practice into the natural environment. When I begin to walk with clients, we will often take the first few minutes to notice five things they can see, four things they can hear, three things they can touch, two things they can smell, and one thing they can taste. Other times the client and I will find a particularly beautiful tree and lie down under it, noticing patterns among the leaves, the way they sway in the wind, etc. Sometimes we will hear the wind and then count how long it takes for the wind we hear to make the leaves on the tree move. Lying down in the open grassy field near

Nurture House is conducive to finding shapes in the clouds, encouraging a form of projective testing in the natural world.

The potential positive effects of the natural environment on attention are an especially intriguing avenue for exploration in this chapter, as we see so many traumatized children who have difficulty sustaining attention to necessary tasks while simultaneously overattending to potentially threatening sounds, sights, smells, etc., in their environment. To understand the explanation for positive changes in attention following exposure to the natural environment, we must begin with William James' (1892) distinction between involuntary attention (a form of attention requiring no self-motivation or willful focus) and voluntary attention (attention that requires us to bring our focus to a particular point or topic). Berto (2005) created an experiment in which participants were mentally fatigued by completing a challenge that required prolonged attention. He then showed participants one of three types of images: restorative environments, nonrestorative environments, and geometric shapes. All three groups were then asked to return to the task requiring sustained attention. The only group to make gains in sustaining attention was those who were exposed to the restorative environment images. This research builds on the earlier work of Kaplan and Kaplan (1989), who outlined an attention restoration theory (ART) in which they posited that aspects of the natural environment draw on involuntary attention, which is seen as supporting restoration from psychological exhaustion. For this discussion, restoration is defined as "the process of recovery from a depleted psychological, physiological or social resource" (Hartig, 2007). Kaplan built on James's earlier ideas about voluntary and involuntary attention, equating voluntary attention with an effect he named *directed attention fatigue* (Kaplan, 2001) and equating involuntary attention with *fascination*, a process in which you cannot help but have your attention captured. I feel this process at work in me as I sit on the bank of the Harpeth River editing this chapter. The intensity of focus leads to mental fatigue, but then, all of a sudden, a beautiful dragonfly with otherworldly blue and green coloring perches on a leaf nearby. After watching the dragonfly for 30 seconds or so, I return to focus on the chapter, feeling internally refreshed. According to Kaplan's hypothesis, this enthrallment allows for rest and recovery of the attentional system. In this way, spending time in the natural environment can mitigate the intense attention that is often required for a client to process trauma. Roe and Aspinall (2011) looked at the restorative properties of the natural environment in two groups of people—those with good and poor mental health—as they experienced two different environments (an urban walk and a rural walk). They found that, in general, both groups experienced the greatest gains in positive mood in the rural environment, with people with poor mental health benefitting most greatly. People with poor mental health also seemed to benefit from walks in urban environments (one hypothesis is that the gains have to do with the social context). So many of the children we see have difficulty with attention to tasks. This may come from an organic inattention issue or may be a symptom of trauma or an anxiety-based disorder.

In either case, natural settings can be helpful in extending attention (Berto, 2005; Tennessen & Cimprich, 1995).

There are several additional benefits of walking with a child or teen client. The first is that walking is a very small ask for most children, as it is part of their competency repertoire already and will result in an experience of mastery. Sometimes, despite our best efforts, the introduction of expressive arts or play materials places demands on the client to perform at a certain level of competence or creativity. The simple mastery of walking mitigates the approach to hard topics. It contributes to a sense of normalcy in the child. If we return to the concept of the triune brain, we are targeting the reptilian brain stem first as we walk and engage in self-regulation through ambulation.

Second, the client is getting kinesthetic input and keeping their somatic system occupied in ways that are rhythmic and grounded, allowing for an easier regulation of the limbic brain and potentially more access to cognitive processes. Third, when a client and therapist are walking together, there is a titration of relationship happening. The therapist is not staring at the child or insisting that the scared teen make eye contact while beginning to explore scary stuff. Walking together, the child can set a pace that is comfortable for them, and the therapist can match this, using the movement as its own form of attunement. It allows for the creation of a different kind of space between the client and myself as we become a unit—an "us"—navigating the larger environment.

Even more specifically, for traumatized children, the natural bilateral stimulation that is derived from the simple act of walking aids in the integration of trauma content (Shapiro & Forrest, 2016; Shapiro & Solomon, 1995). In fact, an appreciation of this method of cross-hemispheric integration has led some treatment agencies to invest in treadmills. When walking can be accomplished outdoors, the therapeutic benefits of both exercise and nature can deliver a "double whammy" to clients (Barton, Hine, & Pretty, 2009).

Metaphors in Nature

One of the treatment goals for traumatized children and their families is to help them understand the defense mechanisms that have been developed to cope with fear-inducing situations. I recently went on a walk with Becky, a 12-year-old girl who has fetal alcohol syndrome and cognitive delays, along with anxiety issues, attachment issues, and significant social difficulties. She often walks with her head down, looking only at the path just in front of her feet. I introduce various ways to help bring her head up, capture her eye gaze for various moments, and engage her in cycles of opening/closing communication loops. During our walk, I began to feel frustrated that she did not seem to be able to move her eyes from the ground. I was breathing through my own desire to strive to have her engage when Becky stopped abruptly. She had noticed a giant furry caterpillar on the path in front of her. I have never seen a caterpillar of such great size. Moreover, it was black and prickly. It was almost

as big as the palm of her hand. It looked dangerous and potentially poisonous. We both thought it was "so cool," and the novelty of this discovery pulled her gaze upward. She made eye contact with me and used her words to ask if we could take it back to Nurture House. What a setup! I was able to give her a big yes, but then we had to figure out how to accomplish the job.

We were both in agreement that the bug could be poisonous and we did not want to touch it for fear of it stinging us. I had not brought a bug catcher, a bag, or anything else to pick it up with, so we engaged together in a problem-solving process where we would find different leaves and sticks to try to support the caterpillar, but none of them were strong enough to support its weight while we moved it to its new home—hear the metaphor? Eventually, I took off my hat and used it as a carrier to get the caterpillar back to Nurture House. Once we arrived, we looked up "big spiky black caterpillar" and found out that this caterpillar becomes the giant leopard moth. We read enough to realize that Harry, the name my client gave it, is not dangerous in any way, and then we took turns feeling its spiky body. This action alone was an exposure exercise (for both of us), as we were unsure just how sharp (i.e., painful) the spikes might be, so we were unsure of how much pressure to use. If we used too much force, we might hurt the caterpillar or our fingers, so we agreed to start with a very gentle touch and then try again if we needed to. Another therapeutic benefit was the refocusing that this caused around our somatic "knowing." When she felt it, Becky squealed. Then she went back and felt it again. I asked her what it felt like to her. Becky thought the caterpillar's hair felt like the bristles of a hair brush. Even that required her to experience the caterpillar somatically and then move from that form of knowing to a cognitive knowing, searching her experience for something to equate it to and then verbalizing that to me so I could share it with her. Her desire to communicate this unique experience to me mitigated her approach to finding the right words, which is her scary stuff. She is self-aware enough to recognize that her words sometimes fail her, and that she cannot articulate things as well as her peers.

We spent time looking for a proper container for Harry and then began transferring Harry from my hat to the container. Harry curled up in a ball and played dead. My client was alarmed at first and said, "We killed it!" I explained that sometimes when creatures get scared, they have a defense mechanism that has them freeze and pretend to be dead. As we reviewed together the ways in which small creatures protect and defend themselves against threats of harm, she said, "Once he's in there (the container), he will start moving again." We put him in the new environment, and sure enough, after a couple of minutes, Harry began to move. As we engaged with this caterpillar, the immobilzation system, identified in Stephen Porges' polyvagal theory was unpacked in a child-friendly way. We saw a state of hypoarousal/collapse as the caterpillar curled up and froze. While a scientific explanation may have been too wordy for Becky, she was given permission for her own immobilization responses as she learned about the caterpillar's way of coping with fear. Becky asked

how long it would take for the caterpillar to become a giant leopard moth, and when we looked it up together, we found that while different caterpillars can take different lengths of time to "become," this one takes many months of hibernation. Using the rich metaphors offered to us by our exploration of the natural world, we normalized states of hyperarousal and collapse, and we normalized the truth that growth and change can take different amounts of time for different people. As Becky and I looked at pictures of what the prickly caterpillar would become, we both exclaimed at the beauty of the giant leopard moth, which is white with black spots. We marveled at how something so prickly and hairy could become something so beautiful. We looked at two or three more images and then came across an up-close image of the moth. A finger was holding up the wings to reveal a body that was rainbow-colored.

BECKY: Wow! I thought he was only white and black.
ME: Yeah, me too. You have to look really closely to see all those colors.
BECKY: We can only see them because he's holding up his wing.

It struck me, when I heard Becky say this, that these words describe one of my constant hopes in work with traumatized children and their parents—that I can hold up the child in a different light so they can see themselves differently and the caregiver can see the beauty of the vulnerable parts that are often covered up.

Another metaphor in nature presented itself to me last week as I was working with a boy who had recently been adopted and his newly adoptive father. For the purposes of our narrative, we will refer to them as Jack and his dad. Jack, age ten, had a sexually abusive father who ended up being prosecuted and is currently imprisoned, a nonprotective mother, and an interim foster placement of several years with a safe family before he was placed with his adoptive family. While he had known the "dad" of this family for several years in an extended community network, Jack had been in his new adoptive family for about five months at the time I began seeing him and at this point called his new father figure by his given name, Ned.

One day I went out to meet Jack in the lobby. The weather was perfect, and I offered to take him on a walk. He hesitated and then said, "Ned too?" I was delighted that he wanted his new father's company and said, "Of course! Ned, do you want to join us?" It was heartwarming to see how Jack's preference for Ned's company affected Ned. I find that adoptive parents are often offered such mixed messages by their adopted children that they become very unsure of their importance. When adopted children can give signals of preference, adoptive parents receive the reinforcement that often comes normally in a day in, day out attachment cycle between biological children and their parents. The biological child may, for example, scream and cry and have to be held and rocked for a long time before bed. Certainly, nursing mothers are sacrificing sleep on a regular basis to get up every two to three hours to answer the hungry cries of their babies, but then they go out to run an errand, and when

they return, the child smiles widely and reaches out their arms to be picked up, clearly preferring the mother to all others. This cyclical reinforcement helps the child feel safe and secure but also provides repetitive experiences for the parent of being preferred and vitally important. The reinforcement for the parent of their own vital importance sustains them through the long watches of the night.

My guess was that the offer of a walk—which requires a deeper level of trust both on the part of the clinician and the client—was mildly anxiety-provoking for this child and he felt more anchored by having his father figure with him. We began walking toward the river. As we moseyed, I asked Ned to tell me one thing he has seen Jack really grow into since he has known him. Ned talked about how he used to startle easily and had trouble asking for what he needed, but how he has become much more relaxed at home and uses words more often now. We began talking about trust and shared with Ned Jack's decision to continue calling him "Ned" until he "felt" like he was ready to call him Dad. This was a topic that Ned and I had been over together already, and he was well prepared to reflect Jack's need to feel more connected and to build more trust before he would be ready to call him Dad. Ned exerted no pressure, and I also gave permission for the client to take his time, explaining that he will know if and when he is ready to call him Dad, and that Ned does not "need" this from him. Ned will continue to show up and meet needs and delight and connect regardless of what Jack calls him. As we approached the bridge, we stopped and looked at the water.

Jack immediately said, "There's a beer bottle." Both Ned and I had to search the river for several seconds to see the sunken bottle, but Jack had noticed it right away. Ned said, "Jack always notices details." I said, "I bet he does. Children who have grown up with some scary things happening to them or around them learn how to constantly be scanning the environment for any signs of danger. Sometimes this is cool because kids can feel really ready for whatever comes, but it can get really tiring to have to be constantly on guard." Jack listened quietly to this and took one unconscious step closer to where Ned and I were standing. Jack exclaimed, "Look!" and then showed me the flashes of silver that were happening in the water below. Ned watched, and when he saw the same flashes, he was able to explain that the fish who are gray on top, in order to blend in with the water, have a shiny color on their underbellies. When they become excited and flip over, you can see them. Jack said, "I'd like to catch one." I said, "We can go down there if you want." Jack was very excited about this idea, and Ned agreed that it would be fun to see the fish up close. This entailed climbing down lots of big gray rocks to get to the edge of the river.

Let us be clear about one thing. There is no graceful way to climb down a rocky slope. As we struggled down, we held on to each other, we held on to the rocks above us, and occasionally we placed a foot on a rock that wobbled. If you have ever been rock climbing at the edge of a body of water, you have experienced the feeling of placing your foot on a surface that you thought was

stable, solid, supportive, and then having it disappoint you, as it was not able to hold your weight, to properly support you—do you hear the metaphor yet? We got all the way down to the water's edge, myself rather ungracefully in my flip-flops, and Jack spent a few minutes trying to catch the fish. We talked about how hard they are to see, with their protective camouflage, and how the fish only show themselves when they feel like there is no threat—hear the other metaphor? We watched a couple of fish spontaneously jump out of the water, delighting all of us, creating a moment of shared enjoyment of a novel experience (another win in creating positive shared history between Jack and his dad), and then it was time to climb back up to the road. As we walked back to Nurture House, I said, "You know what I noticed while we were down there? Sometimes I would place my foot on a rock that I thought was stable, and it would hold me. Other times I placed my foot on a rock that I thought would hold me, and it wobbled. It was unstable. But both rocks looked equally big, equally solid, so it's hard to know which is which." I stopped talking and kept walking. There is something powerful in itself about walking together in the same direction with someone else. Bilateral stimulation is occurring in an ongoing manner within both participants, and spontaneous thought, conversation, reflections, wonderings, and new associations can be made. Moreover, for highly resistant or shut down children, the lack of necessity to make ongoing eye contact or have intensive focus on the relationship can mitigate the client's approach to hard questions. In this case, a few moments after I fell silent, Jack said, "It's hard to tell which ones are stable and which are not." I reflected his statement and then said, "And yet we've got to step on the rocks to get down to the river. Which ones do we step on?" Jack's biological dad was unstable and abusive. Now that he has a "new dad," how will he solve the very real problem of answering the very important question of whether this dad is trustworthy, is solid enough, is stable? As we walked, Jack thought about it and eventually said, "I guess you have to look for how deep into the ground it goes. If it's really deep, it won't move." I looked at Ned, who seemed to hear the unspoken layer of our communication, and said, "I think that is a very wise answer, Jack. You just have to see how deep it goes and then you'll know if it's stable."

Sometimes the children see the metaphors in nature before I do. Recently, I was on a nature walk with an older boy who is wrestling with some complex emotions related to his younger brother. Both siblings (we will call them John and George) were removed from a neglectful home and placed together into foster care. Although they are now in a safe home together, their physical safety is not becoming "felt safety" at the same pace. Both children showed up at their new home dysregulated and, according to their foster parents, "bouncing off the walls." The boys were often aggressive with one another with a ferocity these parents had never experienced with their own children. One of the dynamics at play here was the trauma bonding that occurred in their abusive home. The ways in which these trauma bonds manifested often included aggression and control between the boys. For the purposes of this

conversation, I will define a trauma bond as an ultimately maladaptive but probably necessary pattern of relating in relationship to one another in a traumagenic environment.

The older of the two boys, John, is a deep thinker, has a personality that appears to be matching the culture of the foster-to-adopt family very well, and is able to soothe and entertain himself much more frequently than his brother. As we have worked together, John has been able to gain more and more control over himself in his interactions with his brother. However, his brother continues to hurt him and make threatening statements during many interactions. During this walk, John and I began exploring the agency's decision to place them together in a home. We talked about the pros and cons of this decision and about how things might look/feel/be different if they had been placed separately. We walked and talked until we were standing on the Bicentennial Bridge. The water completely caught our attention, as there had been a big storm the night before and the water level was significantly higher than normal. The river was moving more quickly than we had ever seen before. As we stood on the bridge and looked, we realized that the water in the distance was the river rushing as it moved around to the right and the water in front of us was the much slower moving (almost still) tributary. John and I watched the water for a while, and then John spontaneously said, "The raging part back there, that's like George, and this part is like me." Wow. The power of metaphor in nature. I think when we run out of words to explain our experience, we return to the natural world. The more often we are interacting with the natural world, the more expanded the potential metaphoric languaging options we offer to our clients (see Figure 7.7).

Focusing Our Attention

Sally is an eight-year-old girl I began seeing after her father died of a sudden cardiac episode. Sally has processed through a significant amount of grief, including a belief that it was her fault that her father died—if she had found him sooner, if she had known how to help her dad would still be alive. Her family is restabilizing, learning how to live in the world again, and her mom is learning how to do the job of both parents. Her mom, who had been a stay-at-home mom until her dad died, got a full-time job and worked sometimes from before school until almost dinnertime. Sally's mom talked about her irritation at the bickering that goes on between Sally and her brother and bemoaned the fact that they were always irritated with each other.

On a particularly beautiful fall day, Sally arrived for her session and asked to go on a walk. We walked down to the Harpeth River and stood for a time at the overlook. Sally and I both sat quietly for several minutes with our arms resting on the fence and our chins resting on our arms. Sally said, "It's so deep." I was surprised to hear this, as the river is fairly shallow on a good day and on this day had been without rainfall for a week and a half. I responded by

Figure 7.7 The Raging and the Still Water

saying, "It looks really deep to you." Sally said, "Yeah. See right out there in the middle, you can see the reflection of the tree in the water." I looked and was able to refocus on the reflection. Sally then said, "I'm trying to figure out if that branch is really in the water or if it's a part of the reflection." Again, I needed a moment to refocus my attention to notice the branch she had

identified. I validated her observation, saying, "It is hard to tell whether it's a separate branch or part of the picture." We both stared deeply for a while, shifting our visual focus between the bottom of the river, where the branch outline could be seen, and the top of the water that reflected the tree above in its mirror-like calm. After a few moments, Sally concluded that it was indeed a separate branch. As I lessened the intensity of my focus in and on the water, I realized that there was a whole swarm of gnats buzzing just slightly above the surface. As the light hit them, they became glaringly obvious and engendered a desire to immediately step away from them. However, neither Sally nor I had previously noticed they were there, such was the intensity of our focus on what was below. On the walk back to Nurture House, Sally remarked more than once on how she had not noticed the gnat swarm at all. I wondered out loud if our ability to overlook annoying things might depend on where we put our focus. Sally commented that sometimes her brother was like that annoying swarm of gnats—an irritation, a constant blur of movement. Sally said, "Yeah, and I didn't even notice it when I focused on the water." We then began pairing potential shifts in focus with Sally's management of her brother's irritating behaviors.

Experiencing the changing of seasons in nature offers rich fodder for metaphor work. We have had a delayed spring this year, and the earliest trees were beginning to bloom as I went walking with Christy, a teenage client. Her therapeutic work right now is related to taking risks in social engagement. People are often confused by her, as she looks like she should be socially adept, and yet every experience of meeting someone's eyes (especially if they are not well known to her), exchanging pleasantries, or asking for a certain item in a restaurant or store is perceived as a risk for her. So we go on walks together and decide what store we might enter, what question we might ask, what social engagement we will complete during a session. Recently, during one of these walks, she either opened or closed a circle of communication at least seven different times, a new record for her, and spontaneously said, "I enjoyed this walk, Miss Paris," when we returned to Nurture House. I have felt that she carries some shame in relation to her social self, as she is self-aware enough to understand her own social interaction patterns and recognizes that socially she is much younger than her peers. As we were walking, we passed a house where a beautiful cherry tree was blooming. The sun was out, the wind was gently blowing, and petals were mingling with the air currents—so many petals that we stopped walking to see where they were coming from. We stopped and looked up. A man came out on the front porch. I smiled at him and said, "What a beautiful tree you have! It graces the neighborhood." He said, "Thanks. I don't actually know what kind of tree it is." Christy remarked, "I think it is a cherry tree." When he went back inside, she commented that it had not been too hard to talk to him. Then she noticed the dormant tree next to the blooming one. Below is both the picture of the two trees and our conversation about them (see Figure 7.8).

Figure 7.8 Late Bloomer and Early Bloomer

CHRISTY: Maybe that one's dead. They should cut it down before it falls over."
ME: "Hmm . . . let's see," and walked closer to see it up close.
She and I noticed at the same time that there were the tiniest little buds beginning to show on the branches.
ME: "I think it is alive. It's just taking longer to bloom." I was struck by the profound parallel between the way we had misunderstood the tree and the way my client, in her delayed development, is sometimes misunderstood.
CHRISTY: "Well, I guess we have to wait for it. Maybe it will bloom by next week."
ME: "Yes, we will need to be patient."
CHRISTY: "Patience sucks."
ME: "It does suck sometimes to have to wait."
Christy sighed and said, "We'll come see it next week," and we left the tree to grow.

Making Nature Soup

Social engagement can be explored and expanded in an outdoor context in lots of ways. On day three of Camp Nurture, every child had grown in relationship with their buddies enough to be able to go outside. All the children and buddies followed, and it almost felt like a mini group marathon. The target was a wooden playset with two large trees that provided shade for it.

The big trees were dropping their seed pods, and one child picked up several, then asked his buddy to hold his shirttail like a sack, and the child dumped scores of seed pods into the shirt basket. Another child noticed what was happening and started gathering leaves. I commented on the green of the leaves and the brown of the seed pods. I said, "Wonder if we could find some things in nature that have other colors . . ." The children brought their focus even more connectedly to the present moment and immediately found smaller yellow leaves from a bush and tiny red seeds from another plant. We lined up all of these natural elements next to each other, and then I said, "Each of these is like an ingredient. I am thinking about a story called Stone Soup. In the story, the soup starts out with only a stone, but eventually each villager brings an ingredient to the soup, and it becomes a delicious soup and makes enough for everyone to feel full." One of the campers said, "Yeah, let's make soup!!" and an intern ran back to the building and brought me back a clear plastic bowl with water in it. I sat down on the floor of the fort of this playset, and the first child came and dumped in the seed pods. The second child came in and put in the leaves. Another child went and got little red seeds that were on the ground, and pretty soon every child had added an ingredient. This may seem like a very simple exercise, and it was certainly unplanned, but let us reflect for a moment on what skill sets and what presence of mind were necessary in order for each child to participate.

First, the bowl itself, the container for all the ingredients, was a shared space. Everyone had to negotiate and compromise about what ingredients would go into the shared space and in what quantity. Second, each child had to bring an offering and had to want to share the space (there was, of course, no requirement that everyone participate, but by this time their individual static was quieted enough that everyone was interested in exploring being together—at least for intermittent intervals). Third, each child had to become highly present, grounded in the natural world, ensconced in their natural environment and noticing the details of the world around them. After the seed pods and leaves were taken, other children spent time looking for "an ingredient" with a different color or a different texture. They would then bring the ingredient back, offer it to the group, and negotiate its addition to the soup. The final product was a really magical-looking soup with green, brown, yellow, and red colors, shiny and dull finishes, rough and smooth surfaces—all the differences making the soup more interesting. You can probably hear the richness of metaphors. All the children seemed proud of what they had created and asked that we bring the soup into the group room. We had several more hours of camp that day, and during our last Nurture Group of the day, we reflected on the experience of making the soup. Everyone took turns, if they wished, talking about what they had added and why (although the why was minimal). After all the children (supported by their buddies) had shared about their ingredient, one of our four-year-olds asked, "What did you add, Miss Paris?" As we all sat and pondered this, one of our older campers, one who had been very difficult to reach, spoke up and said, "You are the bowl. You hold us all together." The profundity of what had happened among us, among our connections to each

other, and in our understandings of the natural world and our role in it was profound. That camp was three years ago, but that experience and that child's ability to function in the natural world and make contact with the environment around her and then extrapolate to a different developmental plane that involved synthesis, symbolism, analysis, and metaphor were profound to me and reinforced the power of nature in healing and its continuous communication with us, if we are willing to listen.

Warmth

I am often made physically uncomfortable by air conditioning. I do not enjoy feeling cold. In fact, I find it painful. I often walk outside in between sessions in the summer just to feel the "hug" of the heat and regulate myself. If I have a similarly cold-natured client, I will invite them to join me. We may even lie down on the driveway to absorb the warmth of the concrete, behaving almost like iguanas on their hot rocks. This also serves as a very informal assessment tool for whether a particular child in my care is able to translate information from lower brain regions into self-care actions. Can they read the signals when their body is telling them they have absorbed enough heat and are ready to return to the air conditioning, or have they been conditioned to disconnect mind and body? Children from hard places, especially those who may have had an injury to their developing brains in utero through drugs, alcohol, or excessive stress hormones, will have impairments in their ability to "sense" when they are too hot or too cold. The reptilian brain stems of traumatized children—responsible for body temperature as well as several other regulatory functions of the body—are often compromised during development. These children do not know when they are overheated. This potential for internalized feedback from the natural world is becoming more and more limited as our society moves toward a disconnection with the natural environment.

Conclusion

Nature is a powerful force for regulation and a powerful ally in the world of metaphor. Since we have expanded our outdoor play options for children at Nurture House, we have seen families approach harder content faster as the child swings and the parent and I push them back and forth. We have seen children who I thought were fairly concrete in their ways of relating to the world end up using a powerful metaphor to describe their sense of their family dynamics or their own sense of self. Walking together in the same direction has long been a way for humans to experience the world and increase shared mindsight together. For all these reasons, the role of nature is given special attention on the Play Therapist's Palette.

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8 Humor, Novelty, and Shared Delight

Humor

Humor is another mitigator of the approach to trauma content on the Play Therapist's Palette. Embracing humor and other expressions of delight can help with the dance toward and away from the trauma content while it further enhances the therapeutic relationship. Humor is likely to be appreciated in a sequence that moves from playful verbal interaction to a smile to laughter. Laughter is most frequently a shared experience and is likely to draw people closer together (Provine, 1992; McBrien, 1993; Scott, Lavan, Chen, & McGettigan, 2014). Laughter itself is broken up into protohumor (a slightly milder form of enjoyment) and laughter that expresses true enjoyment. It is often accompanied by the Duchenne smile (Duchenne, 1990), which is a combination of the activation of the zygomatic major muscles of the mouth and the contraction of the eye muscles. While many women strive to avoid wrinkles around their eyes, I see them as the trail of true enjoyment in a person's life. Duchenne laughter, which is the only form that expresses strong emotions and can have emotional health benefits, is closely associated with the Duchenne smile.

The physical health benefits of humor are real (Hasan & Hasan, 2009). From biblical references to laughter as good medicine to recent research finding that people who embrace humor tend to live longer than those who do not (Seligman, 2004), the health benefits of humor have long been supported. Laughter, it seems, has the same health benefits whether it arises from simulated or spontaneous humor (Mora-Ripoll, 2011). On a purely biological level, when someone laughs, their muscles become activated, oxygen is sent to the bloodstream, the heart pumps more vigorously, and they experience a sense of well-being. Charles Darwin made the persuasive argument that a behavior as pervasive, loud, and sometimes physically uncomfortable as laughing must serve some sort of survival function or it would not have remained in our behavioral repertoire over time. He suggests that laughter functions, evolutionarily, as a social signal of happiness and builds group cohesion that is adaptive in communities (Gruner, 1997; Wild, Rodden, Grodd, & Ruch, 2003).

Positive emotion, rather than cognitive understanding of a joke, is most strongly associated with an increase in flexibility and problem-solving abilities. The perception of humor activates the dopamine-based reward centers of the limbic system, enhancing an experience of pleasure. Humor can alleviate stress (Abel, 2002; Cann, Holt, & Calhoun, 1999; Cann & Etzel, 2008; Lefcourt et al., 1995; Lehman, Burke, Martin, Sultan, & Czech, 2001; Newman & Stone, 1996; Overholser, 1992; Prerost, 1988), mitigate depression (Nezu, Nezu, & Blissett, 1988), and positively impact our resilience in the face of adversity (Berg, 1995; Keltner & Bonanno, 1997; Lefcourt, 2001; McGhee, 2010). When humor is shared between two people, it acts as another form of "love connector," becoming a bridge between the pleasurable feelings of each participant and creating a shared history around these. The neurochemical boxing match that aids in trauma recovery was discussed in Chapter 2, but the power of laughter as an ally in this neurochemical grappling deserves special attention. Since cortisol is often released in massive and damaging quantities in our bloodstreams during intensely stressful moments, oxytocin can be a balancing agent in trauma recovery.

The bottom line is that we need as much oxytocin on board as we can get as we heal from trauma. Oxytocin is released during nursing between a mother and a baby, creating a deeper sense of connectedeness. However, oxytocin can be accessed in several other ways, one of which is humor. Neuroscientists have found that laughter stimulates the 5-hydroxytryptamine 1A receptor. This receptor, once activated, stimulates the release of oxytocin. Interestingly, the neurochemical process is compared to the experience people have when taking ecstasy (Thompson et al., 2007). Oxytocin itself inhibits the release of cortisol (Spitzer, 2001) and modulates the amygdala's response (Kirsch et al., 2005) to signs of danger in the environment. These inhibitions decrease the traumatized child's felt sense of danger and potentially the need for hypervigilance—at least in the moment of shared humor. In fact, laughter involves auditory cortices (Woodbury-Farina, 2014) and activates our social engagement system, and oxytocin strengthens our attention to social cues and can function as a powerful bridge to an internalized sense of felt safety with the laughing partner.

The use of humor in a relational context can moderate the psychological distress caused by stressful life events (Fritz, Russek, & Dillon, 2017). When traumatized children or families are coming for treatment, they are often full of trepidation about how deeply, how quickly, or how overtly they will be asked to approach the trauma content. The use of humor mitigates the approach, providing a form of titration of positive relational interaction in the approach to hard things. When I hear laughter happening between a clinician and a child, parent, or family in a treatment room of Nurture House, I believe the healing process is being activated neurochemically while shared mindsight about whatever has been found humorous is being grown between the therapist and the client relationally.

Laughter can become the great equalizer in a session, giving humanity to a therapist who may have otherwise been perceived as more of an expert or

technician than a human being and helping counter the hierarchical relationship that sometimes occurs in therapy (Nasr, 2013). While humor and laughter do not always occur simultaneously, when we find something humorous, we are likely to laugh or at least produce a precursor for laughter—a smile. Believe it or not, these intuitive ideas that smiling is good, that laughter is good medicine, are only now starting to have scientific explanations. Researchers are beginning to map the neural correlates of laughter and humor, and some are even interested in how this works specifically in children. There are at least 16 different forms of smiles, but the Duchenne display is the smile of enjoyment There has been some fascinating research on the difference between authentic expressions of positive emotions and those that are forced. In fact, these two different forms of expression seem to have separate neural substrates (De Paulo, 1992; Ekman, Friesen, & O'Sullivan, 1988).

Children, especially, are often able to discern the difference between a truly authentic expression of enjoyment made by one of their safe grown-ups and the Pollyanna, falsely cheery smile of the teacher welcoming the child whom she knows is going to require several corrections throughout the school day. The more deeply I explored the research on laughter, the more clearly it became a mystery. Many authors have posited the neuroanatomical structures involved in laughter, but there is as yet little agreement. However, "nearly all authors agree that there must exist in the brain stem a final common pathway for laughter, integrating facial expression, respiration and autonomic reactions" (Wild et al., 2003). After synthesizing the current research, Wild et al. posit that the frontal and temporal regions are involved in how we perceive humor and trigger laughter and musculature changes within the face that are mediated by the ventral brain stem. I and other therapists find humor to be especially effective in mitigating a teenager's approach to difficult content in family therapy sessions (Gladding & Wallace, 2001).

Early writings on humor often talked about the potential perils of its inclusion in a therapeutic context (Kuiper, Grimshaw, Leite, & Kirsh, 2004). However, more recently, people have begun citing a sense of humor as a hallmark of optimal mental health and as a brother or sister to processes like creativity, spirituality, and flexibility (Gladding, 1995; Myers, Sweeney, & Witmer, 2000; Seligman, 2004). There are widely differing perspectives about the potential role of humor in therapy. Some therapists believe there is no place for humor in therapy, and that the potentially deleterious effects of misusing humor or minimizing/making light of a client's actual psychic pain could bring injury to the client. Others, however, see multiple benefits of using humor in therapy. Family values, cultural expectations, and resistance levels must all be explored prior to introducing humor. Experiments have shown that humor can expand creativity and influence cognitive processes toward more flexibility, as humor often brings together two concepts that would normally be incompatible. Some researchers call this incongruity theory (Cardeña, 2003). Some researchers have also posited that because humor involves being able to keep more than one interpretation in mind at the same time while wrestling

with incongruity, it is to growth in cognitive flexibility as a hand weight is to building arm muscles. To grapple with humor requires perspective shifting and can allow for a stressful experience to be reframed or evaluated from a less threatening position.

In some laboratory experiments in which groups of participants have been shown gruesome images from accidents, the participants who reported the lowest levels of disturbance around the imagery were those who used humor to cope. In these studies, the participants self-reported lower levels of distress. Objective measures such as heart rate and skin conductance provide evidence of reduction of the physiological effects of stress. We have all been on the receiving end, however, of humor or laughter that is ominous or even cruel (Provine, 2000).

My approach during supervision, when the issue of the therapist's use of humor comes up, is to orient the conversation to a question: whose need is being met here? Therapists may intuitively use humor when things get "too heavy" in therapy. If the "too heavy" is referring to the client's window of tolerance for processing hard things, then kudos to the therapist. He or she is judging, in an attuned fashion, when a dose of oxytocin and the buffer of connection with the therapist in a playful way will mitigate the approach to the scary stuff. If the "too heavy" has more to do with the therapist's window of tolerance, it behooves us to expand our own containment capacities while learning how to regulate ourselves more intentionally to meet the client's need.

The contrary impulses we all wrestle with—between self-focus and other focus, between overreactions and underreactions—in our attempts to get needs met and our constant dance of attunement, rupture, and repair in all of our interactions with other humans leave us no choice but to embrace the ridiculous. Being able to embrace this allows for a distancing as well as a potential laughing at the self that makes room for a change and shift in the way we see ourselves and the ways in which we deal with each other. To this extent, I believe the potential of using humor as a tool in therapy is worthy of further exploration.

Gladding and Drake Wallace (2016) talk about humor as a constructive expression of strong feelings, that humor provides a safety valve for the release of emotions that might otherwise be difficult to hold. With the advent of functional magnetic resonance imaging (fMRI), people are beginning to study what happens neurologically in the presence of something humorous. In one study, participants were engaged in event-related fMRIs while being exposed to episodes of Seinfeld or the Simpsons. The researchers were hoping to separate the neural substrates of humor detection from an appreciation of humor. The most interesting finding, for the purposes of this discussion, was that the amygdala and bilateral regions of the insular cortex were activated during humor appreciation. In other words, in order to appreciate humor, one has to have neural pathways that support the expression of affect (Moran, Wig, Adams, Janata, & Kelley, 2004). The amygdala's role in our reaction to traumatic events has been expanded upon earlier in this volume as well as in *Play Therapy with Traumatized Children*. If the amygdala can be triggered

for fight, flight, or freeze responses by any number of environmental triggers, perhaps our trauma responses could be mitigated by building up the positive neural network of amygdala-facilitated humor responses. One of the fascinating questions that is evolving from this research is whether there is a common structure that is activated in both crying and laughing, but perhaps to varying degrees. This is purely my hypothesizing now, but it seems to me that intense emotional responses, like those expressed following grief, often vacillate between tears and laughter; in fact, the only constant is the intensity of both. Moreover, tears are viewed by many of my child clients as a lot less desirable than laughter, so perhaps laughter—and the humor that accompanies it—might be the most accessible way to help child clients begin working through window of tolerance issues related to intense emotion.

Goldin et al. (2006) believe that there is a cathartic effect of humor that helps people feel more present, more vigorous, and more equipped to solve problems and utilize their creativity to achieve life goals. Seven forms of humor that have been categorized and are potentially helpful in therapy are 1) anecdotes, 2) jokes, 3) puns, 4) stock conversational witticisms, 5) irony, 6) hyperbolic statements, and 7) self-enhancing or self-effacing statements. Multiple scales have been created over time to try to get at the heart of humor. The Humor Styles Questionnaire (HSQ) (Martin et al., 2003) looks at four styles of humor, two of which can create iatrogenic effects (aggressive and self-defeating) and two of which are edifying and may positively enhance relationships between people and contribute to a healthy sense of self (affiliative and self-enhancing).

There are also five forms of humor that are generally agreed to be negative. These forms often create uncomfortable feelings and could certainly create iatrogenic effects in a therapeutic setting. They are 1) satire, 2) sarcasm, 3) dark, grim, or depressing humor, 4) teasing, and 5) blue/risqué. These forms of humor often involve sexually inappropriate references and therefore have no place in the therapeutic relationship. While humor can bring people together, anyone who has been on the receiving end of a sarcastic or meanly intended joke knows that humor can also be used to diminish or shame. The decision about whether to integrate humor into therapy will have to do with answering the following questions: does the use of humor promote client well-being? and does the incorporation of humor promote positive change in the client or client system? Part of the decision may depend on how humor is already being used in the family system, and for this reason, measures such as the Relational Humor Inventory (De Koning, & Weiss, 2002) may be useful.

Sarcasm, for example, may be an aggressive form of humor or an affiliative form based on the context. Some of the context has to do with how much more cognitively developed the one providing the sarcasm may be than the one receiving it. For example, many teenagers feel more connected to their parents as they share in some form of sarcasm together—perhaps making light of a situation at school or "ragging on" a pop star and their latest exploits. The teenager may feel that their intellect is being respected when they are sharing a joke with someone who "gets" them. However, the child

who does not yet have the cognitive sophistication to understand sarcasm may simply feel confused, minimized, or even shamed by not understanding the joke made by the caregiver or older child. Parent-child interaction therapy, a protocolized model intended to enhance the relationship between parent and child, increases child compliance, decreases parental stress, and relies heavily on equipping parents with a new set of skills to use in communication with their children. To this end, the first didactic training session with parents offers them the PRIDE skills (praise, reflection, imitation, description, and engagement). A handout is also given regarding what kinds of interactions are to be avoided during special playtime. Commands, questions, and criticisms are the three broad areas of communication to be avoided. Interestingly, as "criticisms" are unpacked, parents are asked to avoid using the words "don't," "stop," "not," "quit," and "no" during the five minutes of special playtime, but parents are also asked to avoid using sarcasm. The way I have explained this to parents is that young children understand that there is a joke and feel like the joke is at their expense but do not understand the content, so it just makes them feel bad. For a parent who needs a deeper explanation, it can be helpful to explain that most children do not understand the meaning of ironic statements until they are around six years old and may not perceive irony as funny until they are eight or nine, as it requires what Piaget termed a "theory of mind," an ability to infer the beliefs or intentions of the other.

Humor can be used to enhance group identity and is used in family, group, and individual therapy with various theoretical underpinnings (Galloway & Cropley, 1999; Isen, 2003; Jacobs, 2009; Fry & Salameh, 1987). There are several clinicians and researchers who have put forth models for using humor in therapy (Berlyne, 1972; Fox, 2016; Franzini, 2001). There are some who have used humor as a projective technique, asking the child client to identify their favorite joke, the idea here being that the content of the joke may reveal important intrapsychic conflicts or unresolved issues. Freud talked about humor as one of our most sophisticated and freeing defense mechanisms (Martin & Lefcourt, 1983). In fact, Freud saw humor as evidence of self-actualization, an ability to evoke pleasure out of excruciatingly painful situations (Goldin & Bordan, 1999).

In 1987, Mosak articulated five therapeutic uses of humor. Humor can help establish therapeutic rapport between client and therapist (Mosak, 1987; Richman, 1996). Richman talks about laughter in a session as enhancing our human commonalities and as therefore a powerful tool for building rapport and establishing trust. Some clients come to therapy with either a fear or a distorted (to the point of intimidation) view of the therapist and his or her expertise. When a hierarchical relationship is in danger of being established, humor or shared laughter can be the great equalizer (Chapman & Chapman-Santana, 1995; Goldin & Bordan, 1999). While some have given a nod to the potential use of humor in building rapport, others have created specific interventions that harness the power of the ridiculous for change in family systems (Sultanoff, 2013).

In our own family, there are times where one of us (myself, my husband, or one of my three children) has become dug in to a behavior or a point of view that is truly arbitrary. If we can insert humor at the right moment, we immediately take ourselves and our arbitrary dug in behavior less seriously. Ricks et al. (2014) designed an intervention, Laughing for Acceptance, specifically for high-conflict and highly resistant families. The intervention consists of having each family member create a comic strip related to the conflictual interactions. After all family members have shared, the clinician asks a series of questions geared toward reflection and giving permission to find humor in the patterns of interaction and that offer creative solutioning potentials. Odell asks people to engage in silliness, in part to interrupt the pattern of family interaction. Examples have been given of humor as adaptive coping among trauma survivors (Garrick, 2005; Lipman, 1991).

Children lacking a sense of humor tend to have higher conflict in relationships, lower self-esteem, and higher anxiety and other subsets of depressive symptoms (Erickson & Feldstein, 2007; Fox, Dean, & Lyford, 2013; Yarcheski et al., 2008). A sense of humor is associated with a sense of being able to impact the world, access to positive coping skills, and more positive relationships with others (Erickson & Feldstein, 2007; Fox et al., 2013; Yarcheski, Mahon, Yarcheski, & Hanks, 2008). Understanding a client's use of humor can reveal important information about his approach to emotions more generally.

While there is limited empirical evidence to date supporting the therapeutic benefits of humor in therapy, many potential therapeutic uses seem possible. Insight can be gained, hope can be ignited, and positive affect can mitigate a client's approach to difficult content. In fact, in a controlled study, humor presented in hierarchical scenes was found to be as effective as traditional systematic desensitization (SD). Of particular interest was that the hierarchical scenes were not paired with relaxation training—an aspect of SD work seen as necessary to counterconditioning the fear response (Ventis, Higbee, & Murdock, 2001). As humor is often associated with dopamine release in the brain, this "feel good" neurochemical reaction may render the need for relaxation training unnecessary. As humor is paired with difficult emotional or phobic content, emotional toxicity can be leached away from the scary stuff. Abrami's definition (2009) of humor is the "capacity to appreciate and derive some pleasure from that which is incongruous, ludicrous, absurd, or unexpected" (p. 7). There is an American Association of Therapeutic Humor and a whole journal given to the topic of humor.

Delight

In my case conceptualization, I always include consistently expressed delight in the client (whether this is a child, teen, or parent) as the most powerful mechanism of change in clinical work. Infants who are securely attached can spend long periods of time absorbing and returning the loving gaze of their

parents. Toddlers and preschoolers who have had caregivers delight in them really do see the world as their oyster and other grown-ups as interested in everything about them. Each of my children would run up to participants in my trainings and tell them everything they had for breakfast and everything we were going to do when the training day was over. They simply believed that the other would care. When children have not been able to absorb multiple experiences of delight expressed by a safe boss, they are often playing catch-up, and one of the therapist's roles is to provide delight. We do this in part with a loving eye gaze, the warmth we infuse in our tone of voice, and even the kinds of smiles we provide as we are saying hello in the lobby.

The Safety of Sound . . .

What we have always known to be comforting, the prosody of the mother delighting in her baby, now has multiple layers of scientific explanation, including Porges' polyvagal theory. Our social engagement system is activated by the vagus nerve embedded in the brain stem and connected to the musculature of the face and head. The muscles of the inner ear are a powerful antenna in the neuroception of safety. Our nervous system evolved to perceive the low-frequency bass sounds that have historically been associated with the vocalizations of an aggressive male. The tones of a male voice startle us, whereas melodic female voices are comforting (Devereaux, 2017). Another fascinating piece of the puzzle is that the same activation of the vagus that controls eyelid movement also tenses the stapedius muscle in the inner ear, which enhances our ability to hear the human voice. When the inner ear is tensed, the ossicular chain is activated, and it dampens the prominence of low-frequency sounds in the environment, helping us hear the human voice. When this age appropriate prosody is accompanied by a Duchenne smile, the child has the message "you are delightful" communicated to them in an amplified way. The child then squeals and smiles in response, and the delight circuit is completed, as the mother also feels delighted in. An important part of communicating delight is making sure your tone, cadence, etc., is age appropriate. When I am traveling, I often get on the phone to say goodnight to each of my three children, who span in age from eight to 16. People have commented that they can tell which child I am talking to based on the tone, volume, and cadence of my voice. Attuning ourselves to the communication of nurture and delight appropriate for each child in our care is part of the job of the trauma therapist. Paying attention to the child's physical body and celebrating who they are by decorating them (Theraplay) is one of my favorite activities (see Figure 8.1).

Children who come to therapy with their amygdala armed and with deeply held beliefs that they are damaged goods or bad kids can be positively shaken by our initial delight in who they are. The delight might begin in the lobby with an observation of their beautiful brown eyes, it may erupt spontaneously as the child beats me repeatedly at getting a ball through a hoop, or it may be expressed as I notice the child's propensity for drawing. Authentic delight

Figure 8.1 The Love Is All Over Their Faces

requires us to set the child's bar in a place that is attainable. One of my biggest wins is when I can help a parent reposition the bar for a child in their care to a level where they can celebrate the steps or risks a child is taking to grow.

Delight can be communicated through nurturing touch, such as high fives, fist bumps, or hugs. Delight can also be communicated in the shared novel experience. My family and I travel quite a bit, and it never ceases to surprise me that the moments we remember most about our trips, the shared mindsight that is most deeply concretized, are always the places/people/experiences we happened upon, not the ones that were planned into the itinerary. The unexpected, the serendipitous happening, can build shared delight. Shared delight can be powerfully enhanced by inviting shared novel experiences into a family. Many examples of this are given in the chapter on nature, as the natural environment is always changing and offering elements of surprise in the plant life, the animal life, even the sky. Some of my hardest clients have resulted in some of my most novel toys, as they needed an anchoring in novel, often kinesthetic, experiences to mitigate their approach to hard things.

Tools like funny videos and funny snippets of songs can be powerful therapeutic aids. I particularly enjoy the apps that take your face or voice and morph them in some way, making your voice sound like a chipmunk or like you have ingested too much helium, or extending your forehead so you look like an alien, or bulging

your eyes. I have a dear friend who has moved away, and in order to stay connected, we will each occasionally create a video in which we are singing each other a song but then morph the voice quality or the facial expression in a way that embraces the ridiculous. We each laugh out loud when we receive these, each feeling remembered by the other and more closely connected through the moment of shared humor. The Photo Booth application on Mac computers has provided many moments of silliness with clients who were otherwise very serious. Dress up itself can be a way to bring spontaneous laughter into a session. In the tradition of Patch Adams, some hospitals have experimented with therapeutic clowning and have found a reduction in both children's perceived pain during procedures and parental anxiety (Koller & Gryski, 2008; Wolyniez et al., 2013; Dionigi, Sangiorgi, & Flangini, 2014). Fake teeth and silly hats are great ways to bring giggles as are apps that morph one's voice or appearance (see Figures 8.2 and 8.3).

Another way to delight in a client system is to celebrate expanded competencies. When a client grows in any area that they were hopeful to grow in, we get to celebrate with them. The child who was not able to sleep in his own bed by himself, the teenager who had wanted to break up with her abusive boyfriend but had not been ready to before, the client who was willing to try working in the sandtray even though she had proclaimed herself to be without creativity—each of these provides a moment of sheer delight as the therapist witnesses and reinforces the courage and the expanded competence of the client. I had a recent family in which we identified the young man's goal as being able to do things that are uncomfortable for him. We created a beautiful poster and gave the family a set of cutout butterflies. Each time the client did anything that was uncomfortable for him, from brushing his teeth to tying his shoes, the parents wrote it on one of the butterflies. At the next session, I asked his parents to recite for me out loud each of his moments of pushing through discomfort to do a hard thing anyway. At the end of the session, he asked for another set of butterflies. I am not, at heart, a behaviorist, but delight can be communicated in many ways—including a celebration of competence.

With children who come to therapy already feeling like they need to perform well to be valued, a tool like the one described above might create an iatrogenic effect. With that child, we simply delight in his being—being with him in a grounded, perfectly contented way in session no matter what the content. To these children, I want to communicate through both my verbal and nonverbal actions that if they never accomplished anything ever again, they would be delighted in just the same simply because they were created.

The final way I believe we delight in traumatized children is by *staying present in their pain*. This idea, when whittled down, involves a constant communication of this message: *I see what you are showing me, you can show me more, and I will be delighted with whatever you show me because it embodies the great trust and holding we have developed between us.*

My most powerful example of this was given to me by a four-year-old child, Thomas, adopted at birth. He had significant medical issues and lots of sensory defensiveness. When I met him, he seemed to always feel like the world was coming at him, not that he was a participant in it.

Figure 8.2 Fake Teeth

He was a participant in a week-long camp experience in which regulation and learning to use his voice to express needs were the most important goals. Thomas learned more about his internal cues for regulation, and he found some of his first words at camp. He had started the week with very few words,

Figure 8.3 Changing Face and Voice App

grown in his vocabulary and self-regulation over the course of the week, and then decompensated on the final day of camp. When it was time to leave, he was picked up by his father to be carried out to the car. He began to hit his father with a toy he had just received as a transitional object and began to revert to old behaviors. I put my arms around Thomas and his dad together and said, "Use your words, buddy. I know you can. I am right here to listen,

and I want to understand." His face crumpled up, the aggression left him, and he began to wail, "I . . . will . . . miss . . . you!" This was the first honest expression of pain at a separation that Thomas had ever offered. All of the caregivers involved teared up, held the big feelings, and validated the pain of saying goodbye to people who had become important to them. There is a form of delight that can be expressed in sharing someone's pain. In this case, it was a privilege to help Thomas find the words to express his pain. His parents delighted also in his ability to communicate his pain so effectively, and even delighted in the pain itself, as it provided evidence that the relationships had been meaningful for this child.

Conclusion

While there continues to be debate within the larger field of therapy, I believe that most play therapists would acknowledge the powerfully positive role that humor has played in their relationships with traumatized children and families. This would be a good topic for expanded discussion in another volume. Most play therapists have also seen how, when a child pushes up against the edge of his window of tolerance for grappling with difficult content, the introduction of a novel toy or stimuli can help to extend the window for the work. Delight, and the many ways it is communicated, continues to be my preferred and primary change agent in work with traumatized children and parents. Delight in the child, delight in the parent, delight in the pain, and delight in the healing are all held together by the wise play therapist.

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9 Holding the Hard Story
Narrative Nuance

The Dance Toward and Away From the Trauma Content

One of the foundational concepts of the TraumaPlay™ model is the therapist's stance of respectful titration in our approach to the scary stuff, whatever that might be for a hurting child or family. Children will show us or tell us their story through glimpses and snapshots. We can honor and extend these moments of holding their trauma content through play therapy, expressive arts work, sandtray work, songs, creative writing, verbal storytelling, and the attaching of content to prop-based game play. Children who might only share so much on their own can go further and deeper with the help of a therapist armed with the Play Therapist's Palette. This chapter will provide a multitude of case examples demonstrating how we move towards coherent narratives with clients by weaving in the creative tools that can extend their window of tolerance for holding the hard story.

Holes in the Story: Using Jenga in Life Narrative Work

A colleague of mine at Nurture House, Shelby Henson, had been pressing into finding new ways to kinesthetically mitigate a client's approach to life narrative work. She began to recognize the process of Jenga play, pulling out blocks, as leaving holes in the structure that compromises the integrity of the building. She used the metaphor of holes in the structure to mitigate an approach to Ray's life story work. Below is an excerpt from a session in which she introduced this play to Ray, a ten-year-old adopted at three. As we worked on it together, we talked about how memories can be confusing. Sometimes we have an actual memory encoded in autobiographical memory. Other times someone tells you the story of what happened, and this telling becomes a memory. Still other times you are not sure about something you think you know and you may have a question about it. We decided to attach colors to each kind of memory: orange for things kids were told, purple for autobiographical memories, and red for questions.

SHELBY: Today, we're going to play Jenga . . . and here's another one of my metaphors [*laughing at herself*]. You know we've been working on

creating your life story, right? We will get to add to that today by playing Jenga. From what you know about Jenga, what happens when you start taking out more and more blocks?

RAY: It falls.

SHELBY: Exactly. That's just like people's stories. The less information—or in this case, blocks—that we have, the weaker the story becomes and can lead us to feeling yucky. The empty spaces are like unanswered questions. So today, as we play Jenga, we're going to start writing your story with as many memories that you have to make your story stronger.

RAY: Sure.

SHELBY: For each memory you tell me, I want you to tell me if it's something you remember, it's something someone told you, or if it's something that you aren't sure happened or if you have a question about it.

RAY: Okay.

SHELBY: All right, let's start! You go first.

RAY: I'm going to make this hard! [*Ray chose a hard one to pull out.*] Ahh, got it!

SHELBY: Wow, you are making this hard. Okay, tell me your very first memory.

RAY: Well, I guess it would be that I was born. I don't remember it, but I know it happened. So I guess use the orange marker [*to indicate someone told him*].

SHELBY: Got it. Okay, my turn. [*Shelby pulls one out.*] That one was too easy. Okay, your turn again.

RAY: Next thing would be going into foster care [*pulling out block*]. But I don't remember that either because I think I was like one or something. But I know it happened. That would be orange.

SHELBY: Yeah, it's hard to remember things when you're that young. Do you know why you went into foster care?

RAY: Yeah, my mom couldn't take care of herself. I think she had like some blood clot issues or something.

SHELBY: Got it. Mom couldn't take care of herself [*repeating back as she writes*]. Okay, I'll go [*pulls out block*]. Okay, your turn!

RAY: Next, I guess it would be when my mom now offered to adopt me [*pulling out block*]. I don't know exactly when that happened.

SHELBY: It's okay if you can't remember all the dates and ages. We're going way back in time.

RAY: Yeah, I don't remember it all happening, but I've just been told that. So that one would be orange too.

SHELBY: You've done a lot of thinking back to your past today! I think this is a good place to pause this game and go play our outside game.

Shelby had earlier made a compromise with this client that they would spend part of the session on life narrative work and part involved in more full body kinesthetic play. Shelby kept in mind at all times while working with this client the need to slowly stretch his window of tolerance for looking at or

talking about hard things while mitigating the approach with lots of play and pleasurable sensory input.

Shelby facilitated a nuanced titration of narrative rehearsal here. Notice that every "memory" that her client identified was a piece of his history that was told to him by others and held for him by others, some of whom he no longer has contact with. Part of what this means is that eventually helping the caregivers hold the hard pieces of his narrative with him will be necessary because it will solidify their positions as history keepers for him. With this new dimension of history-keeping will come a deepening of the attachment relationship with his adoptive parents and more coherence in his internal narrative as well as more coherence in the caregivers' narrative that they hold for him. This client's first pass at life story work was rendered more "doable" by the client because he already knew how to "do" Jenga blocks, as Shelby sought to mitigate the approach to difficult content with the mastery experiences of kinesthetically pulling blocks from the stack without them falling. In essence, the client's success in pulling out parts of his story, including foundational parts of his story around why his mom chose to let him be raised by other parents, allowed him to pair competence-enhancing play experiences with the hard work of narration and coherence building. Shelby reflected on her work with him during the week following and wondered if he was ready to hold some of the less comfortable pieces of his narrative. She then tweaked the activity to be less predictable and to include a metaphor for memories being less neatly placed.

In the next session, Shelby chose to use something different than the Jenga blocks to continue to create his life story. She used a bag of blocks that were all different shapes, sizes, and colors. She explained to Ray that no one's life looks like a perfectly crafted Jenga tower, with every block being the same shape, size, and color. She said that most people's lives look like something created out of the bag of blocks I brought in. She had client start to build a "Jenga" tower using the different sized, shaped, and colored blocks to continue the life narrative work.

As Ray was building, he used all of the flat and similarly shaped blocks first to build the base of the tower. As the tower grew, he was left with using blocks that were cylinders, ramps, triangles, etc. As he struggled to make them fit and stay, Shelby reflected, "Sometimes there are pieces that just don't seem to fit." She then asked him, "What would you like to do with those pieces?" He said, "Can we just get rid of them?" She told him that while that seemed like the easiest solution, we had to use all the blocks somehow. She compromised and told him he could place them to the side for a while, and then he could make the decision for what to do with them.

After the client completed the tower using the "normal" blocks, they then continued to write down and label the memories that he could remember from his past. After he had written down several for the day, Shelby readdressed the blocks that had been put to the side. She said, "So, these blocks over here are a lot like the stories in our past that we'd rather just get rid of or ignore, but we can't just delete them. We can acknowledge that they're here, and we can also choose what we do with them." She then asked him, "So what can we do

with these blocks?" He said, "Well, we can add to them to have them make more sense." She reflected, "Yes, I remember seeing you stack two ramps on each other going opposite ways to make them flat." He agreed. Shelby went on, "So with your story, maybe that means adding more information around confusing things to make them make more sense?" He agreed. Shelby continued, "Yeah, we can do that. Also, we can know they're here and just try to put them on the tower and make them fit the best we can and know it just may not look perfect." Ray nodded, "Well, it sure isn't perfect . . . but it's kind of cool."

Trauma Narrative in Creative Writing

When trauma processing is occurring, whether it is in sandtray form or in art, clay, or storytelling, there are frequently shifts to a somatic focus for a piece of the work. An example follows: Jenny, a 16-year-old girl who was sexually abused by a significantly older cousin during multiple family gatherings, had shared the verbal narrative of her memories of the abuse on two or three separate occasions. As we grew in trust together, she was able to acknowledge that, for her, referring to what had happened to her as "my abuse" provided a level of removal from the actual events that kept her regulated, but she acknowledged that this did not help her with resolution of her PTSD symptoms. Jenny brought creativity to many other areas of her life, and we began titrating doses of exposure to previously unexplored experiences of the trauma through creative writing. Jenny's family has allowed her writing to be shared here in the hopes that it might be of value to other survivors and the clinicians who work with them. This particular excerpt is her memory of one abusive moment.

"Blow," he would say.
"Harder," he would yell.
As a four-year-old, this made no sense. What does he mean? I am blowing. Why was he screaming at me? What was I doing wrong?

Many times he would yell at me to do things.
"Take off your clothes," he would say.
"*Let's play a game*."

What was this feeling I felt? Was it pleasure? Or was I uncomfortable? I was a girl, he was a boy. They are supposed to kiss and hug, but what was this? Why do boys and girls do this?

It doesn't matter, he is my cousin. And I look up to him. He is like my best friend. I'll do whatever he wants. Even if his mouth tastes like Takis.

Yet, this feels weird. Why do I have to put his penis in my mouth? Why does he have to put his mouth on my vagina? Why does it feel good?

We are breathing so hard. Why are we underneath blankets? It's hot in here. Can I take them off for a second? I can't breathe.

Wait! Don't pull the blanket back! I need some fresh air!

Done. Finally . . .

Ooh! What's that bag of color packet things? Lipstick? Cool! Hold on . . .

Wait, you want me to wear it? What color? Red? I'm not allowed to—okay.

What, Mom? Oh, I'm putting on red lipstick for dress up with Ty Ty. Yes, it's just pretend.

Ugh. I can't get this on my lips! Jo Jo—can you help me? Thanks.

Now to our game. Again.

"Blow," he would say.
"Harder," he would yell again.
As a five-year-old, this still made no sense. What does he mean? I am blowing. Why was he screaming at me? What was I doing wrong?

Auntie, is that you? Hi! What's wrong? You look scared. Ty Ty and I were just playing a game. Why are you yelling at him? You're scaring me! What's wrong?! Why are you wrapping me in a towel? I can just put my clothes back on. Please tell me what's wrong! Can't you see I'm crying?

Auntie? Uncle? . . .

. . . . . .

Momma's home! Are you gonna tell her what happened? Come on, tell her! Tell her! Why won't you tell her? . . .

Should I?

. . . . . .

As the film reached its end and the memory faded . . . so did a child's faith in the protection her family once provided her.

Sometimes the richness of what is possible through writing is underappreciated. Jenny read this narrative out loud to me once and said it felt good to read it out loud. I offered to provide bilateral stimulation as she read it again, and we did so. As she continued processing, she became at one point hyperfocused on the feeling of Ty Ty's hot, wet breath on her neck. She had a somatic reactivation of a body memory. This is an example of a memory stored in the body—an implicit memory—being activated as she explored a chain of associations that were deepened by her experience of first writing the narrative and then reading the narrative out loud while we were engaged in bilateral processing. It could then be integrated. When clients reexperience somatic intrusions as part of their processing, I offer an alternative nurturing experience for that part of the body. In this case, I offered the client essential oils, and we applied a particular scent to her neck that resonated for her with

strength, clarity, and hope. We sent some home with her in a scent jar to continue engaging in self-care. We also began creating a ritual in which she could put some of the strong/hopeful scent on the palm of her hand and place the palm of her hand over her collar bone, giving herself the measure of compassion that she would give to any of her friends.

Even this kindness to self was a process that had to be titrated, first by imagining that she would provide this kind of nonjudgmental comfort and healing to a friend and giving herself small doses of the same compassion she would have offered to others. Jenny had so much self-loathing related to her sexual abuse that she engaged in self-injurious behavior when I first met her. She was eventually able to show me the cuts on her arms and allow me to take physical care of them, providing healing lotion and Band-Aids to the affected areas. Her mom also gave this care at home when Jenny found things just too hard to handle. Eventually, as we processed through her trauma, integrating parts, offering compassion, and fostering self-compassion, she began to take a different kind of care of herself. Jenny stopped wearing long sleeves, and she would come in with violent red writing on her arms and wrists (see Figures 9.1 and 9.2). Instead of cutting herself, she would bring a red ink pen to school and draw lines on her arm. Eventually, the lines of red and the violent words began morphing into a recognition of her own numbness and slowly into hopeful words and images, such as *fearless and brave* and *individual growth* and *not a spirit broken*. She also began to draw smiley faces, hearts, and other symbols she perceived as hopeful.

Healthier digestion of difficult content is the goal and desensitization and/or diffusion of the memories is an important part for the work, as is the creation of a coherent narrative. As Jenny was moving toward an ability to morph her urges to inflict harm upon herself into more positive uses of voice, we began doing some expressive arts–based work through an internal family systems (IFS) lens. After Jenny had been stabilized and was experiencing some success in using her adaptive coping, I explained to her that we all have many parts to ourselves, and that sometimes we can isolate these parts from one another, but as we build bridges and start to give room for all of the parts of us to have a voice and be heard, we can begin to integrate them. I asked her to focus on the moments just before she cuts. I wondered aloud if she could name the part of her that wants to cut. She paused just a moment and then said, "Harley." I then asked Jenny how old Harley was. She paused, visualizing this "Harley" part in her mind, and said, "She's five." I then simply asked if Jenny could focus on the Harley part of her and draw a picture of her (see Figure 9.3).

If you look closely at the picture, you will notice several things. First, you will see the handprint of the 16-year-old Jenny layered, almost like a watermark, on the paper—perhaps representing the struggle for dominance between the five-year-old self and the 16-year-old self. You may also notice the erasure marks and ghostly half present legs that were first drawn and then erased as she became more and more aware that the Harley part was on her knees, hands

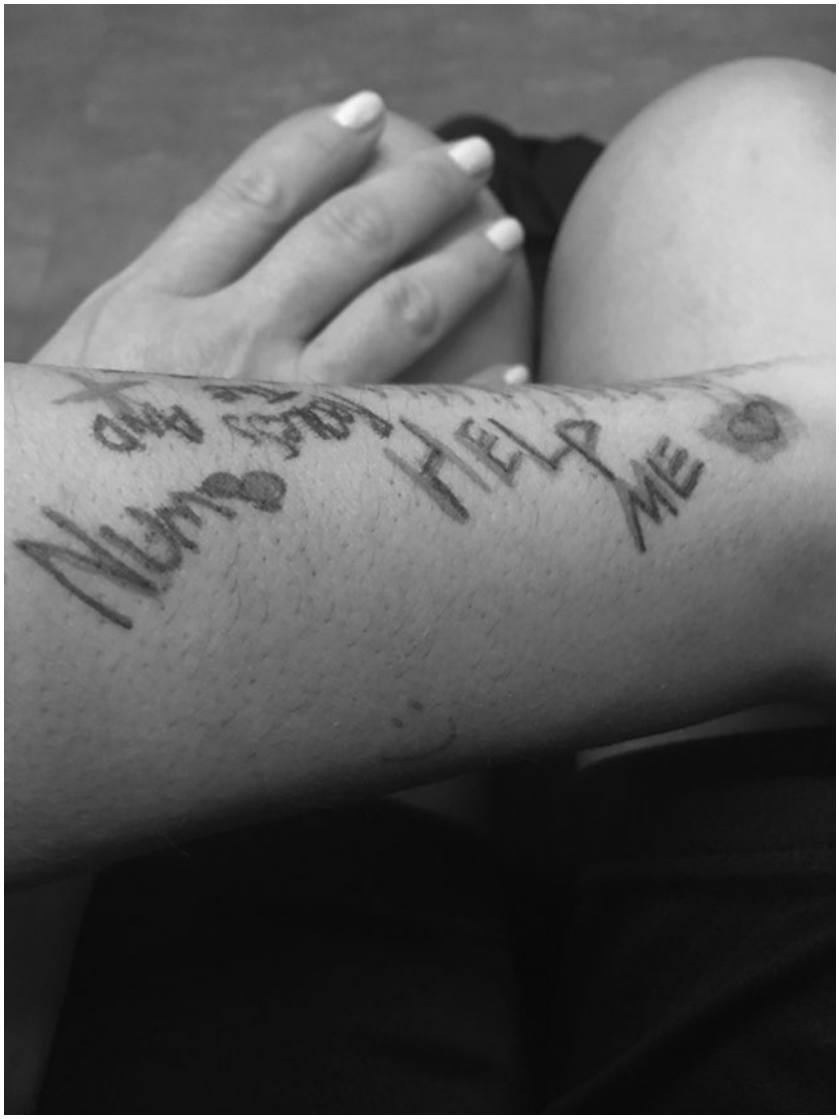

Figure 9.1 Recognizing Numbness

tied behind her back, with her mouth sewn shut. I asked Jenny if she could try and talk with Harley. What would she say to her? It was remarkable, really, the transformation that occurred as this now 17-year-old saw her cutting behavior as a much younger part of herself. She began to speak to her Harley part and said things like, "It's OK. I know you are scared. We are in this together. I know you didn't have any power then. But we don't have to hurt ourselves.

Figure 9.2 Individual Growth

We will get through this together." And ultimately, "If you could just come to me when you are scared, I will take care of you . . ." This was the beginning of a new season of self-compassion that had not been present before.

As we continued to process together and integrate parts of the self into a functional whole, Jenny began to be kinder to herself. The family ended up having to make an abrupt move out of state before her therapy was complete.

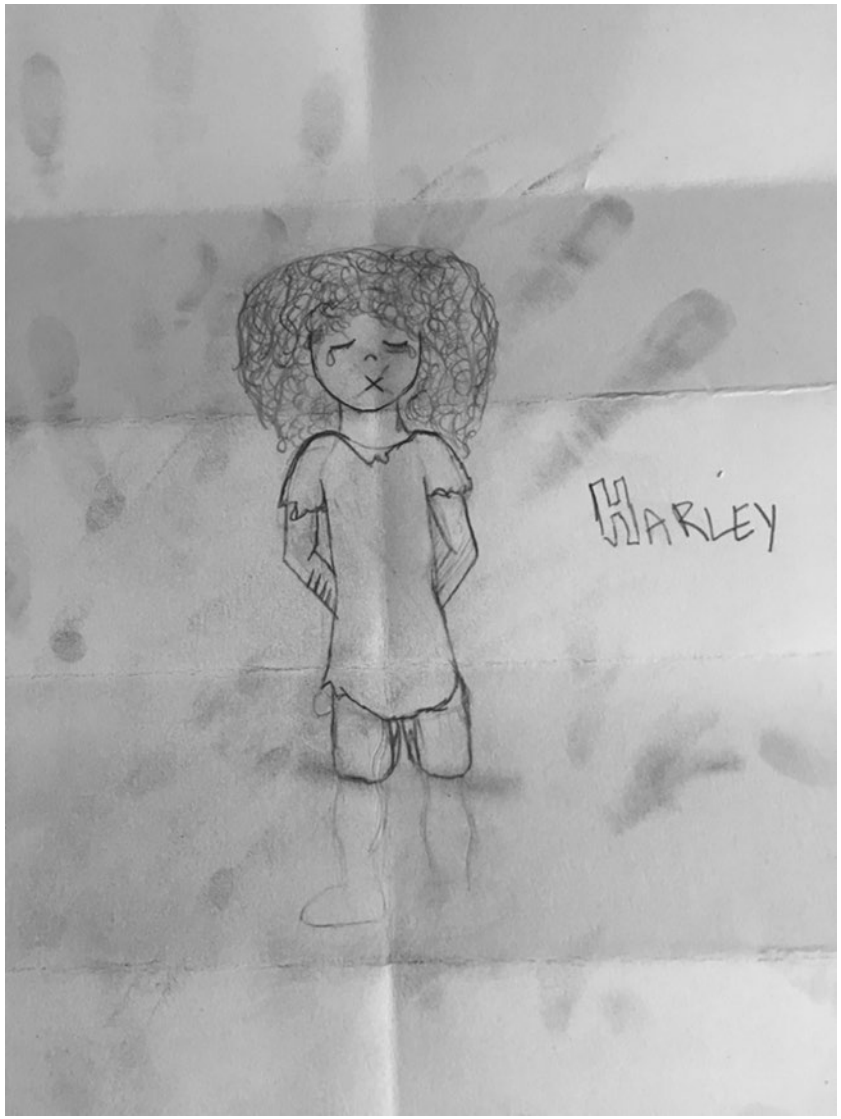

Figure 9.3 The Five-Year-Old Harley

Normally, when I am completing a termination process with a client, especially a teenage client, I engage them in the Before, During, and After intervention outlined in *Play Therapy with Traumatized Children*. In this case, I tweaked the format to account for our piece of work and to help her articulate (in trans-hemispheric language) her treatment goals for her new therapeutic

relationship. I asked the client to draw a picture that represented her experience of herself before therapy (see Figure 9.4).

She drew a self-portrait and then cut out another square of paper, scribbled on it, and placed it over her face. Then she took another square of paper and wrote "Just Another Body" on it (see Figure 9.5). She talked about the dual meaning of this statement for her. She talked about how disconnected she had been from her body and recognized after all our work that this dissociative coping had been really helpful to her during her abuse but was no longer needed. She also talked about how people see her tall, curvy, beautiful body now and appreciate her for just her body, not bothering to even look for her true self. I then asked her to draw a picture to represent how she saw herself now, at the end of our time together. She chose to take the picture she had drawn and make some changes. She began by removing the face covering, and then she crossed out the words "Just Another Body" and wrote her name and the words "A Human Being" (see Figure 9.6).

She talked about how she had come back into her body and felt comfortable in her own skin now. We had also done some work around humans "being" vs. humans "doing," and she felt equipped to engage in mindfulness practices when she started to become anxious. I had taken a picture of the first image, and we put the two side by side. We looked at them together, and I asked,

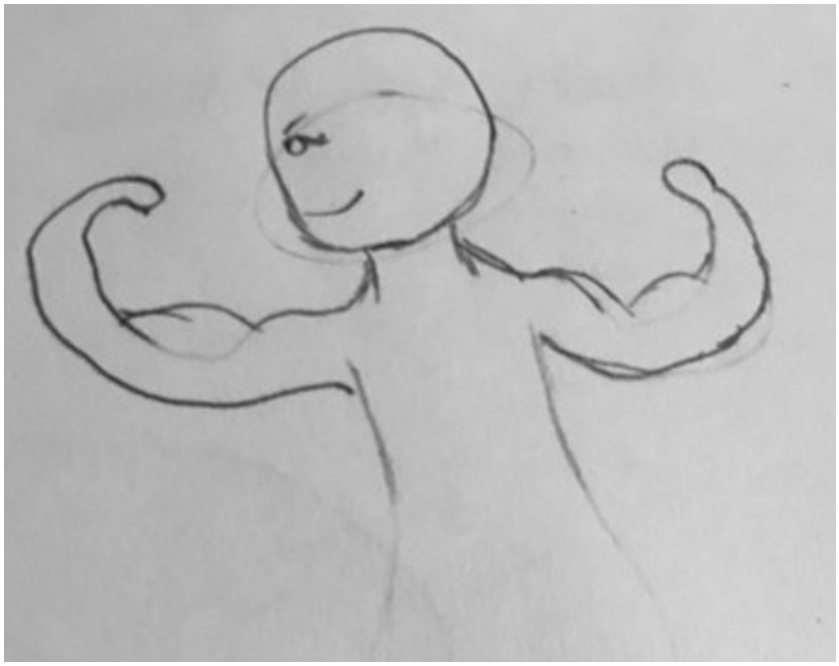

Figure 9.4 Jenny Accepts Harley as a Safe Part

Figure 9.5 Just Another Body

"What do you notice about these two pictures?" She immediately said, "My hands. They're behind my back." I acknowledged having noticed this too and wondered out loud what it meant for her. She thought for a moment and then said, "I guess, although I'm more me now, I don't interact with the world the way I want to. I'm not very confident with others." I asked if she wanted to draw a new picture or change this one in some way to show what she would like to see for herself.

She created a new picture, filling the page with more of herself than she had done in her previous drawing. She has one arm up in front of her, making the peace sign, and her other hand is on her hip/back pocket. Her shirt, in this picture, covers her whole midriff. She then wrote on the paper "take it or leave it" (see Figure 9.7). Jenny was quick to say, "I'm not being mean. It's not like a snotty take it or leave it. It's just me being secure and confident about me and willing to reach out to others." It never ceases to amaze me how much our right brains want to tell us about what we need, what we most deeply desire. Drawing the pictures first and then bringing verbal articulation to the drawings gave her a richer, wiser reflection and allowed for a more fully felt process of goal setting for her next therapy relationship.

Posttraumatic Play and Storytelling

Trauma narrative can be done in sand, in art, in puppetry, in music, in dance, and sometimes in plain storytelling. This next case example is an example that illustrates the resolution of a discrete traumatic event. The approach interweaves trauma-informed play therapy with storytelling and EMDR. I received a call one day while I was on vacation. A set of twin three-year-olds had been on an outing to the park with their babysitter. They took their scooters and began moving along a bike path attached to the park. A man who had been parked in the parking lot followed them and attacked the babysitter. She screamed to the three-year-olds to run away. They did run away, but we did not understand until I started working with them that they went to search for rocks and stones to throw at the "bad guy." When their mom and dad came for our initial session, they were in crisis. The boys were asking questions that the parents did not know how to answer. They were deeply afraid that they would say the wrong thing and further traumatize the children, so they did not answer the questions at all. The children were deeply afraid, and these previously independent sleepers not only insisted on sleeping with their mom and dad but would also ask repeatedly for their parents to lock the bedroom door at night to keep the bad guy out. The family was asking for immediate relief, so I brought the twins in together for the first couple of sessions. In both sessions, they responded in fairly classic posttraumatic play scenarios, choosing perpetrator figures and multiple jails and jailing the bad guys (see their containment work in Chapter 4). These more purposeful moments of play were peppered within significant stretches of dysregulated play. I wanted to give them more mastery experiences, particularly around the restoration of their sense of power in the environment. At home, they seemed to be grasping for power by assuring themselves that the doors were being locked, so I began hunting for a way for them to play this out.

I found a wooden house-shaped box with a door on each side and four keys, one that fit each of the four locking doors. I simply added this toy to the playroom where we had already been meeting. The more regulated of the two twins gravitated toward it and began locking and unlocking the doors. He

Figure 9.6 A Human Being Front View

put symbols inside each door. Eventually, he left some unlocked and locked others. When he went home, he was much less focused on making sure the bedroom door was locked.

Meanwhile, I asked the mom to record the children's questions and I asked the parents to come together, and we crafted an appropriate story. Sometimes this process is long and grueling. How to talk about rape in a way that is developmentally appropriate can feel like an impossibility to parents whose whole goal to date has been protecting their children from ugliness. The goal is not to say everything "just right" but to craft a story that is able to be absorbed and held by both the parents and the children. These parents have given me permission to share the story we crafted in the hope it will inform the work of other therapists who are helping to speak the unspeakable.

Figure 9.7 Take It or Leave It

The Story of What Happened

One day Laney was babysitting Robert and Ronnie. All three went to the park to feed the ducks. They played on the playground also, and then Laney took them to ride their bikes on the trail. They were riding their

bikes, when Laney said, "It's time for lunch." They turned their bikes around to go back to the truck. A man walked past Robert and Ronnie as they were riding their bikes. The man threw Laney to the ground. Laney knew the man was dangerous and was making bad choices. She wanted to keep the boys safe, so she yelled, "Run, boys!" She hoped they would run to safety. But the boys wanted to help, so they looked for rocks and sticks and couldn't find any. They got a little lost, and then they found Laney again. When they came back to Laney, they saw the man on top of her. He had his hand over Laney's mouth because he didn't want her to scream for help. But she did scream anyway and kept screaming for help. The boys also saw that Laney's pants were down and wondered why. The man made a bad choice to take her pants down without her permission and to touch her body without her permission. The man hurt her and then jumped up and ran away. Laney jumped up too, fixed her clothes, and said, "Boys, it's an emergency." They left the bikes, ran to the truck, and drove home quickly. Laney ran into the house screaming. Daddy came running and started helping right away. They were back in their safe place at home. Daddy called the police, and police officers came, an ambulance came, and a fire truck came. Mommy rushed home and helped Laney go to the doctor while Daddy stayed with the boys. The doctor helped Laney's body feel better. Jennifer came back from her trip to help take care of the boys and to help the family feel safer. A couple of days later, they went to see Laney, and the boys saw that she was safe with her mom. Now Laney is safe with her family just like Robert and Ronnie are safe with their family.

The End

The posttraumatic play expressed prior to the EMDR session was important preparation, and yet these children needed an overtly articulated story of what happened that could be held by the whole family. Once this story had been told, most of the posttraumatic symptoms receded immediately.

Nurturing Narrations

Hands are powerful on many levels. They are the primary instruments by which we touch other people. Handshakes, high fives, and even hugs begin with outstretched hands. But they can also represent our ability to do things—typing, cooking, building, tending. I am remembering a very important session for a dad and his newly adopted daughter. We engage in a process at Nurture House that we call Nurturing Narration. It combines Theraplay principles with trauma narrative work. It was our first session of nurturing dyadic work, and we were checking for hurts. The dad worked in construction, and as we began to pay attention to his hands, we saw the "stories" from his work all over them. The little girl was unused to nurturing touch, and I thought it best to model what she and I would do with her dad first. I asked if I could

have his hand, and as I inspected it, I noticed an old scar and a new scrape. I offered a little lotion for the old scar, and while I was taking care of the scar, I asked the dad to tell me the story of how he got it. He had cut it on a piece of heavy machinery when he used to work in a car manufacturing plant. The little girl piped up with "I didn't know you made cars!" I commented, "You didn't know that about daddy. Sometimes when we pay attention to the hurt places, we get to hear new things about each other." Sally thought about this for a moment and then rolled up her pants leg to show us both the scar on her knee. I offered to put some lotion on it, and she scooted toward me, bringing her knee closer.

I applied the lotion while asking, "How did you get this scar?"

She looked at her knee while saying, "My brother was playing with his pocket knife, and he was mad that I was changing the TV to watch my show and not his. He threw the knife at me, and it hit my knee."

I kept a hand on her knee and reflected her words to her. "He was playing with it, and when he got angry, he threw it at you. It cut your knee. I imagine you were bleeding."

"Yeah, I was bleeding." She moved slightly closer again.

"You were bleeding and you needed help."

"Yeah, I ran to Mom's room, but she was asleep and told me to stop crying and get a Band-Aid, but I couldn't find them."

"Then what?"

"Well, I didn't want to wake her again. She'd be mad. So I just used a paper towel."

"So, you helped yourself. Daddy, that day she had to help herself, but now you are here to help her." Then, to mitigate this potentially threatening interweave, I shifted my attention to concrete things: "I have five different kinds of Band-Aids in this jar."

Her dad took the jar from me, opened it up, and dumped out the Band-Aids. He said to his daughter, "Which one do you like?" She scrambled into his lap and carefully perused all the Band-Aids, finally landing on a My Little Pony Band-Aid.

Her dad said, "I'm sorry that you had to handle that hurt all by yourself. From now on, I'm here to help with hurts," and he put the Band-Aid over the scar.

The little girl jumped up and said, "More Band-Aids! More helps!"

I said, "You want to find some other things to put Band-Aids on."

She ran to the circus tent where the puppets were kept and brought back several. She would choose one, say how it was hurt, and then offer that body part—a beak, a paw, an exposed tummy—to her dad and tell him which Band-Aid to put on the doll. Her dad put each Band-Aid on with care. When she was finished, she arranged them all among the comfy pillows of our snuggle nook. She and her dad looked at them together, and she said, "They'll be OK now."

We have found that this approach, Nurturing Narration, invites storytelling by pairing it with nurturing touch (aimed at actively taking care of hurts), and caregiver engagement often elicits parts of the child's narrative that might not have been accessible without these supports. There is a risk a child takes when they give us more of their story. When the story is received and listened to with interest and compassion by a safe adult, the risk is rewarded. The reflection of the child's story by the safe grown-up meets three goals: 1) it lets the child know that the therapist is not overwhelmed, immobilized, or left speechless by the information; 2) it can bring an additional level of organization or coherence, as the child can listen to the story being told by another; and 3) it can help structure and support the child in sharing more of the story. I talk a lot about the various ways we communicate to children "I see what you are showing me, and you can show me more." It is the same with telling.

In other cases, there may be events in the child's life that are confused or misunderstood or have not been narrated for the child. I was recently in session with an adoptive family. Derrick, the nine-year-old boy, had just become regulated enough for us to begin making sense of his history. At the beginning of the session, I was joining with each family member, and the mom expressed relief about an adoption outside of their family that was, after much time, energy, hope, and disappointment, going to be able to happen. The mom said, "So, we finally got a yes! The kiddo can be adopted!" Derrick, who was sitting on the pillows with a cover partially over his head, popped his head out and asked loudly, "Am I going to be adopted?" His mom said, "You already are adopted. You are a part of our family forever." Derrick replied, "What is *adopted*?" As his mom began to explain, Derrick was struck by the phrase "tummy mommy" and blurted out, "But I grew in your tummy!" I offered these words: "It sounds like Derrick is really asking to better understand his story of being adopted. Let me run and get my 'tummy mommy' figure, and you guys can start picking out sandtray miniatures to be mom, dad, and Derrick." I explained that, for Derrick, the story would be easier to grasp and remember if it was told with concrete symbols of the various players. I offered two separate sandtrays and set them up in different parts of the room so that tummy mommy's story, as she was pregnant with Derrick, could be played out in a different location than his parents' story. His parents acted out going to an adoption worker and asking to be parents, waiting expectantly, and then getting news that a baby had been born early in a hospital in another state. They learned that this could be their baby if they could drop everything and come and get him. Derrick blurted out, "We need a car . . . I'll get it." Clearly, he was now very invested in the story. I moved back over to the tray with "tummy mommy" and clarified, "So, Derrick was born in a hospital over here?" His mom nodded. I asked, "Did you meet tummy mommy?" His mom said, "Nope. Oh, I guess that's an important part of the story. Tummy mommy knew she couldn't keep Derrick and said goodbye quickly to him and left the hospital. I think she was sad about saying goodbye and wasn't able to stick around." I asked, "Who took care of Derrick while you were

driving to get him?" She replied, "The nurses were with him, and he spent one night with a nice woman named Gina." As his parents narrated, I would stop and ask clarifying questions. As we took the story step by step, Derrick asked questions and ran to get more miniatures. Afterward, his parents shared their astonishment that there were so many places of confusion or misunderstanding in his story. More than likely, he will need several more repetitions of narration before he really has the coherent story inside of him. To this end, I had his mom take pictures of the various scenes as we went along. They will print them out, and we will type up the narrative and make it a family exercise for the family to create the hardcopy version of the story that can be told again and again.

The ways in which narratives are created and retold are vast, and different children may need different ways to access their story after the initial telling. I was helped in my understanding of this by Loto, a nine-year-old boy with Down syndrome who was internationally adopted after living on the streets of his hometown for several years. Loto's developmental differences and his slow acquisition of English as a second language made communicating story challenging. Prior to entering treatment, his parents had created a timeline complete with important dates for him. His mom requested a consult, as Loto had begun engaging in a behavior that was bewildering to her. She described a frequent scenario in which she is driving and Loto begins to shout out from the backseat, "2009! Born!" His mom will say, "Yes, you were born in 2009." Other times he will just shout out a date, but in both cases it had become perseverative. His mom was exhausted with trying to understand what he was asking for each time he made an exclamation and was even more exhausted with repeating herself. I explained that Loto seemed to be seeking assurance regarding the parts of his story he remembers and may be asking for more elaboration or deeper coherence regarding other parts of his story. To this end, we decided to narrate his story in the sandtray first and videotape it so he could rewatch the video narrative at will. We also took pictures and made a hardcopy book and then had the parents record their voices reading the book. When done this way, it can even be fun to include a sound like "bing!" at the end of each page to indicate to the child that it is time to turn the page. This allows for the parent and child to snuggle together and read the story (my preference) and for the child who needs more repetition than the parent can tolerate to be able to hear the story retold in a read-along fashion.

This is where another critically important aspect of narrative work must be understood. The narrative itself and the ways in which the narrative is delivered must honor the needs of the system. You might be saying, "Don't you mean the needs of the child?" Nope, I mean the needs of the system. To unpack this further, we must be asking a series of questions all along the way as we are crafting, concretizing, and conveying the story. Are we answering the question asked? Is the information being shared in a developmentally appropriate manner? How much information can be tolerated by the child right

now? How much information can be tolerated by the caregiver right now? In family work, the caregivers become the holders of the story, and if they cannot buy into the narrative that is shared, then they will be likely to go way "off script" in a moment when they feel triggered. Finding the balanced, nuanced story that will work for the system becomes the sustainable goal.

The delicacy of this balancing act is often brought front and center in divorce cases that are highly conflictual. We find ourselves sometimes working with divorcing parents for several sessions, holding the big feelings related to the hard truths of the grown-up story so that they can tolerate the withholding of developmentally inappropriate information from the shared narrative both parents support for the child. Most child therapists would agree that a simple explanation that does not assign blame is best—something like, "Mommy and Daddy are not able to get along together anymore and are going to live in separate houses. We both love you very much, and you will have a forever place with each of us." In other cases, the story might go like this: "Mommy and Daddy have been having some grown-up problems and have decided to divorce." These are the simplest constructions but can often be painfully difficult for parents to implement. The dad who is divorcing mom because she had an affair may want the child's understanding to reflect his own judgment—that mom's "bad choice" caused the divorce. The mom who has spent ten years as a stay-at-home mother and wakes up to a husband who says, "I don't want to be married anymore," may really want her children to understand that she did not choose the divorce. Parents who have a deeply rooted faith-based belief that divorce is wrong may have even more trouble with creating a narrative they can live with. Often, I am entering into these negotiations with this guiding question: "What is the story that will provide as much truth as possible at an age appropriate level in a way that can be consistently repeated and held by both parents and child?"

One of the dimensions of narration that my parents struggle with the most is summed up in the small distinction between using the word "couldn't" and using the word "wouldn't." Sometimes a parent is gone because of mental illness. Perhaps that parent has bipolar disorder and does not take the medicine that is prescribed. If it can be argued that bipolar disorder can be regulated through medication, does it become a "choice" on that parent's part not to take the medication, or is it part of the pathology? Does the story for the child become "Daddy couldn't take his medicine regularly" or "wouldn't take his medicine regularly," and which version is more helpful to the child? Get ten therapists in a room and they will give you ten different answers. In some cases, a child may have taken on the burden of blame, and using language about choice in reference to the parent may be freeing for the child, providing relief that he did not choose to be without his parent. For other children, however, the idea that a parent chose something, whatever it might be (drugs, alcohol, an affair), over the current family system might reinforce an already pervasive sense of rejection. How does this difference in language affect the child? This tiny little difference in language is the ballgame for many people.

Many parents feel strongly that the other parent had choices and chose to abandon the family.

I have worked with several parents with the same story: "I was at work when I got a call from the school saying that my daughter wasn't picked up from school." In all of these cases, this phone call marked an abandonment by the other parent, either due to alcoholism, drug addiction, or mental illness or the other parent having abruptly left without a word and remaining unreachable for days, months, or years. In such cases, there is a myriad of narratives available to the remaining dyad. For one dad and his son, the narrative became that mom had a sickness in her mind that made it difficult to take care of herself or others. At one point in treatment, it became important for the sense of abandonment that each felt to be acknowledged by the other. I drew a large figure for the dad and a smaller one for the son and gave them Band-Aids. I asked if they could show me any hurts on the inside or outside that needed a Band-Aid. They both put Band-Aids in their midsections, slightly below their hearts, to represent the mom/wife leaving. The child also put Band-Aids for concrete hurts on his legs, and the dad put a Band-Aid on his head and talked with me briefly about how much harder it was for him to trust than it used to be. This art activity became the anchor for rich nurture and holding of big feelings between dad and son.

Who Am I? Enhancing a Child's Internalization of a Parent Who Has Died

The image shown below was created by the child referenced earlier in this book. This child found his father in his study no longer breathing. He called 911 and provided CPR to his dad for a significant period of time before the ambulance and emergency workers arrived. He believed, deeply, that his father had died because he had not been strong enough to give the compressions properly. He was helped to tell his story by the kinesthetic involvement and concrete nature of domino people, lining them up and knocking them over. He used these domino people to work through the blow-by-blow of what happened that night and to arrive at the conclusion that there was nothing he could have or should have done differently. He resigned himself to the fact that his father had, in essence, already died at the time his son found him. While absorbing this truth was initially painful, it ultimately brought him relief and absolution. This resolution of guilt opened him up to celebrating the parts of himself that are like his father. We began by taking a precut hand template and attaching it to paper. We asked his grandmother (who had brought him into the session) to help and had his grandma paint the client's hand. He put his handprint inside his dad's, and then we talked about how many parts of his dad lived on in this child. He talked about how his blue eyes came from his dad. He remembered his dad telling him to brush his teeth and talked about the love of sports he had learned from him. At the end of the session, I asked him to title his creation, and he decided to call it My Daddy in Me (see Figure 9.8).

Figure 9.8 Encoding Transmission of Positive Attributes

Anchors for Activation

What do I mean by the phrase "an anchor for activation"? In play therapy, the miniatures, toys, and other play materials are all made available to the child in the context of a safe therapeutic relationship. The trauma-informed play therapist is able to be with the child in play at the same time he or she is

always watching for the moments of "quickening." In these moments, a child might become more intense in their attention, sometimes by intensely rejecting or embracing an object. In the moment of intense rejection of an object or symbol in the playroom, the therapist's antennae go up, and they pay closer attention, as there are several possible responses.

One approach would be to simply reflect the action and the child's embedded emotional relationship to the object. The child may be communicating feelings of intense anger, and the child may simply need to have these feelings and their actions reflected to them. For example, if a five-year-old girl picks up the male baby doll and throws it across the room (and has just had a new baby join the family who is taking most of mom and dad's attention), that child may simply need the play therapist to reflect the intensity of her anger with the new baby by reflecting her action and holding the big emotion that comes with it. The therapist might say, "You seemed so angry at that baby when you threw that baby doll across the room."

Another approach would be to view the rejection of the object as a rejection of parts of the self, parts that may need to be approached with curiosity and compassion in order to heal and become fully integrated into the child's sense of self. Through an internal family systems (IFS) lens, there may be emotional parts of the child that have been exiled. Through a trauma narrative lens, there may be an activation of trauma content that the child is hopeful to avoid. In some cases, the traumagenic material may include feelings about themselves at certain ages or stages of their life. Tracking these moments of rejection can be very helpful in understanding where the unresolved, incoherent life narrative moments remain.

Case example: Sally is an 11-year-old girl who was adopted by her family at birth. However, the in utero threats were real and persistent during her gestation. She generates various realities around how she was left, all of which have an undertone of self-loathing and deserved abandonment. She and her mother have been seeing me for help with their attachment relationship. When they first started seeing me, Sally would become almost feral whenever her sense of shame was triggered. Her shame was triggered if she was told no, it was triggered whenever her mother tried to teach her something new, and it was triggered whenever her sibling was the focus of attention, even briefly. She was set up, both neurologically and psychologically, to perseverate and often did so on negative thoughts about herself. She believed she was stupid. She believed she was ugly. She believed that no one liked her. She believed she had been left in an alleyway because she was trash. These were pieces of her narrative. She misperceived many looks given to her by her parents as looks of loathing even when they were attempting a soft, loving eye gaze.

The first long period of work was simply spent helping this little girl develop trust with her adoptive mom. As trust was developed, we began tackling harder things in sessions. One day Sally and her mom accompanied me to the sandtray room. Sally began her work by making a zoo where each animal was

Figure 9.9 The Baby in Mother's Womb Activates the Client

caged separately, had its own space, and everyone got along. As she perused the sandtray shelves, she noticed the figure I have of a baby inside the translucent torso of its mother (see Figure 9.9). Her loud and immediate exclamation was, "EWW! That's gross!" I commented, "That seems really yucky to you. Mom, can you hand it to me?" Her mom handed me the figure, and I held it cupped in both of my hands, silently gazing at it. Sally looked surprised

and carefully watched me for a moment before turning away. She continued choosing animals for her tray. As she remained kinesthetically engaged elsewhere, I spoke to her mom, saying, "You know, mom, I've been thinking a lot lately about how babies can either be made to feel really, really safe and welcome in their mommies' tummies or not safe or wanted. When a mom isn't sure how it will go to have a baby—maybe she is worried about whether or not she can take care of it, whether or not she will be in trouble for being pregnant in the first place [*this related to this child's birth story*]—she can release a lot of stress hormone into her bloodstream, and it can make the developing baby feel unsafe." Sally, who had given no visible sign that she was listening, stopped what she was doing and asked, "There's a chemical for that?" I said, still looking at the baby, "Yep. The fancy name is *cortisol*. Cortisol can make it hard for the growing baby to feel good, even in the womb. One of the first things that babies hear is the heartbeat of their mother. If a mom feels pretty calm and content during her pregnancy, the baby hears this [*I thump my hand rhythmically against my own chest*]." At this, Sally turned to look at me, and her jaw literally dropped. "You mean babies can hear inside?" "Yep, and if they have a mom who is scared sometimes or stressed sometimes, what they hear is [*I thump my hand several times very quickly and then slower in a dysregulated pattern*]. Babies can have a hard time feeling safe when the sounds don't even stay the same." Sally looked directly at her adoptive mother and said, "That explains a lot!" I said, "Looks like this means something for you." "Yeah, I'm scared all the time. I didn't know it started back then." I returned my gaze to the symbol in my hand and said, "Sometimes the baby thinks there is something wrong with her, when really the mom was just so stressed she couldn't make it safe for the baby." I shift my focus to Sally and say to her mother, "Mom, how 'bout you hold the baby while Sally tells me about her sandtray." Her mom held the baby for the rest of the session.

In the above case example, Sally experienced a moment of activation in relation to an object in the room. This provides rich material for work. She vehemently rejected a sandtray miniature of a baby in its mother's womb. Sensing the intensity of rejection as a moment of activation, I chose to extend the moment of interaction enough for us to work with it. Since the question of why she was given up for adoption has not been fully resolved for her and her narrative of how it happened keeps changing, the vulnerable baby exposed through the translucent womb sparked feelings of fear and self-loathing. Whatever the core question that needs to be answered for trauma resolution to begin, we begin the dance toward and away from the question in part through these moments of activation. Here, Sally does not take the time to examine her feelings of discomfort when she attends to the baby in the womb but pours her rejection of the vulnerable parts of herself into the symbol. The good news is that if we track the moments of intense rejection or embrace of symbols in the playroom, we can begin to track the moments of the life narrative that need help to become more coherent and integrated into the child's story.

As soon as Sally would begin to get some clarity about one aspect of self, it would seem to drift away, and a new worry would become the defining force in her life. Earlier in our work together, as the worries had been so interruptive and overlapping, I offered her the Worry Worms activity (Goodyear-Brown, 2010) as a way to categorize and bring some executive functioning voice to the anxieties she carried. I hid rubber worms around the room, and each time she found one, she would verbalize another worry that she carried. The number and kinds of worries filled the whole page and continued on to another page and included the following:

1. Being treated like a baby.
2. Sleepovers.
3. That all my clothes will be ripped.
4. That I won't get enough food.
5. That I'll be embarrassed in front of my friends.
6. That if I keep eating I'll get fat.
7. That my sister will get hurt.
8. That we'll have to go to the doctors.
9. That I might be touched inappropriately.
10. Getting blood drawn.

You will notice themes among her worries. She described these worries almost like a Ferris wheel in her mind—they all revolved in her head and got recycled many times a day, with different worries being most vivid at different times. As her attachment relationship with her adoptive mother became more trusting, she began to articulate these worries to her mom while she was having them. Having a connecting co-regulator in her mom really helped take the intensity out of them. We began to understand that the worries came in waves, but she could decide which ones to ride and know that eventually that worry would shift, become smaller, and recede into the background. This new way of relating to her worries equipped her to move beyond full-time management of her anxiety to deeper questions related to her core sense of self.

After several sessions that focused on building self-compassion and narrative integration through play, Sally seemed ready to approach her sense of self more head on. I asked her if she could create a sandtray to show me how she saw herself. She chose a beautiful princess and began draping her with handcuffs. The room remained very quiet, her mom and I both maintaining a respectful silence while she worked. When she was finished, she stepped back and said, "OK." The image you see below was her central creation (see Figure 9.10).

I asked if she could describe the princess now. Sally said, "Trapped." We all continued looking at the figure. After another silence, Sally said, "Each handcuff is a trap." I said, "Oh, she has a lot of traps." Sally said, "Yeah." Then she pointed to one and said, "This one is the stuff in my head from the computer." She pointed to another and said, "This is the way I always think my friends

Figure 9.10 Self-Object Covered in Handcuffs and Weapons

are laughing at me." She pointed to a third: "This is me always thinking I'm ugly." The client had moved from a strictly symbolic/metaphoric approach to storytelling to an ability to articulate her own reality in a left brain linguistic way after creating and experiencing the symbolic representation with primary weight given to right brain ways of knowing. The hemispheric integration that

we were beginning to see in her work mirrored the integration of parts of the self that were beginning to be allowed to exist and be named. We spent time working with each of the traps.

Sally had been exposed to some pornographic imagery and was internally harassed by pictures that had morphed together in her mind and could not easily be shaken. She described a very specific image and then said, "It's hard to describe." I asked if she could draw a picture of the image that stuck in her mind (see Figure 9.11). She perceived herself as being forever tainted by what she had seen. The image is that of a mouth-like opening with teeth at its center and, below, the words "My mind is forever swollen with the memories of thy sin." The word *swollen* may describe her experience on multiple levels. It may reference the pleasurable sensations she experienced in her own physical body when looking at the images, the images themselves, the sense of being "too full" of this content without a way to digest it, or a sense that she was being gnawed at by the perseverative nature of the visual images, rehearsing them again and again in her mind's eye. She has gone through cycles of blaming the creators of the imagery and then blaming herself for looking at them. We have since worked with this image, helping it lose some of its power over her.

Sally's belief that her adoption meant she was dirty or bad was so pervasive that even moments of attempting to make a positive self-statement were followed immediately by negative ones. She would often gravitate to extremes in language, saying in the same breath, "Everyone is jealous of how pretty I am,"

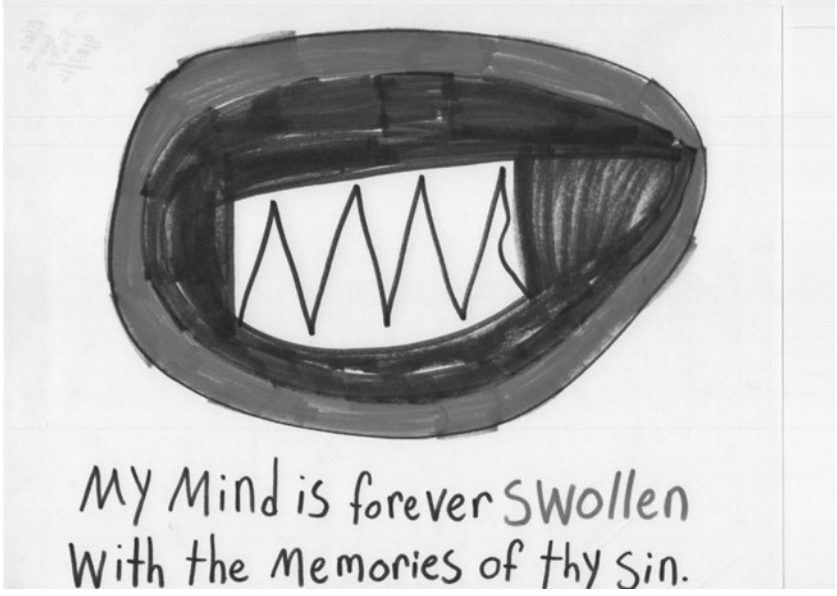

Figure 9.11 Hard to Forget

followed immediately by "I am so fat." It felt like Sally was unable to reflect on her feelings of brokenness and questions of worth in a meaningful way, but rather ping-ponged back and forth between extremes of grandiosity and deep self-condemnation. Expressive arts materials can be very useful in beginning the work of integration around self. In Sally's case, I simply asked her to create a self-portrait. Her first response was, "I'm a terrible drawer." I offered all the materials and said, "There is no right or wrong way to do this, and you can use any of the materials that you see." Her self-portrait (see Figure 9.12) was fascinating.

She spent time painstakingly trying to make the two sides of her face symmetrical. She actually asked for a measuring tool and tried to measure how far each of the eyes was from the midline of the face. And yet, the finished version is an extremely out-of-balance face. One cheek is carrying a bruise, possibly reflective of her belief that she is damaged goods and her extrapolated belief that everyone can see the damage when they look at her. Her mouth is placed so off center that it almost looks like it is in her cheek and reflects feelings of deep uncertainty. When I asked her to describe what the expression in the drawing was communicating, she said, "What else is gonna happen to me?" If you look closely, you will also see that there is a person reflected in her eyes. When I noticed the figure drawn in the eyes, her response was, "That's just a person." This may indeed be true for her and may portray her feeling that her sense of self is defined by the "other" who is seeing her and is shaped by what they are communicating or how she perceives their communications. She is

Figure 9.12 Unintegrated Sense of Self

easily buffeted by the feelings, actions, and facial expressions of others, as she often overperceives disgust and underperceives admiration. Since Sally's sense of self is constantly tied to how she believes others are experiencing her and she is carrying the core question "What else is gonna happen to me?" she is constantly in a hypervigilant place, leaving little room for the development of trust or an autonomous self.

One day, her mom shared with me about a birthday party Sally had attended. During the party, she told the other girls that she "had been left in a box in an alley" when she was little. All the other girls cried, but the narrative she had told was not the truth, and this concerned her mom greatly. I said to Sally, "It sounds like you are asking the question 'Please help me understand my early life better.'" Sally looked relieved, and we decided it was time to dig deeper into her questions about her birth parents. We agreed that mom, dad, Sally, and therapist would all sit down together and create a book that answered her questions in ways that were developmentally appropriate for her. We began slowly, asking Sally simply to create a cover for her life book. Below is the first cover she created (see Figure 9.13).

Shattered. This was a powerful expression of her anticipatory fear that her birth story would prove that she was broken beyond repair. For me, it resonated most strongly with the shifting shards of self that we had been identifying in the playroom.

Before we began the life book, I asked her if she could draw her birth mother the way she has pictured her. Sally got right to work and drew the "svelte, skinny woman in the skin tight pants" (Sally's description) you see below (see Figure 9.14). She had been carrying a story inside her in which her birth mother was a 16-year-old "slut"—again, Sally's word, not mine. Notice that this figure is also without facial features. After saying the word *slut*, she then carefully wrote on the page "Had sex with her high school sweetheart."

Sally also believed that her birth mother did everything she could to attract male attention, including wearing skintight pants and shirts that showed her midriff and making sure her long hair was always styled. The simmering rage she felt for the betrayal by her birth mother is hinted at in her characterization of her mom as "the freaking woman who didn't give a _____ for me." When asked to fill in the word out loud, Sally mouthed "shit."

I began her life story work by asking her to generate a list of questions. She had lots of questions, ranging from "Where was I born?" to "Why did she leave me?" She was very surprised to understand that her mother had been in her 30s when she was born and had been in a relationship with one man, and that they had broken up before he knew her birth mother was pregnant. I sometimes have to be reminded of how children absorb (and don't) different parts of their narrative. Sally had been rehearsing one story in her head and heart for so long regarding where she came from that it was very difficult to overwrite this distorted narrative with aspects of the real events as they unfolded. During the first session in which we began answering some of these questions, she made the only cognitive shift around her birth mother's age. Having been told her birth father did not know she existed did not change her internal narrative.

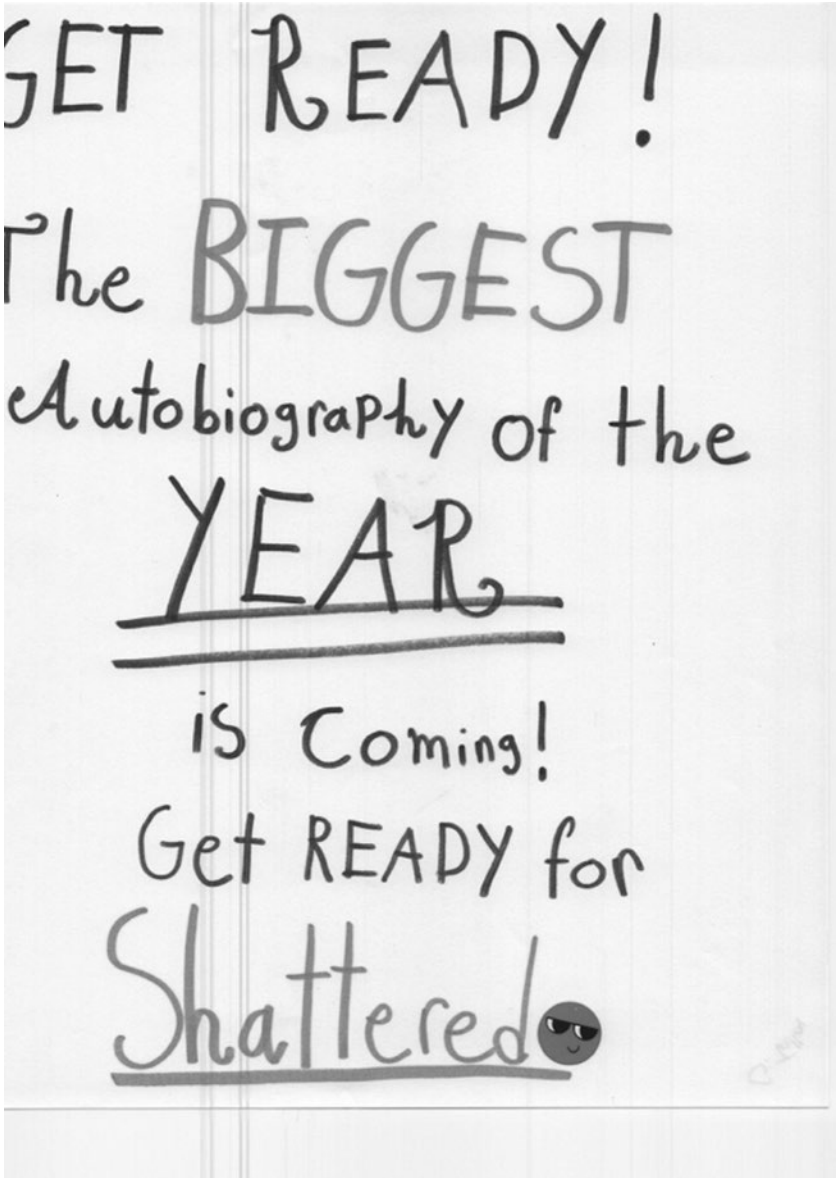

Figure 9.13 First Cover of Sally's Life Book

Next session, she spontaneously said again, "I hate him. He left us." She had rehearsed the story of how her birth father had left both her and her mother so many times that simply correcting the distortion verbally was not enough. We played it out in the sandtray—the sequence of events from birth mom and dad being together to them breaking up to mom's learning she was pregnant to

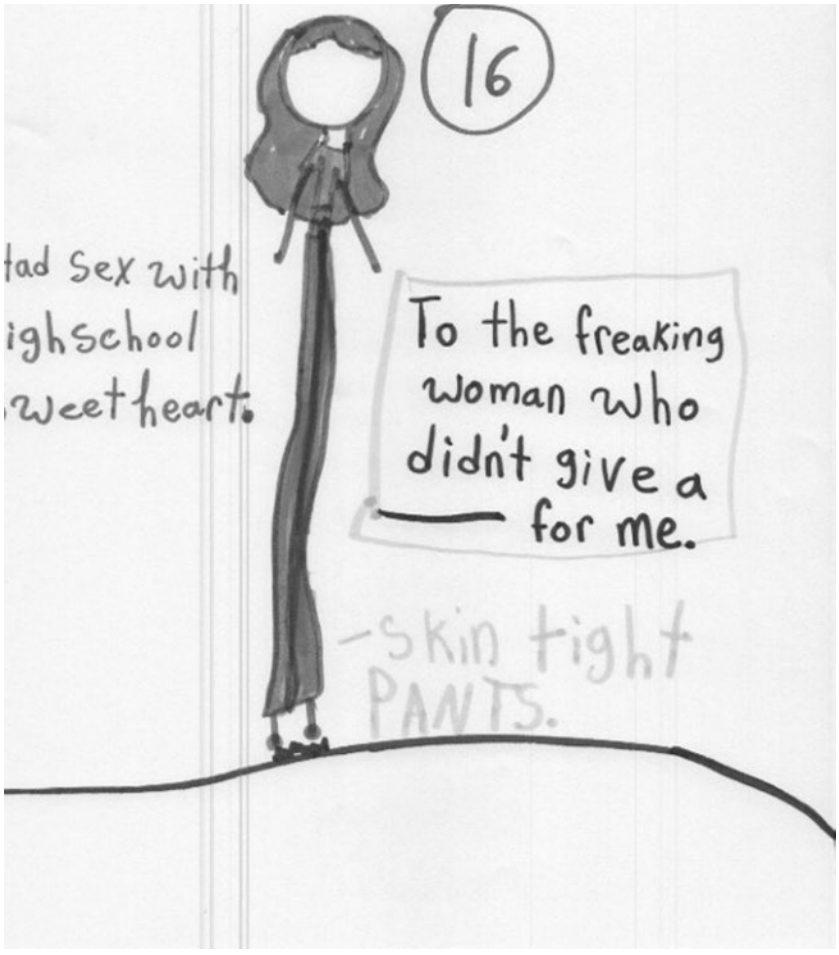

Figure 9.14 Sally's Internal Story About Her Biological Mom

Sally's being given to the people who have been mom and dad ever since. We were four sessions into rehearsing the story differently before Sally was able to interrupt her own old story with "No, wait, he didn't know about me."

As we did the laborious work of helping her piece together the story of her beginnings and how sought after she had been by her current parents, we saw her internal coherence and her ability to trust her mom and dad increase. She is still an emotionally labile child and can become anxious very quickly, but now she seeks out her mom for support and can allow her mom to hold parts of her story with her that she used to try to hold herself. In a recent sandtray, I asked Sally to create her family in the tray. Many times children begin a tray with one configuration and then move the figures as they tell the story. Below

Figure 9.15 Family of Origin

Figure 9.16 Internalized Nuclear Family

are two pictures taken as Sally was working in the sandtray (see Figures 9.15 and 9.16).

Notice that her birth mother figure has remained the same since her initial connection to this figure. She said, "This was my birth mom and my birth dad. I made him a helicopter because he left. Well, he was gone before I was born. I mean, he didn't know about me. The baby is me after I was born." Notice that she still has the chronology confused but is able to self-correct as she works. She then went and got a second, smaller sandtray and placed it inside the first. She created her current family in that tray, and she moved her father figure over to the other side of the tray. She is the girl with the cowboy hat, her father is a heroic figure, her younger sister is happily roller skating, and her mother is her cheerleader and placed so closely behind her you can only see her hands and pom poms from the angle at which I took the picture. This shift was so striking to me. There were very clear boundaries now between her nuclear family and the rest of the world. Her birth mom and birth dad are clearly apart from one another and are still present but are on the fringes of the world. It seems that the life story work—which allowed her to ask questions and have her parents answer them—allowed her to experience them as her history keepers in a new way. Their new roles as history keepers opened Sally more and more to accepting them as her safe bosses and to an overarching new sense of them as her nuclear family. We are further down the road now in her healing

Figure 9.17 A Day at the Beach, Emerging Boundaries

process. Recently, I invited her to create a world in the sand. She created a tray that was built around one of her favorite memories with her family—a trip to the beach. She put two chairs in the shade where she and her mother could sit. She included "monuments" for the family to see during their trip and a safety fence to keep the water at bay (see Figure 9.17). We begin to see new boundaries emerging and more organization and coherence in her creations.

Future Circles

I have become enamored of circular sandtrays in the last few years. They offer a kind of containment that is reminiscent of the mandala and offers the hope of completion by making a journey all the way around the circle. Because the circle offers no beginning and no end, it encourages the perception of trauma recovery as revolutions or iterations of experience, spiraling toward deeper levels of integration and/or further distance from the traumatic event. The sandtray pictured below was created by a mother and her son Jimmy. The mother had been driving with the son in the backseat when they were in a car accident that resulted in injuries. The family was unsure about how to process the trauma together and brought the son to Nurture House. I worked through the TraumaPlay™ model with them, and when we arrived at the trauma narrative piece, I checked in with the mom for any important details that Jimmy might have encoded. She had found Jimmy hunched in the floorboard of the backseat in the wake of the accident and assumed he had seen very little. I threw a bunch of google eyes in the sandtray, and Jimmy and I played a game of hide-and-seek in which he would tell me the first thing he saw, the next thing he saw, etc., each time he found an eyeball.

Jimmy really enjoyed hide-and-seek, and, once again, the playful experience of finding the hidden eyes induced a surge of competency chemicals that was released in his brain and absorbed as strength in his body. These chemicals mitigated his approach to sharing visual pictures that he had previously kept to himself. Most of these images lined up with his mom's account of the trauma, but at one point Jimmy shared about the moment he peeked over the backseat, and saw a disturbing sight that he had never shared with his mom. The family had been unaware that Jimmy was holding this picture in his head, and they were all relieved when the memory was exposed and could become part of the shared narrative, allowing the parents to hold it with him. As we were ending treatment, Jimmy and his mother came in together to create a "Forward Circle." People often use the phrase "We've come full circle," and sometimes this implies that you are back where you started, but after a process of building coherence, integrating somatic and emotional content, correcting cognitive distortions, and journeying toward healing, families are never right back in the place they were. So these sandtray reflections, often done during the termination phase of treatment, are meant to honor the journey toward healing while moving forward to the next chapter of the family's story.

Figure 9.18 Future Circle Sandtray

Mom and Jimmy were given a circular sandtray, offered a collection of miniatures, and asked to create a tray depicting their journey from the accident to now. The dyad decided to place fencing pieces in the sand, dividing their story into three sections. Jimmy represented himself and his mom with two swords in the middle of the tray. As events swirled around them, they stuck together. The dyad chose a cage to describe their initial response to the accident. Both felt trapped in feelings of guilt, shame, fear, and sadness. The next quadrant shows the beginning journey in therapy, sifting through all they were carrying (represented by the trash can) and a sense of trying to stay afloat in a sea of chaos (represented by the lifesaver). The last quadrant has several symbols representing growth moments (the flowering vine, the treasure chest). While the image below is an approximate recreation of the original tray, the two black grocery carts had been used by both mom and Jimmy and became important symbols, representing for them the work they had done to understand what feelings and responsibilities belonged to each of them (in terms of the car accident) and the permissions they had learned to give each other for having differences both in how they remember the event and how they move forward in healing (see Figure 9.18).

The family felt this new ability to honor each other's experiences and perceptions while maintaining their own truth would be a valuable skill in managing whatever life brought them in the next season. These creations of Forward

Circle sandtrays encourage shared storytelling and shared story holding while offering left/right hemisphere integration in a way that talk therapy alone would not. They also paint a picture of how the dyad wants to move forward in the wake of trauma recovery.

Conclusion

Narrative Nuance is really the heart of this text. My hope in this chapter, and in all the preceding chapters, is to applaud the children and families in our care for the myriad ways in which they titrate and allow us to titrate the approach to hard things in therapy. There are as many ways for a child to express their pain, confusion, joy, or love as there are stars in the sky. The trauma narrative examples in this chapter have detailed how the Play Therapist's Palette and the various mitigators offered are harnessed by the client system and supported by the therapist. As we remain present with our families and ask ourselves regularly what the client needs right now, being willing to flex ourselves to meet the therapeutic need, my hope is that we will each continue to have the great privilege of participating in the healing of traumatized children and families.

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Note: Page numbers in *italics* indicate a figure.